

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/19/2023	
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130			
(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
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00403990, IN00404248, IN00405239, IN00406254 and IN00406678.</p> <p>Complaint IN00403990 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00404248 - Federal/State deficiency related to the allegation is cited at F760.</p> <p>Complaint IN00405239 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00406254 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00406678 - Federal/State deficiency related to the allegation is cited at F760.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: April 17, 18 and 19, 2023</p> <p>Facility number: 000110 Provider number: 155203 AIM number: 100271120</p> <p>Census Bed Type: SNF/NF: 100 SNF: 15 Total: 115</p> <p>Census Payor Type: Medicare: 17 Medicaid: 74 Other: 24 Total: 115</p>			F 0000	/p> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after (5/5/23)		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Mark Bowman

Executive Director

05/03/2023

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 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 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.

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/19/2023	
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130			
(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
F 0552 SS=D Bldg. 00	<p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on April 20, 2023.</p> <p>483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:</p> <p>§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.</p> <p>§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.</p> <p>Based on interview and record review, the facility failed to ensure a resident (Resident F) was notified when a scheduled appointment was canceled for 1 of 3 residents reviewed for resident rights.</p> <p>Findings include:</p> <p>The clinical record for Resident F was reviewed on</p>			F 0552	<p>F-552 Right to be Informed / Make Treatment Decisions 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident F was discharged on 4/17/23.</p>		05/05/2023

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130		
(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	
	<p>4/17/23 at 3:00 p.m. The diagnoses included, but were not limited to, dementia without behavioral disturbance and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 2/28/23, indicated the resident's cognition was moderately impaired.</p> <p>A confidential interview, during the survey period, indicated Resident F had an appointment scheduled with her outside primary care physician. The physician was to assess the resident for dementia. Resident F had gone down to the lobby downstairs to wait for transportation to pick her up. The transport service never showed up. A staff member went down to the lobby to inform Resident F that the appointment had been canceled. Resident F was never informed of the appointment cancellation or why it was canceled.</p> <p>The progress note, dated 3/9/23 at 9:58 a.m., indicated the resident had an appointment on 3/13/23 at 11:00 a.m. Transportation was to pick up the resident at 10:00 a.m., and the resident was aware.</p> <p>The clinical record lacked documentation of the cancellation of the appointment, resident, or resident representative notification that the appointment had been canceled.</p> <p>During an interview on 4/17/23 at 4:18 a.m., the Social Services Assistant (SSA) indicated it was reported to her that the resident had an appointment and needed transportation set up. She spoke with the resident who told her the appointment was for a check up. She then spoke with the ADNS (Assistant Director of Nursing Services) about the appointment. Since they could not tell what the appointment was for, the ADNS</p>		<p>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 potential to be affected by the alleged deficient practice. On 4/28/23 DNS reviewed all appointments ordered for the past 2 weeks; all appointments were attended. On 4/28/23, the facility began in-servicing all administrative staff and licensed nursing staff on the residents right to be informed and make treatment decisions by notifying the resident, family, and NP of any changes in condition, plan of care or treatment.</p> <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ED / DNS / designee will review each appointment order and ensure transportation is scheduled. If an appointment requires rescheduling or cancelation the resident, family and NP will be notified, and a progress note will be added to the resident's medical record. Appointments will be tracked for follow-up using a follow up tool completed by DNS/Designee..</p> <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance</p>		

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

PRINTED: 05/10/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/19/2023	
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
F 0760 SS=D Bldg. 00	<p>canceled the appointment.</p> <p>During an interview on 4/19/23 at 1:16 p.m., LPN (Licensed Practical Nurse) 4 indicated when a physician's appointment was canceled, the resident and family should have been notified.</p> <p>On 4/19/23 at 12:25 p.m., the Director of Nursing provided a current copy of the document titled "Resident Rights". It included, but was not limited to, "Resident rights...right to a dignified existence, self-determination, and communication with and access to...persons...services...outside the facility...Be informed, in advance, of changes to the plan of care...."</p> <p>3.1-3(n)(1) 3.1-3(n)(2)</p> <p>483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure residents (Residents B and K) were free of medication errors for 2 of 4 residents reviewed for significant medication errors.</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 4/17/23 at 1:42 p.m., The diagnosis included, but was not limited to, diabetes.</p> <p>The physician's order, dated 2/28/23, indicated the resident was to receive humalog insulin (fast acting), 15 units three times a day at 8:00 a.m.,</p>			F 0760	<p>program will be put into place? The DNS/designee will be responsible for the daily completion of a CQI follow up tool to track each appointment and the completion of the resident change of condition QAPI audit tools weekly times 4 weeks then monthly times 6 to ensure that the resident, family, and NP are notified of any cancellations or rescheduled appointments. The results of these audits will be reviewed monthly by the QAPI committee overseen by the ED. If a threshold of 90% is not achieved, an action plan will be developed.</p> <p>5. Date of compliance: 5/3/23</p> <p>F – 760 Residents are Free of Significant Med Errors 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident B and K medication errors were immediately recognized and reported to the NP by the nurse. Each resident received treatment and monitoring as ordered by the NP. LPN #5 was in serviced on medication</p>		05/05/2023

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/19/2023	
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>12:00 p.m. and 5:00 p.m.</p> <p>The physician's order, dated 2/28/23, indicated the resident was to receive glargine insulin (slow acting), 60 units twice a day at 7:00 a.m. and 9:00 p.m.</p> <p>The progress note, dated 3/16/23 at 8:38 a.m., indicated LPN (Licensed Practical Nurse) 5 mistakenly gave the resident the incorrect dose of humalog insulin. The nurse practitioner was notified with a new order to monitor the resident's blood glucose every 15 minutes.</p> <p>The written statement, dated 3/16/23, indicated LPN 5 checked the resident's blood glucose which was 115. LPN 5 administered 60 units of humalog to the resident. Approximately 10 minutes later, LPN 5 realized the resident should have had 60 units of the glargine insulin. LPN 5 immediately notified the nurse practitioner with a new order to monitor the resident's blood glucose every 15 minutes.</p> <p>During an interview on 4/18/23 at 2:55 p.m., LPN 7 indicated the 5 rights of medication administration were the right dose, right route, right time, right resident and right medication.</p> <p>2. The clinical record for Resident K was reviewed on 4/19/23 at 12:10 p.m. The diagnosis included, but was not limited to, diabetes. The admission MDS (Minimum Data Set) assessment, dated 4/15/23, indicated the resident's cognition was intact. Review of the resident's advance directives indicated Resident K's family member was her guardian.</p> <p>The physician's order, dated 4/10/23, indicated the resident was to receive insulin glargine, 40 units,</p>				<p>pass procedure with skills validation completed.</p> <p>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 potential to be affected by the alleged deficient practice. On 3/16/23, DNS began a daily insulin administration audit tool for all shifts to ensure insulin orders are being followed accurately, all residents received insulin as ordered. The CEN began "medication pass procedure" skills validations, began in-servicing on basic medication administration and the prevention of medication errors with all licensed staff.</p> <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS/designee will perform a daily audit on all shifts using the daily insulin administration audit tool to ensure insulin orders are being followed accurately. If there is an inaccuracy noted, the resident, NP and family will be notified, and the nurse will be given additional education or appropriate disciplinary action.</p> <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance</p>		

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/19/2023	
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130			
(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
	<p>twice a day at 8:00 a.m. and 8:00 p.m.</p> <p>The physician's order, dated 4/9/23, indicated the resident was to receive Novolog insulin (fast acting) per sliding scale.</p> <p>The care plan, dated 4/11/23, indicated the resident received glucose lowering medications for diabetes and staff were to administer medications as ordered.</p> <p>The progress note, dated 4/14/23 at 8:20 p.m., indicated while giving the resident her night time insulin, Resident K noticed the insulin pen and said it was not the right one. The nurse had given approximately 20 units of Novolog before stopping. The LPN immediately double checked the resident's order and the resident was correct, it was the wrong dose of insulin. The resident's blood glucose was monitored.</p> <p>The clinical record lacked documentation of physician and guardian notification.</p> <p>During an interview on 4/19/23 at 12:35 p.m., Resident K indicated she was supposed to get 40 units of slow acting insulin. The nurse (LPN 6) was starting to give her 40 units of the fast acting insulin. She told LPN 6 it was the wrong insulin and she gave her all 40 units.</p> <p>During an interview on 4/19/23 at 1:36 p.m., LPN 6 indicated she had picked up the wrong insulin pen. She notified the resident's non-guardian family member, as the resident was on the phone with her at the time. The 5 rights of medication administration were the right dose, right medication, right resident, right time and right route.</p>				<p>program will be put into place? The DNS/designee will be responsible for daily insulin administration audits to ensure accurate insulin administration. The results of these audits will be monitored using the Medication Error QAPI audit tool which will be completed weekly times 4 weeks, then monthly times 6. The results of these audits will be reviewed monthly by the QAPI committee overseen by the ED. If a threshold of 95% is not achieved, an action plan will be developed.</p> <p>5. Date of compliance: 5/5/23</p>		

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

PRINTED: 05/10/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/19/2023	
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	<p>During an interview on 4/19/23 at 1:16 p.m., LPN 4 indicated when a medication error occurred, the physician and family should have been notified.</p> <p>On 4/19/23 at 12:25 p.m., the Director of Nursing provided a current copy of the document titled "General Dose Preparation and Medication Administration" dated 1/1/22. It included, but was not limited to, "This Policy...sets forth the procedures related to...medication administration...Prior to administration of medication...Facility staff should...Verify each time a medication is administered that it is the correct medication, at the correct dose...."</p> <p>On 4/19/23 at 12:25 p.m., the Director of Nursing provided a current copy of the document titled "Medication Errors" dated 11/2018. It included, but was not limited to, "Policy...It is the policy of this provider to ensure residents residing in the facility are free of medication errors and the facility maintains a medication error rate of less than 5%...Procedure...When a suspected medication error is identified, the nurse will immediately...notify the physician of the event...Documentation in the medical record will include physicians/family notification...."</p> <p>This Federal tag relates to Complaints IN00404248 and IN00406678</p> <p>3.1-48(a)(1)</p>						