STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 00 B. WING	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HILLCREST VILLAGE	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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00401792, IN00402393 and IN00402410. Complaint IN00401792 - Federal/State deficiency related to the allegations is cited at F622. Complaint IN00402393 - No deficiencies related to the allegations are cited. Complaint IN00402410 - Federal/State deficiency related to the allegations is cited at F773. Survey dates: March 8, 9 and 10, 2023 Facility number: 000110 Provider number: 155203 AIM number: 100271120 Census Bed Type: SNF/NF: 105 SNF: 15 Total: 120 Census Payor Type: Medicare: 14 Medicaid: 75 Other: 31 Total: 120 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 14, 2023.	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 (3/21/23)	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Bowman	Executive Director	03/22/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	§483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that			

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	failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including			

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	a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on interview and record review, the facility failed to ensure a resident (Resident B) discharged to the hospital was allowed to return for 1 of 3 residents reviewed for acute care hospital discharge. Findings include: The clinical record for Resident B was reviewed on 3/8/23 at 1:07 p.m. The diagnoses included, but was not limited to, depression and mood disorder with depressive features. The care plan, dated 7/22/22, indicated the resident had a behavior of throwing his meal tray. The interventions indicated staff were to calmly approach, redirect to enjoyable activity, give the resident options, allow the resident to advocate for himself and to give the resident an opportunity to eat where he would like to eat. The progress note, dated 12/9/22 at 7:17 p.m., indicated the resident was very combative towards staff and other residents. The resident threw his dinner tray, hitting, kicking and throwing any item within reach. When the resident's roommate entered the room, the resident began to throw items and yell at roommate. Staff attempted to redirect the resident several times, which was unsuccessful. The nurse practitioner was notified with a new order to send out for evaluation. EMS (emergency medical services) arrived and would not take resident due to the resident refused to go. The resident's roommate was moved to another room.	F 0622	**F-622 Transfer an Discharge Requirements** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Residents B was transferred to Hospital and did not return. **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?** On 3/20/23 Facility reviewed all hospital transfers for the last 30 days. Out of 33 transfers, 6 remain hospitalized with plans to return and 1 expired. No other residents were affected by the alleged deficient practices. On 3/20/23, ADNS began a in servicing the Licensed Nursing staff on the facilities Hospital Discharge / Transfer Policy. **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 review each hospital transfer using a IDT Hospital Discharge / Transfer record review Tool. Any hospital transfers noted to not meet all the	03/21/2023

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	The progress note, dated 12/10/22 at 2:31 a.m., indicated the resident's behavior had improved. The progress note, dated 12/12/22 at 7:03 a.m., indicated the resident was seen by psychiatric nurse practitioner. New orders were obtained to increase Depakote (mood stabilizer) and to add seroquel (antipsychotic) and hydroxyzine (antianxiety). The progress note, dated 12/16/22 at 4:24 p.m., indicated the resident complained of a continued cough and weakness. The resident requested to be seen at the hospital for evaluation. The nurse practitioner was updated with a new order to send the resident to the hospital for evaluation. The facility provided transportation. The IDT (interdisciplinary) behavior note, dated 12/17/22 at 8:04 p.m., indicated the resident the resident was yelling and threw his lunch tray and remote towards the roommates side of room. The roommate left the room until the resident was transferred to the hospital for a psychiatric evaluation. The hospital progress note, dated 12/17/22 at 1:37 a.m., indicated the emergency department attempted to send the resident back to his facility on oral antibiotics but the facility stated they did not have a bed for him anymore and did not want the patient to return. There were no behaviors documented while at the emergency department. During an interview on 3/9/23 at 11:38 a.m., the Executive Director (ED) indicated the resident was having combative behaviors and throwing things. He had spoken to the physician from the emergency department at around 1:00 a.m.		requirement criteria, the nurse responsible for the transfer will be subject to disciplinary action. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The DNS/designee will be responsible for the daily review each hospital transfer using an IDT Hospital Discharge / Transfer record review Tool. These tools will be reviewed by the ED weekly times 4 weeks, monthly x 6 by the QAPI Committed overseen by the ED, then quarterly thereafter until continued compliance is maintained for 2 consecutive quarters. If threshold of 90% is not achieved, an action plan will be developed. **5. Date of compliance:** 3/21/23	

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	(12/17/22) and they wanted to send the resident back. The ED told the physician that the resident needed to have a psychiatric evaluation before sending back. He had also spoken to the resident's daughter who agreed the resident needed a psychiatric evaluation. The resident was only at the hospital for a couple of hours. The ED did not tell the hospital that he could not come back, but told them he did not have a bed until he had a psychiatric evaluation. The clinical record lacked documentation of the resident's behaviors on 12/16/22 by the nurse, and any conversation with the hospital and the resident's daughter. On 3/10/23 at 10:17 a.m., the Director of Nursing provided a current copy of the document titled "Behavior Management" dated 7/1/22. It included, but was not limited to, "Procedure...If the behavioral expression is new, worsening, or high risk, the nurse will record the behavior using the New/Worsening Behavior Event...." On 3/10/23 at 12:44 p.m., the Director of Nursing provided a current copy of the document titled "Hospital Discharge/Transfer" dated 5/03. It included, but was not limited to, "Policy...It is the policy of this facility to make the transition for residents transferring from one facility to another safe and to provide continuity of care and services...Procedure...The resident must be permitted to return to the facility unless the facility determines that circumstances outlined...The assessment of the resident's condition...must be made based on the resident's current status rather than that upon discharge from the facility...." This Federal tag relates to Complaint IN00401792			

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	3.1-12(a)(3)			
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on interview and record review, the facility failed to ensure a resident's (Resident C) abnormal labs were addressed, in a timely manner, for 1 of 3 residents reviewed laboratory services. Findings include: The clinical record for Resident C was reviewed on 3/8/23 at 1:42 p.m. The diagnoses included, but were not limited to, diabetes, hypertension and chronic kidney disease. The care plan, dated 10/28/22, indicated the resident was at risk for fluid imbalance and to notify the physician for signs/symptoms of fluid imbalance. The progress note, dated 1/2/23 at 2:27 p.m., indicated the nurse practitioner was notified of the resident's refusal of medications. A new order was received for a BMP (basic metabolic panel) in the morning (1/3/23).	F 0773	**F-773 Lab Services Physician Order / Notification of Results** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Resident no longer resides in facility. **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 3/20/23, DNS and NP reviewed a Lab Due Report and results for the last 30 days. No other residents were affected by the alleged deficient practices. On	03/21/2023

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	The final lab report, faxed to the facility on 1/3/23 at 10:38 a.m., indicated the resident's sodium level was 157 (normal reference range between 136 to 145); the potassium level was 3.1 (normal reference range between 3.5 to 5.3); and a chloride level of 118 (normal reference range between 96 and 110). The lab was signed as reviewed by the nurse practitioner on 1/3/23. The clinical record lacked any intervention related to the abnormal lab until 1/5/23. The physician's order, dated 1/5/23, indicated the resident was to receive Sodium Chloride 0.45% at 50 ml (milliliters)/hour intravenous. The progress note, dated 1/6/23 at 2:16 a.m., indicated a midline was placed and staff were awaiting IV fluids which were ordered STAT. The pharmacy report indicated the IV Sodium Chloride solution was delivered on 1/6/23 at 5:25 a.m. The progress note, dated 1/6/23 at 7:21 p.m., indicated STAT labs (CMP - complete metabolic panel, and CBC - complete blood count) were attempted and unable to obtain and phlebotomy was notified of the need to come in and draw STAT labs. Review of the 1/6/23 lab results indicated a critical sodium level of 163, a potassium level of 3.2 and a chloride level of 122. During an interview on 3/9/23 at 4:05 p.m., the nurse practitioner indicated she may have signed the wrong date on the lab. She saw the labs on the same day that she wrote the order (1/5/23) for the		3/20/23, ADNS began a in servicing the Licensed Nursing staff on the facilities Lab, Diagnostic Tracking Procedure. **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 review Lab Due Report daily to confirm that each lab has been obtained along with MD/NP notification. These findings will be documented on a Labs/Diagnostic audit tool to ensure procedural compliance. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The DNS/designee will be responsible for the daily review of each lab / diagnostic using the Labs / Diagnostic audit tool. These tools will be completed weekly times 4 weeks, monthly x 6, then quarterly thereafter until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI Committed overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. **5. Date of compliance:** 3/21/23	

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	IV fluids. She could not recall whether she was notified prior to 1/5/23. On 3/10/23 at 10:17 a.m., the Director of Nursing provided a current copy of the document titled "Labs and Diagnostics" dated 11/2017. It included, but was not limited to, "It is the policy...to provide or obtain laboratory...services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services...The facility must promptly notify the...nurse practitioner...of lab or diagnostic results that fall outside of the clinical reference ranges...." This Federal tag relates to Complaint IN00402410 3.1-49(f)(2)			