

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N LINCOLN ST GREENSBURG, IN 47240
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00130309.</p> <p>Complaint IN00130309 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 19, 20, 21, 24, 25, and 26, 2013</p> <p>Facility number: 000244 Provider number: 155353 AIM number: 100288790</p> <p>Survey team: Barbara Gray RN TC Sharon Lasher RN (June 19, 20, 21, 24, and 25, 2013) Leslie Parrett RN Angel Tomlinson RN</p> <p>Census bed type: SNF/NF: 26 Total: 26</p> <p>Census payor type: Medicare: 1 Medicaid: 18 Other: 7 Total: 26</p>	F000000		

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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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 6/27/13 by Suzanne Williams, RN</p>				

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure Social Services were provided to address increased depression, for 1 of 1 resident reviewed for depression in the stage 2 sample of 19 residents. (Resident #16)</p> <p>Findings include:</p> <p>Resident #16's record was reviewed on 6/21/13 at 1:15 p.m. Diagnoses included, but were not limited to, anxiety and depression.</p> <p>Resident #16's annual, MDS (Minimum Data Set) assessment, dated 4/4/13, indicated the resident's BIMS (Brief Interview for Mental Status) was a score of 8, with a score of 8-12 indicating moderate cognitive impairment. The MDS also indicated a depression scale of 20, indicating severe depression.</p> <p>Resident #16's quarterly, MDS assessment, dated 1/10/13, indicated Resident #16's depression scale of 11, indicating moderate depression.</p>	F000250	<p>F 250 S/S D PROVISION OF MEDICALLY RELATED SOCIAL SERVICES It is the policy of this facility to provide Medically Related Social Services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident including provision of social services for residents with increased depression. <u>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> 1. Resident #16 had a new BIMS=11 and a PHQ9 =8 completed on 6/25/2013 and again on 6-26-13 BIMS=11and PHQ9=5. Resident's physician and psychologist were notified of her fluctuation in BIMS and PHQ9 scores. Medications have been adjusted. Psychologist will see resident on the next scheduled visit. <u>2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?</u> 2. A depression/PHQ9 audit was completed on all residents. This was completed on 7-9-13. No other residents were found to be affected. However, if</p>	07/12/2013

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	<p>Resident #16's care plan, dated 8/24/10, and updated 4/11/13, indicated "Problem, I become tearful at times and cry, I do have a diagnoses of depression, I also become anxious and don't want to wait on help. Goal, I will be free of signs and symptoms of depression and no declining daily activities of changes in sleep patterns, with target date 7/11/13. Interventions, provide an emotional outlet for me to express feelings, have the psychiatric doctor see me if needed, give me my medication as ordered, provide me assistance as needed and remind me to use the call light."</p> <p>Resident #16's physician's orders, indicated the following: - 12/12/12, trazodone (antidepressant), 100 mg (milligrams), by mouth, at bedtime for insomnia - 1/18/13, Cymbalta (antidepressant), 30 mg, by mouth, daily</p> <p>During an interview on 6/24/13 at 9:00 a.m., Resident #16 indicated "Yes, I am depressed. I worked all my life and also took care of my children and now I am here alone. I am just here and don't feel like even going out of my room."</p>		<p>a resident is found to be experiencing depression in the future, the SSD and the DON will make sure that the physician and psychologist are notified for any new or revised interventions. The resident's care plan and CNA assignment sheet will be reviewed by the interdisciplinary team and updated to include the new interventions. A behavior log will be initiated so that staff can document the resident's behavior and response to the interventions. Attachment D <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> 3. Social Services was re-educated on identifying the signs and symptoms of increased /decreased depression on 7/11/13 by Emily Moore BSW. Attachment E As indicated in question #2 the DON will bring the results of her review of the 24 hour report, focus charting, and copies of the physician telephone orders to the morning management meeting that occurs at least 5 days a week. The interdisciplinary team, including the SSD, will review the results of the DON's review, including any resident's behavior that is indicative of new or worsening depression. The SSD and DON will follow #2. At the weekly Standards of Care Meeting the PHQ9 scores will be reviewed by the interdisciplinary team, and if</p>				

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	<p>An interview on 6/25/13 at 11:30 a.m., the Social Service Director indicated the psychiatric physician was not notified of Resident #16's increased depression scale. She also indicated she had not spoken to the resident about her increased depression. Social service notes reviewed did not address the resident's increased depression.</p> <p>On 6/25/13 at 12:30 p.m., Resident #16 was observed in her room with her entire lunch tray in front of her; none of the food had been eaten. When interviewed on 6/25/13 at 12:35 p.m., Resident #16 indicated "I don't want to eat anything because I feel down in the dumps."</p> <p>An interview on 6/25/13 at 1:30 p.m., with LPN #1 indicated Resident #16 attends activities once in a while but not often. She also indicated Resident #16 eats in her room and stays in her room most of the time.</p> <p>3.1-34(a)</p>		<p>there is a change of 5 or more points the MD will be notified, with follow up by the DON and SSD as indicated previously. <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> In addition to the morning management meeting reviews and the weekly monitoring of the PHQ9 scores, the SSD will bring the results of any follow up needed for residents identified as having new or worsening depression to the monthly QA&A Committee meeting for further review and recommendation. The SSD will be responsible for follow up on any recommendations made by the committee and will report the results of those recommendations to the next monthly QA meeting. The QA&A Committee may decide to forgo the SSD's reporting of residents' depression status after 60 days, if 100% compliance has been achieved. However, even when the reporting requirement has been stopped, the process of interdisciplinary team review at the morning management meetings and weekly Standard of Care meetings will continue on an ongoing basis. Date of Compliance: 7/12/2013</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 interview and record review, the facility failed to obtain a laboratory tests of Dilantin (anticonvulsant) and Phenobarbital (anticonvulsant) levels timely for 1 of 10 residents reviewed for medications. (Resident #21)</p> <p>Findings include:</p> <p>The record of Resident #21 was reviewed on 6/21/13 at 1:45 p.m. Resident #21's diagnoses included, but were not limited to, depression, insomnia and seizures.</p> <p>Resident #21's MDS (Minimum Data Set) assessment indicated the resident's BIMS (Brief Interview for Mental Status) was a score of 14, with a score of 13-15 indicating cognition intact.</p> <p>Resident #21's physician's orders, dated 4/7/11, indicated "Dilantin 100 mg (milligrams), by mouth, 3 times a day" and "Phenobarbital 32.4 mg, by mouth, 3 times a day."</p> <p>Resident #21's physician's order,</p>	F000502	<p>F-502 S/S D</p> <p>It is the policy of this facility to provide or obtain laboratory services to meet the needs of our residents.</p> <p><u>What corrective action will be done by the facility?</u></p> <p>1. Resident # 21 had a Dilantin and a Phenobarbital level completed on 6/29/2013 and 7/9/2013. Both results were in normal range. <u>Attachment A</u></p> <p>All licensed staff was in-serviced on lab Policy and Procedures 7/10/2013. Attachment A</p> <p><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></p> <p>2. A lab audit was completed on all residents who require routine lab services to ensure timely lab services. All residents are current with their lab orders and all physicians have been notified of any abnormal lab results. Attachment B</p> <p>If the DON should find that any lab</p>	07/12/2013			

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	<p>dated 6/16/11, indicated Dilantin and Phenobarbital levels every 6 months.</p> <p>Resident #21's laboratory report, dated 7/4/12 indicated "Dilantin, 11, normal range 10-20 and "Phenobarbital, 14, normal range 15-40."</p> <p>An interview on 6/24/13 at 11:13 with the DON (Director of Nursing), indicated Resident #21 should have had a Dilantin and Phenobarbital level in January, 2013 but the last level was on 7/4/12. She also indicated she went into the system to see if a report was generated for the lab to be drawn but a report was not generated for the test.</p> <p>3.1-49(a)</p>		<p>orders have not been followed through or done as ordered by the physician in the future, she will make sure that the Dr. is notified and that the laboratory tests are done as ordered. Once that is taken care of, the DON will re-train the staff involved on the facility policy regarding the timeliness of laboratory testing according to the physicians' orders. The DON may also follow up with progressive disciplinary action for instances of continued noncompliance.</p> <p><u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>3. The Director of Nursing/designee will monitor all routine lab services utilizing the lab tracking log on a daily basis at least 5 times a week for 4 weeks then weekly to ensure timely services. Attachment C</p> <p>The DON will also bring the lab orders and test results to the morning management meeting which occurs at least 5 days a week for review by the interdisciplinary team.</p> <p>If any issues are noted, the DON will follow up as indicated in question #2.</p> <p><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA</u></p>		

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			<p><u>will be put into place?</u></p> <p>4. The Director of Nursing will bring the results of the lab audit to the interdisciplinary team meeting 5 days a week, the weekly Standards of Care meeting, and the monthly QA&A meeting for review and recommendations. The Committee will review and monitor progress of lab auditing for the next 60 days. After 60 days the QA Committee may decide to stop the requirement for reporting results if 100% compliance has been reported. However, the DON or designee will continue to monitor the lab tracking log at least weekly on an ongoing basis.</p> <p>Date of Compliance: 7/12/2013</p>	