

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2015
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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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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 18, 19, 20, & 21, 2015.</p> <p>Facility number: 000346 Provider number: 155543 AIM number: 100288320</p> <p>Census bed type: SNF/NF: 28 Total: 28</p> <p>Census Payor type: Medicaid: 28 Total: 28</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
F 272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI)</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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	<p>specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 2 MDS (Minimum Data Set) Assessments were coded correctly for 1 resident in regard to contractures of his hands. This deficiency affected 1 of 1 resident reviewed for contractures of the hands (Resident #19).</p> <p>Findings include:</p>	F 272	<p>It is the policy that the facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>1. <u>What corrective action will be done by the facility?</u> The MDS assessments were updated to properly reflect the contractures for resident #19.</p> <p>2. <u>How will the facility identify other residents having</u></p>	06/05/2015

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	<p>Resident #19 was observed on 5/20/15 at 10:00 A.M. and on 5/21/15 at 8:30 A.M. with rolled up wash clothes in both of his hands due to contractures of both hands.</p> <p>Review of the clinical record for Resident #19 on 5/19/15 at 2:15 P.M., indicated diagnoses included, but were not limited to, cerebral vascular accident and diabetes mellitus type 2.</p> <p>Interview with the Director Of Nursing (DON) on 5/18/15 at 12:09 P.M. indicated Resident #19 had contractures in both of his hands.</p> <p>Two MDS Assessment sections for Functional limitation in Range of Motion dated 2/5/15 and 4/30/15 included documentation for Resident #19 indicating he did not have any impairment in either of his hands.</p> <p>The Occupational therapy note dated on 4/21/15 indicated Resident #19 had contractures in both of his hands</p> <p>Interview on 05/21/2015 10:48 A.M. with the MDS coordinator indicated both MDS's dated 2/5/15 and 4/30/15 were inaccurate. The MDS Coordinator further indicated she should have coded both of the MDS's Assessment in the section limitation in Range of Motion as</p>		<p><u>the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>The MDS Coordinator and the DON will check all residents with contractures by June 5th 2015 to assure that the MDS for each of these residents accurately records any contractures that are present. The completion of these assessment checks were done on June 5th 2015 and no other residents were found to be affected by this practice. If the DON or MDS Coordinator identifies a resident who has contractures that are not accurately reflected on the MDS, the assessment will be updated to properly reflect that information. Once that has been corrected, the Administrator will notify the RAI Nurse Consultant so that she may follow up with any necessary re-training for the MDS Coordinator. The Administrator will utilize written counseling, as indicated by the identified issue.</p>	

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	<p>a 2 instead of a 0.</p> <p>On 05/20/15 at 2:33 P.M. an interview with CNA #1 indicated Resident #19 was unable to open his hands completely.</p> <p>3.1-31(d)(3)</p>		<p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> The MDS Coordinator will keep a log of all MDS assessments completed in the next 3 months, indicating those residents with contractures. She will also indicate by her initials/date that the contractures are accurately documented on the MDS assessment. When the DON reviews the MDS assessment for signature, she will also confirm that any identified contractures are accurately documented by her initials and review date. The Administrator will review the log at least weekly. Any identified issues with documentation of contractures will be addressed as outlined in question #2.</p> <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> The MDS Coordinator will bring the log to the monthly Quality Assurance committee</p>	

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F 282 SS=D Bldg. 00	<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 interviews and record review, the facility failed to follow Physician's orders in regard to 2 laboratory tests. This deficiency affected 2 residents who had laboratory tests not done according to the Physician's Orders (Residents #18 and #19).</p> <p>Findings include:</p> <p>A. Review of the clinical record for resident #18 on 5/19/15 at 2:15 P.M., indicated the following: diagnoses included, but were not limited to, hyperparathyroidism, kidney disease,</p>	F 282	<p>meetings for further review and recommendations for the next three months. If the log demonstrates 100% compliance, the QA committee may decide to stop the written log review by the MDSC and the DON; however, the review process by both the MDSC and DON will continue on an ongoing basis.</p> <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 respectively</p>	06/11/2015

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	<p>stage 3, and hypertension.</p> <p>A Physician's Order dated 7/9/13 indicated Resident #18 should have had a Comprehensive Metabolic Panel (CMP) laboratory test done every 6 months.</p> <p>The last CMP laboratory test was done on 6/4/14 and there was no CMP laboratory test done in December 2014.</p> <p>On 5/20/15 9:24 A.M. an interview with the Director Of Nursing (DON) indicated the CMP laboratory test for December 2014 was not done. The DON indicated she was unaware the Laboratory requests were discontinued by the Laboratory Company annually.</p> <p>B. Review of the clinical record for Resident #19 on 5/20/15 at 9:30 A.M., indicated the following diagnoses: hypothyroidism.</p> <p>The Physician's Order dated 6/5/14 indicated the resident was on synthroid (a thyroid medication) 100 micrograms daily.</p> <p>The Physician's Order dated 7/25/10 indicated to obtain a Thyroid Stimulating Hormone (TSH) laboratory test to be done every 6 months for Resident #19.</p>		<p>requests that this Plan of Correction be accepted and considered for paper compliance.</p> <p><u>1. What corrective action will be accomplished for residents affected?</u></p> <p>The physician of residents #18 and #19 were notified of the missed lab of each resident on 5-19-2015 for resident #18 and on 1-21-2015 for resident # 19. The labs were drawn on 1-21-2015 for resident # 19 and on June 24th 2015 for resident #18.</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> <p>The Director of Nursing</p>	

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	<p>The TSH Laboratory blood tests for Resident #19 indicated they were done on 6/4/14 and 1/17/15.</p> <p>On 5/20/15 9:24 A.M. an interview with the Director Of Nursing (DON) indicated the TSH laboratory test for December 2014 was not done until 1/17/15. The DON indicated she was unaware the Laboratory requests are discontinued by the Laboratory Company annually.</p> <p>3.1-35(g)(2)</p>		<p>andMDS Coordinator reviewed routine lab orders of all residents utilizing the mostcurrent physician orders. An inservicewill be presented on June 11th, 2015 by the Director of Nursing toall licensed nurses to educate on use of the facility lab tracking form(HC-N-79) on June 11th, 2015. Beginning with the June 2015rewrites, all routine labs scheduled to be drawn in June 2015 will be added tothe facility lab tracking form (HC-N-79). This process will be completedmonthly on an ongoing basis. When the lab is drawn, thecharge nurse on duty at the time of the lab draw will initial the formindicating the lab has been drawn. The charge nurse who receives the lab drawresults will then initial that results have been received and the physiannotified. A nurse who fails to followthe policy/procedure will be re-educated and receive appropriate</p>	

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			<p>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>Results of the 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 audits will be reviewed by the QA&A committee monthly for 90 days to ensure 100% compliance. Further audits will be completed as deemed necessary by the QA&A committee. Once 100% compliance is attained, the committee may decide to stop the audit reports; however, the process as outlined in #3 will continue on an ongoing basis.</p>	