

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/23/2012
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
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F0000	<p>This visit was for Recertification and State Licensure Survey.</p> <p>Survey dates: February 20, 21, 22, 23, 2012</p> <p>Facility number: 000475 Provider number: 155406 AIM number: 100290540</p> <p>Survey team: Tim Long, RN-TC Julie Wagoner, RN</p> <p>Census bed type: SNF: 34 Total: 34</p> <p>Census Payor type: Medicare: 3 Medicaid: 28 Other: 3 Total: 34</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 29, 2012 by Bev Faulkner, RN</p>	F0000	<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 Peru desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on March 9, 2012.</p>	

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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F0309 SS=D	<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 record review and interviews, the facility failed to ensure an assessment of an eye infection was completed and documented for 1 of 6 residents reviewed for infections in a sample of 10. (Resident #31)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #31 was reviewed on 02/21/12 at 11:00 A.M. A physician's order, dated 01/24/12, indicated an order for antibiotic eye drops to both of the resident's eyes every 2 hours while awake for 2 days.</p> <p>Nursing notes, dated 01/24/12 - 01/26/12 did not document any assessment of the resident's eyes or reason for the antibiotic eye drops.</p> <p>A physician's progress note, dated 01/24/12, indicated the resident was diagnosed with "conjunctivitis" The physician did not provide a description of the resident's eye condition.</p>	F0309	<p><b>F309</b> It is the policy of this facility to ensure residents receiving antibiotic treatment will be appropriately assessed. <u>1. What corrective action will be accomplished for residents affected?</u>Resident #31 has been successfully treated for conjunctivitis. On March 9, 2012 the Director of Nursing will in-service licensed nurses on the importance of timely assessing and reporting to the physician when a resident has signs/symptoms of infection. The in-service will also address the importance of documentation of findings and notifications. <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> There have been no other residents identified as being affected. However, if the DON finds that there are orders for antibiotic use for any resident without appropriate documentation, she will re-train the nurse(s) involved on the facility policy regarding assessment and documentation</p>	03/09/2012

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	Interview with the DON on 02/23/12 at 9:00 A.M., indicated she could not locate any further documentation regarding the resident's eye infection.  3.1-37(a)		for antibiotic use. Written counseling and progressive disciplinary action will be utilized for instances of continued noncompliance. <u>3. What measures will be put into place to ensure this practice does not recur?</u> The DON will review the focus charting, 24 hour report and new resident orders at least 5 days a week; this is to be completed on an ongoing basis. The DON will follow up with each antibiotic order to ensure proper documentation and assessment in the resident's medical record. If she identifies any issues, she will address them as indicated in question #2. <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> Findings from the Director of Nursing audits will be reviewed by the Administrator and then forwarded to the QA&A committee for further review at the monthly meeting. After 60 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&A committee. <u>Date of compliance:</u> March 9, 2012		

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to provide proper treatment for a pressure sore for 1 of 4 residents reviewed for pressure sores in a sample of 10. Resident #8</p> <p>Findings include:</p> <p>Resident # 8 clinical record was reviewed on 2/22/12 at 1:55 P.M. The record indicated the resident had a Stage 2 pressure sore on his left heel.</p> <p>During observation of wound treatment to the left heel pressure sore on 2/23/12 at 8:20 A.M., LPN #1 removed the resident's old dressing and applied treatment of Bactroban ointment, covered the wound with gauze and wrapped the wound with Kerlex. LPN #1 was not observed cleansing the wound after removing the old dressing.</p>	F0314	<p><b>F314</b> It is the policy of this facility that residents receive necessary treatment and services as ordered by the physician to promote wound healing. <u>1. What corrective action will be accomplished for residents affected? Resident # 8 continues to show evidence of wound healing. LPN #1 was immediately inserviced on dressing changes and the cleansing of wounds. All other licensed nursing staff will be in-serviced by the Director of Nursing individually and this will be completed by March 9, 2012.</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>The Director of Nursing has clarified all wound treatment orders to ensure the orders include wound cleansing. There have been no other residents identified as being affected by this practice. <u>3. What measures will be put into place to ensure this</u></p>	03/09/2012	

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	An interview with the DN (Director of Nursing) on 2/23/12 at 11:30 A.M., indicated the facility had a standing order to cleanse wounds with "Wound and Skin Cleanser" before applying the new treatment. The DN indicated LPN #1 should have cleansed Resident #8's wound before applying the new treatment on 2/23/12 at 8:20 A.M.  3.1-40(a)(2)		<u>practice does not recur?</u> The Director of Nursing will observe routine dressing changes 5 days a week until all licensed nurses have been checked and competency ensured. Dressing change observations for each nurse will then be completed on a random basis for the 60 days ensuring that each nurse is observed at least once more during that time period. If the DON observes any issues or concerns with the treatment technique, she will re-train the nurse at that time on the facility policy and procedure for dressing changes. <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> Results of Director of Nursing observations will be reviewed by the Administrator and then forwarded to the QA&A. After 60 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&A committee. <u>Date of compliance:</u> March 9, 2012		

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F0502 SS=D	<p>483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY</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 a urinalysis was obtained promptly for 1 of 10 resident reviewed for physician orders in a sample of 10. (Resident #31)</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 02/20/12 between 10:30 - 11:00 A.M., RN #5 indicated Resident #31 had recently been treated for a urinary tract infection.</p> <p>The clinical record for Resident #31 was reviewed on 02/21/12 at 11:00 A.M. A physician's order, dated 02/08/12, indicated an urinalysis with culture and sensitivity was to be completed for Resident #31. There were no nurse's notes regarding the urinalysis until 02/18/12 when an order for an antibiotic was received due to a urinary tract infection.</p> <p>Review of the urinalysis and culture and sensitivity test for Resident #31 indicated the urine was not collected and sent to the</p>	F0502	<p><b>F502</b>It is the policy of this facility to ensure that residents' laboratory services are provided in a timely manner. <u>1. What corrective action will be accomplished for residents affected? Resident #31 labs have been completed with results forwarded to the physician.</u> An in-service for licensed nursing staff is scheduled for March 9, 2012 to review the facility policy on use of the lab tracking form. <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> An audit of the lab tracking form was completed by the Director of Nursing and the Medical Records Designee; no other lab concerns were identified. If any concerns are identified in the future, the DON will make sure that the ordered labs have been completed and the results sent to the physician. She will also retrain and provide written counseling for the nurses involved in the noncompliance. <u>3. What measures will be put into place to ensure this practice does not recur?</u> The DON will review the focus charting, 24 hour report and new physician orders for</p>	03/09/2012			

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	<p>laboratory until 02/16/12, 8 days after the test was ordered by the physician. The test was not completed until 02/18/12.</p> <p>The results of the urinalysis and culture and sensitivity test, completed on 02/18/12, indicated the resident had a urinary tract infection.</p> <p>Interview with the Director of Nursing, on 02/23/12 at 9:30 A.M., indicated she had spoken with the nursing staff and no one could explain the delay in obtaining the urine sample.</p> <p>3.1-49(a)</p>		<p>laboratory services at least 5 days a week on an ongoing basis. She will address any identified concerns as indicated in question #2. <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> Director of Nursing or designee will review lab tracking forms weekly for 60 days, results of the audit will be forwarded to the Administrator for review. Results of the audits will then be forwarded to the QA&amp;A. After 60 days and until when 100% compliance is obtained, further monitoring will be completed as recommended by the QA&amp;A committee. <u>Date of compliance:</u> March 9, 2012</p>		

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure there was complete documentation regarding straight catheterization procedures and a change in condition for 1 of 10 residents reviewed for documentation in a sample of 10. (Resident #31)</p> <p>Finding includes:</p> <p>1. Review of the clinical record for Resident #31 was completed on 02/21/12 at 11:00 A.M. Resident #31 was admitted to the facility on 10/14/11 with diagnoses, including but not limited to, alcohol dementia, chronic seizures, and recent pneumonia.</p> <p>A nursing progress note, dated 12/29/11 at 5:00 P.M., indicated the following: "N.O. (new order) given. get chest xray,</p>	F0514	<p><b>F514</b> It is the policy of this facility to ensure there is complete documentation regarding straight catheterization and any change in condition. <u>1. What corrective action will be accomplished for residents affected?</u> Resident #31 continues to receive straight catheterization for urinary retention following clarified orders to receive straight catheterization every shift. The licensed nurses will continue to notify the physician when a resident experiences a change in condition. They will be inserviced to take care in documenting resident's signs and symptoms when calling the physician for a change in condition. They will also be inserviced to include thorough assessment of the resident's condition. The Director of Nursing will complete an inservice for licensed nurses on March 9, 2012 addressing the</p>	03/09/2012			

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	<p>colect (sic) UA (urinalysis), et give 500 mg Levaquin (an antibiotic) now x1 dose."</p> <p>A subsequent nursing note, dated 12/29/11 at 5:30 P.M., indicated the Levaquin had been given and the xray company had been called regarding the need for a chest xray and the resident's family had been notified of the physician orders.</p> <p>Another nursing note, dated 12/29/11 at 8 P.M., indicated the urine sample had been collected and the xray company had arrived to complete the chest xray.</p> <p>There was no nursing note or nursing assessment documented to explain why the physician had given the orders on 12/29/11 at 5:00 P.M.</p> <p>Nursing notes on 12/29/11 at 9:00 A.M. and 3:45 P.M., indicated the resident's vital signs and oxygen saturation levels had been assessed and a brief description of the resident's status, including respiratory status, had been documented, but there was no abnormal issues documented for Resident #31.</p> <p>Nursing notes, on 12/30/11 at 5:10 A.M. and at 1:40 P.M., again documented the resident's vital signs, oxygen saturation</p>		<p>importance of documentation of completed treatments and complete and thorough documentation related to resident's change in conditions. <u>2.</u> <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 are receiving routine straight catheterization. There have been no residents identified as being affected by this practice. An audit of all resident's nurse's notes was completed by the Director of Nursing; no other changes in conditions were identified without completed documentation. If any concerns are identified in the future, the DON will make sure that the change of conditions are documented with thorough documentation as well as notifying the physician. She will also retrain and provide written counseling for the nurses involved in the noncompliance <u>3.</u> <u>What measures will be put into place to ensure this practice does not recur?</u> The DON will review the Treatment Administration Record 3 days a week for 30 days and then weekly for 30 days. Identified concerns will be addressed with the individual nurse, who will be retrained and corrective action will be implemented following facility policy. The DON will review the focus charting, 24 hour report and new resident orders at least 5</p>				

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	<p>levels, and brief assessment of the resident's condition, but there were no abnormal issues assessed and/or documented for Resident #31.</p> <p>Interview with the Director of Nursing, on 02/23/12 at 8:50 A.M., indicated the therapy department had documented and the resident had been ill the previous two days, very lethargic and unable to follow instructions. The DON indicated in addition, the 24 hour report sheet indicated on 12/30/11, the resident was receiving Levaquin and had been "spiking temperatures." The weekly summary note for Resident #31, completed on 12/28/11 indicated the resident's breath sounds displayed "cough" and "congestion"; however, the daily documentation in nursing progress notes, which included a respiratory assessment did not mention the coughing or congestion. The only documentation in the nursing notes of an elevated temperature was on 12/26/11 at 6:00 P.M., when the resident was given Tylenol for a temperature of 100.4 degrees Fahrenheit. A subsequent nursing note, completed on 12/26/11 at 9:00 P.M., indicated the resident's temperature had decreased to 98.6 degrees Fahrenheit.</p> <p>2. During the initial tour of the facility, conducted on 02/20/12 between 10:30</p>		<p>days a week; this is to be completed on an ongoing basis. The DON or designee will follow up with any changes of conditions to ensure proper documentation and assessment is in the resident's medical record. If she identifies any issues, she will address them as indicated in question #2. <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> Results of audits completed on the treatment sheets will be reviewed by the Administrator and then forwarded to the QA&amp;A committee for further review. After 60 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&amp;A committee. The DON will audit focused charting on an ongoing basis and bring any concerns to the QA&amp;A committee and the daily stand-up meeting for recommendations for further monitoring. <u>Date of compliance:</u> March 9, 2012</p>		

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	<p>A.M. - 11:00 A.M., RN #5 indicated Resident #31 was confused, incontinent of his bladder, and recently had been treated for a urinary tract infection.</p> <p>The clinical record for Resident #31 was reviewed on 02/21/12 at 11:00 A.M. The resident was admitted to the facility on 10/14/11 with diagnoses, including but not limited to, recent pneumonia, urinary tract infection, and alcohol induced dementia.</p> <p>A physician's order, dated 10/24/11, indicated an order for "In and out cath q (every) shift et PRN (as needed)" Review of the nursing notes for December 2011 and January 2012 indicated daily documentation of either "cath daily and incontinent of urine" or "self cath daily."</p> <p>Interview with RN #5, on 02/21/12 at 2:30 P.M., indicated the resident was straight cathed by nursing staff on a daily basis. The DON indicated there was an order to catheterize the resident once a shift.</p> <p>Review of the December and January treatment records did not contain any specific documentation regarding the straight catheterizations. The October and November treatment records indicated the in and out catheterizations</p>			

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	<p>every shift was signed off by the nurse performing the task, but the amount obtained was not documented on the treatment records. The only documentation available for December, January, and February were contained in the nursing notes, which did not usually indicate the amount obtained, incorrectly repeatedly documented the procedure as performed by the resident as a "self cath," and did not always contain documentation the order was performed on a shift to shift basis.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F9999	<p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD) , administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be record in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 4 of 5 newly hired employees had physical examinations completed prior to starting work. (Employee #2, 3, 4, 5).</p> <p>Findings include:</p>	F9999	<p><b>F9999</b> <u>1. What corrective action will be done by the facility?</u> All current employees have a physical completed and placed in their employee file. <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> There have been no residents affected by this practice; however, if an employee is found to be working without evidence of a physical in his/her file, he/she will be sent home and will not be allowed to continue working until a written physical exam is brought to the Administrator. In addition, the Administrator will address the management staff involved and retrain them on the requirements for a physical examination before beginning employment in the facility. The Administrator will also administer progressive disciplinary action for continued noncompliance. <u>3. What measures will be put into place to ensure that this practice does not occur?</u> The Business Office Manager will audit each new employee's file to make sure that all components are in place, including a physical examination, before the employee reports for orientation. She will then forward the file to the Administrator who will check for the presence of a physical examination. The Administrator will place her initials</p>	03/09/2012			

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	<p>During review of the personnel files for Employees # 2, 3, 4 and 5, completed on 2/22/12 between 4:00 P.M. and 5:00 P.M., the following was noted:</p> <p>Employee #2, with a start date of 12/21/11, did not have a physical examination signed by the physician until 01/9/12</p> <p>Employee #3, with a start date of 10/24/11, did not have a physical examination signed by the physician until 11/4/11.</p> <p>Employee #4, with a start date of 11/1/11, did not have a physical examination dated by the physician.</p> <p>Employee #5, with a start date of 2/17/12, did not have a physical examination signed or dated by the physician.</p> <p>An interview with the Director of Nursing on 2/22/12 at 2:45 P.M., indicated she thought the employee physicals could be done when the facility physician made routine visits.</p>		<p>and date on the general orientation checklist in the top right corner to indicate that a check for physical has been done and that it is in the file. If the Administrator is on vacation or otherwise absent, the manager of the employee's department will initial and date the orientation checklist as indicated above. <u>4. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Business Office Manager will bring the names of new employees, their departments and the date of hire, and the date of the physical examination to the monthly QA committee meeting. The QA will review for completeness and compliance. Any committee recommendations for process improvement will be followed up by the Administrator or designated manager. This will continue on an ongoing basis. <u>Date of compliance:</u> March 9, 2012</p>				