

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2014
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 11, 12, 13, 14, and 15, 2014.</p> <p>Facility number: 000346 Provider number: 155543 AIM number: 100288320</p> <p>Survey team: Jason Mench, RN, TC Kim Davis, RN Karen Koeberlein, RN Angela Selleck, RN, May 11, 12, 13, and 15, 2014.</p> <p>Census bed type: SNF/NF: 28 Total: 28</p> <p>Census payor type: Medicare: 0 Medicaid: 28 Total: 28</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000		
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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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F000223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure 2 residents were free from verbal abuse (Residents #20 and #11) and 1 resident was free from seclusion (Resident #20) for 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>1a. The clinical record of Resident #20 was reviewed on 5/13/14 at 9:50 a.m. The record indicated the resident's diagnoses included, but were not limited to Down's Syndrome, dementia with behavioral disturbances, Alzheimer's disease, convulsions, and general anxiety disorder.</p> <p>A nurse note, dated 3/20/14 at 12:20 a.m., indicated, "Res [resident] resting in bed. Res resists care. Does not ambulate. Speech limited. Writer witnessed staff walking by room. Res</p>	F000223	<p>This Plan of Correction constitutes the written allegation of 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 requirements established by state and federal law. Hickory Creek at Huntington desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on <u>F223</u> It is the policy of this facility to ensure residents are free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. 1. <u>What corrective action will be accomplished for residents affected?</u> Residents # 11 and # 20 remain free of verbal abuse. The Social Service Director has met with both residents; neither resident could recall the incident from 3/19/14.</p>	06/05/2014

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	<p>yelled out and staff member mocked resident back. Writer then went down to resident's room. Res was sitting up in w/c [wheelchair] next to door. Writer then notified DON [Director of Nursing], Administrator, doctor."</p> <p>The "Indiana State Department of Health Division of Long Term Care Incident Report Form" was presented by the administrator on 5/13/14 at 10:30 a.m. The form indicated, "...Incident Date: 3-19-2014. Incident Time: 6:30 pm...Immediate Action Taken: (name of staff) was suspended. Physician, Responsible Parties, Administrator, and Director of Nursing notified. Investigation initiated. Preventative measures taken: (names of residents) were placed on 15 minute checks. Social Service Director will follow up with both residents. Both residents have appointments with Psychologist...".</p> <p>"The Follow Up" report for the state agency was completed by the Administrator on 3/27/14. This report indicated the staff member was terminated.</p> <p>The Administrator was interviewed on 5/14/14 at 10:10 a.m. During the interview the Administrator indicated the incident did happen on 3/19/14 at 6:30</p>		<p>Resident #11 has received visits from the facility psychologist on 4/7/14 and 5/5/14. Resident #20 will receive a visit from the facility psychologist on June 2, 2014. Resident #20 could not recall nor could she state how she was feeling when interviewed by the Social Service Director on 4/27/14 following the reported incident of seclusion. 2. <u>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> Employees involved in reportable incidents on 3/19/14 and 4/27/14 were immediately suspended and eventually terminated. The Administrator conducted a viewing of the CMS Hand in Hand inservice on 4-07-2014 and the same inservice will be presented again for all employees on 6-05-2014. The inservice will also include review of the facility abuse policy.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> All employees will be re-educated on the facility abuse policy which will include a showing of the CMS Hand in Hand DVD. The facility Guardian Angel program will be updated to include specific questions for each resident related to verbal,sexual, physical mental abuse and corporal punishment and involuntary seclusion. The department managers will complete Guardian Angel rounds</p>	

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	<p>p.m. and the nurse had notified him immediately. The Administrator indicated upon notification, he came into the facility, suspended the staff member, and began his investigation of the incident.</p> <p>1b. The clinical record of Resident #11 was reviewed on 5/14/14 at 8:15 a.m. The record indicated the resident's diagnoses included but were not limited to anxiety, mild mental retardation, and depression.</p> <p>A nurse note, dated 3/20/14 at 8:00 a.m., indicated " CNA [certified nursing assistant] reported seeing staff member mocking Res [resident] as she walked by res room. Notified DON [Director of Nursing], Admin [Administrator] and doctor."</p> <p>The "Indiana State Department of Health Division of Long Term Care Incident Report Form" was presented by the administrator on 5/13/14 at 10:30 a.m. The form indicated, "...Incident Date: 3-19-2014. Incident Time: 6:30 pm...Immediate Action Taken: (name of staff) was suspended. Physician, Responsible Parties, Administrator, and Director of Nursing notified. Investigation initiated. Preventative measures taken: (names of residents)</p>		<p>three times a week for thirty days and then weekly on an ongoing basis. Results of the Guardian Angel rounds are forwarded to the Administrator and identified concerns addressed immediately. Concerns are then forwarded to the QA&A committee for further review. 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> Results of the Guardian Angel rounds will be forwarded to the QA&A committee for further review by the Administrator. After 90 days and when 100% compliance is obtained, further monitoring will be completed as recommended by the QA&A committee, however, any allegations of resident abuse or neglect will continue to be brought to the next scheduled QA&A committee meeting for review and recommendation on an ongoing basis.</p>	

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F000226 SS=D	<p>were placed on 15 minute checks. Social Service Director will follow up with both residents. Both residents have appointments with Psychologist...".</p> <p>The "Follow Up" report for the state agency was completed by the Administrator on 3/27/14. This report indicated the staff member was terminated.</p> <p>The Administrator was interviewed on 5/14/14 at 10:10 a.m. During the interview the Administrator indicated the incident did happen on 3/19/14 at 6:30 p.m. He indicated the nurse did notify him immediately. The Administrator indicated upon notification, he came into the facility, suspended the staff member, and began his investigation of the incident.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to follow their policy and ensure 2 residents were free from verbal abuse (Residents #20 and #11) and 1 resident was free from seclusion (Resident #20) for 3 residents reviewed</p>	F000226	<p><u>F226</u> It is the policy of this facility to ensure residents are free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. 1. <u>What corrective action will be accomplished for</u></p>	06/05/2014

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	<p>for abuse.</p> <p>Findings include:</p> <p>1a. The clinical record of Resident #20 was reviewed on 5/13/14 at 9:50 a.m. The record indicated the resident's diagnoses included, but were not limited to Down's Syndrome, dementia with behavioral disturbances, Alzheimer's disease, convulsions, and general anxiety disorder.</p> <p>A nurse note, dated 3/20/14 at 12:20 a.m., indicated, "Res [resident] resting in bed. Res resists care. Does not ambulate. Speech limited. Writer witnessed staff walking by room. Res yelled out and staff member mocked resident back. Writer then went down to resident's room. Res was sitting up in w/c [wheelchair] next to door. Writer then notified DON [Director of Nursing], Administrator, doctor."</p> <p>The "Indiana State Department of Health Division of Long Term Care Incident Report Form" was presented by the administrator on 5/13/14 at 10:30 a.m. The form indicated, "...Incident Date: 3-19-2014. Incident Time: 6:30 pm...Immediate Action Taken: (name of staff) was suspended. Physician, Responsible Parties, Administrator, and</p>		<p><u>residents affected?</u> Residents # 11 and # 20 remain free of verbal abuse. The Social Service Director has met with both residents; neither resident could recall the incident from 3/19/14. Resident #11 has received visits from the facility psychologist on 4/7/14 and 5/5/14. Resident #20 will receive a visit from the facility psychologist on June 2, 2014. Resident #20 could not recall nor could she state how she was feeling when interviewed by the Social Service Director on 4/27/14 following the reported incident of seclusion. 2. <u>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> Employees involved in reportable incidents on 3/19/14 and 4/27/14 were immediately suspended and eventually terminated. The Administrator conducted a viewing of the CMS Hand in Hand inservice on 4-07-2014 and the same inservice will be presented again for all employees on 6-05-2014. The inservice will also include review of the facility abuse policy.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> All employees will be re-educated on the facility abuse policy which will include a showing of the CMS Hand in Hand DVD. The facility Guardian Angel program will be updated to include specific questions for</p>				

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	<p>Director of Nursing notified. Investigation initiated. Preventative measures taken: (names of residents) were placed on 15 minute checks. Social Service Director will follow up with both residents. Both residents have appointments with Psychologist...".</p> <p>"The Follow Up" report for the state agency was completed by the Administrator on 3/27/14. This report indicated the staff member was terminated.</p> <p>The Administrator was interviewed on 5/14/14 at 10:10 a.m. During the interview the Administrator indicated the incident did happen on 3/19/14 at 6:30 p.m. and the nurse had notified him immediately. The Administrator indicated upon notification, he came into the facility, suspended the staff member, and began his investigation of the incident.</p> <p>1b. The clinical record of Resident #11 was reviewed on 5/14/14 at 8:15 a.m. The record indicated the resident's diagnoses included but were not limited to anxiety, mild mental retardation, and depression.</p> <p>A nurse note, dated 3/20/14 at 8:00 a.m., indicated " CNA [certified nursing</p>		<p>each resident related to verbal,sexual, physical mental abuse and corporal punishment and involuntary seclusion. The department managers will complete Guardian Angel rounds three times a week for thirty days and then weekly on an ongoing basis. Results of the Guardian Angel rounds are forwarded to the Administrator and identified concerns addressed immediately. Concerns are then forwarded to the QA&A committee for further review. 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> Results of the Guardian Angel rounds will be forwarded to the QA&A committee for further review by the Administrator. After 90 days and when 100% compliance is obtained, further monitoring will be completed as recommended by the QA&A committee, however,any allegations of resident abuse or neglect will continue to be brought to the next scheduled QA&A committee meeting for review and recommendation on an ongoing basis.</p>		

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	<p>assistant] reported seeing staff member mocking Res [resident] as she walked by res room. Notified DON [Director of Nursing], Admin [Administrator] and doctor."</p> <p>The "Indiana State Department of Health Division of Long Term Care Incident Report Form" was presented by the administrator on 5/13/14 at 10:30 a.m. The form indicated, "...Incident Date: 3-19-2014. Incident Time: 6:30 pm...Immediate Action Taken: (name of staff) was suspended. Physician, Responsible Parties, Administrator, and Director of Nursing notified. Investigation initiated. Preventative measures taken: (names of residents) were placed on 15 minute checks. Social Service Director will follow up with both residents. Both residents have appointments with Psychologist...".</p> <p>The "Follow Up" report for the state agency was completed by the Administrator on 3/27/14. This report indicated the staff member was terminated.</p> <p>The Administrator was interviewed on 5/14/14 at 10:10 a.m. During the interview the Administrator indicated the incident did happen on 3/19/14 at 6:30 p.m. He indicated the nurse did notify</p>			

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	<p>him immediately. The Administrator indicated upon notification, he came into the facility, suspended the staff member, and began his investigation of the incident.</p> <p>2. The clinical record of Resident #20 was reviewed on 5/13/14 at 9:50 a.m. The record indicated the resident's diagnoses included, but were not limited to Down's Syndrome, dementia with behavioral disturbances, Alzheimer's disease, convulsions, and general anxiety disorder.</p> <p>The Administrator and Regional Director of Operations were interviewed on 5/13/14, at 11:00 a.m. The Administrator indicated on 4/27/14, the staff nurse approached two Certified Nursing Assistants' (CNA) and told them that he placed resident #20 outside because she was yelling. The CNA's immediately brought the resident back inside. The Administrator indicated that upon termination of the staff nurse, the staff nurse admitted in writing that this happened, but that he intended no harm, or punishment to the resident.</p> <p>Review of the nursing notes show no information charted for this incident.</p> <p>The "Indiana State Department of Health</p>						

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	<p>Division of Long Term Care Incident Report Form" was presented by the Administrator on 5/13/14, at 2:30 p.m. The form indicated, "...Incident Date: 4/27/14 Incident time: 3:45 p.m...Immediate Action Taken: (name of staff) was suspended. Physician, Director of Nursing, Administrator, and responsible parties notified. Preventative measures taken: (staff members name) was suspended pending the results of the investigation. Administrator notified on 4/29/2014 of incident, the two C.N.A's involved were disciplined by the Administrator for failing to report incident immediately. (Staff members name) has not been scheduled to work since the incident occurred..."</p> <p>The "Follow Up Report" was completed by the Administrator on 5/2/14. This indicated the staff member was terminated.</p> <p>The Administrator and Regional Director of Operations were interviewed on 5/13/14, at 11:00 a.m. During the interview, the Administrator indicated the incident did happen on 4/27/14 at 3:45 p.m. He indicated the CNA's did not notify him immediately. The Administrator indicated as soon as he was notified, he called and suspended the staff member, the two CNA's were</p>			

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	<p>disciplined for not immediately reporting the allegation of abuse and he began his investigation of the incident.</p> <p>3. A policy provided by the Administrator on 5/13/14 at 11:15 a.m. and dated 12/1999 indicated:</p> <p>"...Verbal Abuse: Defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to, the following: Threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again..."</p> <p>"...INVOLUNTARY SECLUSION: Separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative..."</p> <p>3.1-28(a)</p>			

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F000282 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 record review and interview, the facility failed to ensure Physician orders were followed for the reporting of weight loss for 1 of 5 residents reviewed for unnecessary medications. (Resident #11)</p> <p>Findings include:</p> <p>The clinical record for Resident #11 was reviewed on 5/13/14 at 8:30 a.m., the record indicated the Resident's diagnoses included, but were not limited to, mild mental retardation, peripheral vascular disease and hypertension.</p> <p>During review of Physician orders, dated 4/30/14, Resident #11 was to have a weekly weight completed every Sunday and to call the Physician for a weight change of 5 pounds. This order was present since Resident #11's admission on 1/27/14.</p> <p>The "MONTHLY / ANNUAL VITAL SIGN AND WEIGHT RECORD" for</p>	F000282	<p><u>F282</u> It is the policy of this facility to monitor and report to the attending physician all resident condition changes including weight changes and to follow physician orders specific to each resident.</p> <p><u>1.What corrective action will be accomplished for residents affected?</u></p> <p>Resident #11 is being monitored by the nutrition at risk committee which meets weekly. He was weighed on 5/18/14 and he had gained 0.3 pounds. Weekly weights for resident#11 will continue to be completed on Sunday as ordered by the physician and any weight change of 5 pound or greater will be called to the physician. The Director of Nursing or designee will review physician orders at least five days a week at the morning clinical meeting which is an established, ongoing, process.</p> <p><u>1.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>	06/05/2014

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	<p>Resident #11 indicated the weight for the week of 2/9/14 was 213.8 pounds. The weight from the week before, with a date of 2/1/14 was charted as 221.3 pounds. This was a weight loss of 7.5 pounds.</p> <p>The weight charted for 4/18/14 was 212.3 pounds and the weight from the week before, dated 4/11/14, was charted as 217.5. This was a weight loss of 5.2 pounds. No indication was found in the clinical chart of the Physician being notified of these weight losses.</p> <p>During an interview with the Director of Nursing (DoN) conducted on 5/13/14 at 2:40 p.m., the DoN indicated she could not find any documentation of the Physician notification of these weight losses.</p> <p>A policy titled "Weight Monitoring," dated March of 2000, provided by the MDS Coordinator on 5/14/14 at 2:00 p.m. indicated:</p> <p>"...4. The licensed nurse will notify the physician, family, and dietary manager of any significant weight changes...."</p> <p>3.1-35 (a)</p>		<p>All residents are weighed monthly and those residents who reflect a 5% weight change will be reweighed within 24 hours. Once a weight change is confirmed, the charge nurse will notify the physician, family and dietary manager. The Director of Nursing or designee will audit all new physician orders at least five days a week for 30 days, three days a week for 30 days and then weekly for 30 days to ensure all physician orders are transcribed appropriately.</p> <p><u>1.What measures will be put into place to ensure this practice does not recur?</u></p> <p>The Director of Nursing will audit all new physician orders at least five days a week for 30 days, three days a week for 30 days and then weekly for thirty days to ensure all physician orders have been correctly transcribed. A nurse who fails to follow facility policy with order transcription will be re-educated on that policy. If further incidents occur with that same nurse, disciplinary action will be completed following facility policy. The Director of Nursing will audit weekly weights to ensure notification of weight changes are completed following facility policy. Results of both audits will be forwarded to the Administrator.</p> <p><u>1.What measures will be put into place to ensure this practice does not recur?</u></p> <p>Results of the Director of Nursing</p>		

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F000502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <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 record review and interview, the facility failed to ensure physician ordered lab tests were completed for 2 of 5 residents reviewed for lab tests. (Residents #13 and #6)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #13 was reviewed on 5/13/14 at 2:30 p.m. The record indicated the resident's diagnosis included but was not limited to, Hypothyroidism (thyroid disease).</p> <p>The current physician orders, signed on 4/30/14, included an order dated 8/18/13 for a yearly TSH (Thyroid Stimulating Hormone) in February.</p>	F000502	<p>audits will be reviewed by the QA&A committee for 90 days and until 100% compliance is obtained. The process of reviewing resident weights and physician telephone orders will continue on an ongoing basis as per facility policy, even when the QA&A committee has determined that the written audits are no longer needed.</p> <p><u>F502</u></p> <p><u>1.What corrective action will be accomplished for residents affected?</u></p> <p>The physician of residents#6 and #13 were notified of the missed lab of each resident on 5-13-2014. The labs were drawn on 5-13-2014 and the results of both were within normal limits.</p> <p><u>1.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>The DON and MDS Coordinator have reviewed the lab draw status of all other residents with routinely ordered labs. No other residents were identified as having missed labs.</p> <p><u>1.What measures will be put into place to ensure this practice does not recur?</u></p>	06/05/2014	

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	<p>The TSH was completed on 2/7/14. The tests results were sent to the doctor. An order dated 2/7/14 indicated "Increase Synthroid to 100. TSH in 6 weeks".</p> <p>Further review of the resident's clinical record indicated no follow up TSH was completed.</p> <p>The interim DoN (Director of Nursing) was interviewed on 5/14/14 at 10:35 a.m. During the interview, the DoN indicated the lab test ordered by the physician on 2/7/14 was not completed.</p>		<p>The Director of Nursing and MDS Coordinator reviewed routine lab orders of all residents utilizing the most current physician order sheet. An inservice will be presented by the Director of Nursing to all licensed nurses to educate on the use of the facility lab tracking form (HC-N-79) on 6-05-2014. Beginning with the June 2014 rewrites which are completed on May 31, 2014, all routine labs scheduled to be drawn in June 2014 will be added to the facility lab tracking form (HC-N-79). This process will be completed on an ongoing basis. When the lab is drawn, the charge nurse on duty at the time of the lab draw will initial the form indicating the lab has been drawn. The charge nurse who receives the lab draw results will then initial that results have been received and the physician notified. A nurse who fails to follow the policy/procedure will be re-educated and receive appropriate disciplinary action. The Director of Nursing will audit the lab tracking form weekly for 90 days and report findings to the Administrator. If any missed labs are identified, the physician will be immediately notified and the lab drawn.</p> <p><u>1. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the Director of Nursing audits will be reviewed by the</p>	

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to develop and implement an appropriate plan of action</p>	F000520	<p>QA&A committee monthly for 90 days to ensure 100% compliance. Even after the written audits are no longer required by the QA&A committee, the lab tracking process will continue on an ongoing basis and the DON will review the lab tracking log at least weekly to make sure that labs are occurring as ordered.</p> <p><u>F520</u> It is the policy of this facility to maintain a quality assessment and assurance committee to develop and implement plans of</p>	06/05/2014

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	<p>to ensure resident lab testing was completed in a timely manner, and according to physician orders. (Resident #6 and Resident #13)</p> <p>Findings include:</p> <p>During an interview on 5/15/14, at 11:15 a.m., the facility Administrator and Regional Director of Operations, were queried regarding QAA (Quality Assurance and Assessment) and the identified concern of the annual survey regarding laboratory testing.</p> <p>1. Ensuring residents received lab testing in a timely manner and according to physician orders.</p> <p>The Administrator and Regional Director of Operations indicated these concerns had not been included in the facility QAA program, and there had been no plan of action in place until these concerns were identified during the State Licensure and Recertification Survey.</p> <p>3.1-52(b)(2)</p>		<p>action to address identified concerns and issues within the facility. 1. <u>What corrective action will be done by the facility?</u> An action plan was created by the interdisciplinary team in conjunction with the QA&A Committee on 5-27-2014 that will monitor the status of lab draws for a 90 day period of time with at least weekly review by the Director of Nursing. On 6-05-2014 the Director of Nursing will in-service the nursing staff on the facility policy for proper completion and implementation of the lab tracking form (HC-N-79). 2. <u>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> No other residents were found to be affected by this practice. The Director of Nursing will audit the lab tracking form (HC-N-79) weekly for 90 days and report findings to the Administrator. If any missed labs are identified, the physician will be immediately notified and the lab will be drawn. Once the lab tests are done, the DON will review the facility policy for laboratory tests and tracking of those tests with the nurse(s) involved – progressive disciplinary action will be done for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The interdisciplinary team has created an Action Plan</p>	

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			<p>on 5-27-2014 that will monitor the status of lab draws for a 90 day period of time and will be reviewed weekly by the Director of Nursing. The Action Plan and results of the plan will be brought to the monthly QA&A committee meeting for review and further recommendations, if any. The Director of Nursing will audit the lab tracking form (HC-N-79) weekly for 90 days and report findings, including identification of concerns or issues, to the Administrator. If any missed labs are identified, the physician will be immediately notified and the lab will be drawn. 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 DON will bring the results of her audits to the monthly QA&A committee meeting for review and recommendations for further process improvement. Recommendations made by the QA&A Committee will be followed through by the DON or other person designated by the Committee, and the results of those recommendations will be brought back to the next monthly QA&A Committee meeting for further review and discussion. At the end of 90 days and when the audits demonstrate 100% compliance, the QA&A Committee may decide to stop the written audits; however, the DON's monitoring of the lab tests</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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			and tracking will continue on an ongoing basis.		