STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155424	A. BUILDING 00 B. WING	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT COLUMBUS	5480 E 25TH ST COLUMBUS, IN47203

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F0000	This visit was for the Investigation of Complaint IN00087586. Complaint IN00087586 - Substantiated, Federal/State deficiencies related to the allegations are cited at F272, F281, and F-309. Survey dates: March 24 and 25, 2011 Facility number: 000284 Provider number: 155424 AIM number: 100290690 Survey team: Sharon Lasher RN/TC Leslie Parrett RN (March 24, 2011) Angel Tomlinson RN (March 25, 2011) Census bed type: SNF/NF: 31 Total: 31 Census payor type:	F0000	This plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Hickory Creek at Columbus desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective May 4, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicare: 1 Medicaid: 26 Private: 4 Total: 31 Sample: 3 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3/31/11 by Jennie Bartelt, RN.			
F0272	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI 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;			

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	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 through the resident assessment protocols; and Documentation of participation in assessment.			
SS=D	Based on interview and record review, the facility failed to ensure the resident received a timely assessment after reporting difficulty in breathing and experiencing a distended abdomen for 1 of 1 resident reviewed related to assessment in a sample of 3. (Resident #C) Findings include: The record of Resident #C was reviewed on 3/24/11 at 11:45 a.m. Resident #C's nursing notes indicated the following: "- 3/9/11 at 8:21 p.m., resident had immediate onset of extreme	F0272	F272 Comprehensive Assessments It is the policy and procedure of this facility to conduct initially and periodically comprehensive and accurate assessments of each resident's functional capacity, including assessments of residents' respiratory and abdominal status. 1. What corrective action will be done by this facility? All licensed nursing staff will be re-inserviced on the facilities documentation guideline booklets and timeliness of assessments by May 4, 2011. The licensed nursing staff will continue to utilize this booklet when completing & documenting an assessment on a resident's condition. The licensed nursing staff will conduct a timely assessment when a change of condition is noticed. Any resident that has an assessment completed because of a change in condition will be placed on the 24 hour report board. 2. How will the facility identify other residents	05/04/2011

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	sweating, respiratory rate 44, labored, crackles to all lung fields and distended abdomen. Blood Pressure 156/90, pulse 118, temperature 95.7 and pulse oximeter 89%). (Physician name) called and gave order for sending to emergency room to evaluate and treat. Arranged transportation with (local ambulance) who is now here. - 3/9/11 at 9:11 p.m., resident began vomiting coffee ground emesis during transfer from bed to stretcher. Resident turned blue and ceased breathing. Nurse initiated chest compressions during run to ambulance. (Local hospital) called time of death 9:05 p.m." (Local ambulance) report dated 3/9/11 indicated, "Incident reported at 8:21 p.m., and arrived at scene 8:26 p.m. Called to Hickory Creek for difficult breathing and congestive heart failure. Upon arrival at Hickory Creek 61 year old man patient was laying in bed complaining of difficult breathing and chest tightness for about an		having the potential to be affected by the same practices and what corrective action will be taken? No other residents have been affected by this practice. The IDT reviews the 24 hours report board at least 5 days a week. Any resident who exhibits a change in condition will be assessed by the nurse when she becomes aware of the resident's change. The nurse will document the assessment and notify the physician of the assessment results. If the DON or the MDS Coordinator finds that a resident has had a change of condition which has not been assessed, she will make sure that an assessment is done immediately to ascertain the resident's status so that the physician can be duly notified. Once the resident has been taken care of, the DON will retrain the nurse(s) involved regarding the facility policy of responding to residents' change in condition and the assessment that is required to be done when these changes become apparent. In addition, the DON will render progressive disciplinary action for continued noncompliance. 3. What measures will be put into place to ensure this practice does not recur and what QA will be put into place? The charge nurse will assess residents when a change in condition has been identified and will indicate this change on the 24 hour report board as well as documenting the assessment	

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	hour." Interview with the Administrator on 3/24/11 at 1:10 p.m., indicated the nurse taking care of Resident #C was informed by the CNA on 3/9/11 at 7:45 p.m., Resident #C's abdomen was distended and the resident had stated he could not breathe. The nurse was doing a treatment on another resident and finished the treatment or cleaned up the mess from the treatment and went to assess Resident #C. After her assessment, she went to the nursing station and called the physician and then the ambulance but did not call 911. The Administrator also indicated oxygen was not started on Resident #C and he was left lying flat in the bed. This federal tag is related to Complaint IN00087586. 3.1-31(a)		results in the resident's medical record. The DON or MDS Coordinator will review the assessment results to make sure that the assessment is timely and reflects the status of the resident. If the DON or MDS Coordinator finds that an assessment has not been done or followed through as per policy, the DON will address the issue as indicated in question #2. 4. How will the corrective action(s) be monitored to ensure the practice will not recur? The DON and/or MDS Coordinator will bring the 24 hour report board and the focus charting books to the next scheduled morning management meeting for the Interdisciplinary Team to review and make recommendations which will be followed through as indicated by the DON, MDS Coordinator, or charge nurse. The DON and/or MDS Coordinator will also bring these changes to the weekly IDT Standards of Care meetings and the monthly QA & A committee meeting for further review. This process will continue on an ongoing basis.	

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F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on interview and record review, the facility failed to ensure professional standards of practice were followed related to providing care requiring emergency measures. The nurse did not raise the head of the bed, start oxygen therapy, or call 9-1-1 when a resident had difficulty breathing. The deficient practice affected 1 of 1 resident reviewed for professional standards of care in a sample of 3. The deficient practice resulted in delay in treatment, and the resident subsequently expired at the hospital. (Resident #C) Findings include: The record of Resident #C was reviewed on 3/24/11 at 11:45 a.m.	F0281	F281 Services Provided Meet Professional Standards It is the policy of this facility that services provided meet professional standards of quality, including the use of emergency measures when indicated by the residents' condition. What corrective action will be done by the facility? The nursing staff was educated on care requiring emergency services on March 18, 2011, including raising the head of a bed if a resident is having difficulty breathing, administering oxygen and when to call 911. The nurse who was on duty and who responded to Resident #C's change in condition was suspended on March 10, 2011 pending an investigation regarding the care she had given to Resident #C. This nurse was terminated from the facility on March 15, 2011. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?	05/04/2011

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	Resident #C's physician recapitulation orders, dated 3/11, indicated Resident #C was a full code (begin life-saving measures if heart or breathing stops). Resident #C's Minimum Data Set (MDS), assessment, dated 2/4/11, indicated makes self understood and has the ability to understand others. Resident #C's nursing notes indicated the following: "- 3/9/11 at 8:21 p.m., resident had immediate onset of extreme sweating, respiratory rate 44, labored, crackles to all lung fields and distended abdomen. Blood Pressure 156/90, pulse 118, temperature 95.7 and pulse oximeter 89%. (Physician name) called and gave order for sending to emergency room to evaluate and treat. Arranged transportation with (local ambulance) who is now here. - 3/9/11 at 9:11 p.m., resident began vomiting coffee ground emesis during transfer from bed to		- No other resident was affected by this practice. The IDT reviews the 24 hours report board at least 5 days a week. Any resident who exhibits a change in condition will be assessed by the nurse when she becomes aware of the resident's change. The nurse will then follow through with emergency measures that are appropriate for the resident's assessed condition, including the use of oxygen and positioning if indicated and will document her assessment and interventions. If the DON or the MDS Coordinator identifies a resident with a change of condition that has not been addressed with appropriate emergency measures, she will make sure that interventions are put into place immediately to handle the emergency situation. Once the resident has been taken care of and is no longer in an emergent state, the DON will retrain the nurse(s) involved regarding the facility policy and procedures for responding to residents' changes in condition with the appropriate emergency measures and progressive disciplinary action will be given where indicated. If the resident emergency has already occurred and the DON identifies an issue with the nurse's response after the fact, she will suspend the nurse	

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	stretcher. Resident turned blue and ceased breathing. Nurse initiated chest compressions during run to ambulance. (Local hospital) called time of death 9:05 p.m." (Local ambulance) report dated 3/9/11 indicated "incident reported at 8:21 p.m., and arrived at scene 8:26 p.m. Called to Hickory Creek for difficult breathing and congestive heart failure. Upon arrival at Hickory Creek 61 year old man patient was laying in bed complaining of difficult breathing and chest tightness for about an hour." Interview with the Administrator on 3/24/11 at 1:10 p.m., indicated the nurse taking care of Resident #C was informed by the CNA on 3/9/11 at 7:45 p.m., Resident #C abdomen was distended and had stated he could not breath. The nurse was doing a treatment on another resident and finished the treatment or cleaned up the mess from the treatment and went to		from employment while an investigation is conducted. At the end of the investigation, the DON will review the facility policy and procedures for initiation of emergency measures with the nurse and will render progressive disciplinary action as deemed appropriate. What measures will be put into place to ensure this practice does not recur and what QA will be put into place? The charge nurse will follow the written guidelines when dealing with an emergency situation and will document her interventions in the resident's chart. The charge nurse will indicate this change on the 24 hour report board as well as documenting the emergency measures initiated in the resident's medical record. The DON or MDS Coordinator will review the occurrence and related documentation to make sure that appropriate action was taken to handle the resident's emergency. If the DON or MDS Coordinator finds that an assessment has not been done or followed through as per policy, the DON will address the issue as indicated in question #2. How will the corrective action (s) be monitored to ensure the practice will not recur?	

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	assess Resident #C. After her assessment she went to the nursing station and called the physician and then the ambulance but did not call 911. The administrator also indicated oxygen was not started or Resident #C and he was left lying flat in the bed. Review of DiGiulio, Jackson and Keogh, Medical-Surgical Nursing, 2007, indicated "Difficulty breathing, interventions: place patient in high-Fowler's (sitting 90 degrees up) or semi-Fowler's (sitting 45 degrees up) and oxygen therapy." Interview with CNA #1 on 3/25/11 at 2:25 p.m., indicated she was in Resident #C's room when the ambulance arrived around on 3/9/11 around 8:30 p.m., and Resident #C did not have oxygen on or the head of his bed up until after the ambulance arrived. Interview with CNA #2 on 3/25/11 at 2:35 p.m., indicated the nurse		- The DON and/or MDS Coordinator will bring documentation for any resident who required emergency care to the next scheduled morning management meeting for Interdisciplinary Team to review and make recommendations which will be followed through by the DON. The DON and/or MDS Coordinator will also bring this documentation and the results of any investigation that has been done due to the nurse's response to the emergency situation to the weekly IDT Standards of Care meetings and the monthly QA & A meeting for further review and recommendation. This process will continue on an ongoing basis.	

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	had assessed Resident #C when she was in his room and he did not have any oxygen on before the ambulance arrived. A document titled "Attention all Nurses" dated 3/16/11 provided by the Administrator on 3/24/11 at 2:25 p.m., indicated the following: The following is guidance and expectations of when an emergency situation takes place. Responding to emergency situations: "- When a resident is experiencing signs/symptoms of distress a full head to toe assessment should be completed by the nurse immediately including a full set of vital signs. - Finding should immediately by reported to the physician. - If the resident needs immediate intervention, call 9-1-1 and then notify MD of transfer to hospital. Do not wait for the MD to call back with an order to send to ER if resident's condition is dire. - While waiting for ambulance to			

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	arrive appropriate life saving measures should be implemented by the licensed nurse. Some of these measures are listed below: CPR if appropriate O2 (oxygen) if resident is in respiratory distress Continuous monitoring of vital signs Position the resident appropriately Stay with the resident at all times (an available staff member can call 9-1-1 if needed and also obtain necessary supplies). This list is not all inclusive and can not pertain to every emergency situation that may arise. You are to call 9-1-1 in an emergency and not (name of ambulance service) or (name of ambulance service)." This federal tag is related to Complaint IN00087586. 3.1-35(g)(1)			

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F0309	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.			
SS=D	Based on interview and record review, the facility failed to ensure the resident received timely care related to the report of the resident's distended abdomen and complaints of inability to breathe. When the	F0309	F309 It is the standard of this facility that residents receive the necessary care and services to attain or maintain the highest practicable care/services, in accordance with the resident's plan of care, including timely care and emergency response to residents'	05/04/2011

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	CNA reported the resident's symptoms, the nurse completed other care before assessing the resident. When the nurse assessed the resident, she failed to implement emergency measures of raising the head of the bed, starting oxygen therapy, and calling 9-1-1. The deficient practice affected 1 of 1 resident reviewed related to emergency care in a sample of 3 and resulted in delay in treatment. The resident subsequently expired at the hospital. (Resident #C) Findings include: The record of Resident #C was reviewed on 3/24/11 at 11:45 a.m. Resident #C's physician recapitulation orders, dated 3/11, indicated Resident #C was a full code (begin life-saving measures if heart or breathing stops). Resident #C's Minimum Data Set (MDS), assessment, dated 2/4/11, indicated makes self understood		changing condition. What corrective action will be done by the facility? It is the policy of this facility that services provided meet professional standards of quality, including the use of emergency measures when indicated by the residents' condition. What corrective action will be done by the facility? The nursing staff was educated on care requiring emergency services on March 18, 2011, including raising the head of a bed if a resident is having difficulty breathing, administering oxygen and when to call 911. The nurse who was on duty and who responded to Resident #C's change in condition was suspended pending an investigation into the care she provided for Resident #C on March 10, 2011. This nurse was terminated from the facility on March 15, 2011. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No other resident was affected by this practice. The IDT reviews the 24 hours report board at least 5 days a week.	

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	and has the ability to understand others. Resident #C's nursing notes indicated the following: "- 3/9/11 at 8:21 p.m., resident had immediate onset of extreme sweating, respiratory rate 44, labored, crackles to all lung fields and distended abdomen. Blood Pressure 156/90, pulse 118, temperature 95.7 and pulse oximeter 89%. (Physician name) called and gave order for sending to emergency room to evaluate and treat. Arranged transportation with (local ambulance) who is now here. - 3/9/11 at 9:11 p.m., resident began vomiting coffee ground emesis during transfer from bed to stretcher. Resident turned blue and ceased breathing. Nurse initiated chest compressions during run to ambulance. (Local hospital) called time of death 9:05 p.m." (Local ambulance) report dated 3/9/11 indicated "incident reported at 8:21 p.m., and arrived at scene		Any resident who exhibits a change in condition will be assessed by the nurse when she becomes aware of the resident's change. The nurse will then follow through with emergency measures that are appropriate for the resident's assessed condition, including the use of oxygen and positioning if indicated and will document her assessment and interventions. If the DON or the MDS Coordinator identifies a resident with a change of condition that has not been addressed with appropriate emergency measures, she will make sure that interventions are put into place immediately to handle the emergency situation. Once the resident has been taken care of and is no longer in an emergent state, the DON will retrain the nurse(s) involved regarding the facility policy and procedures for responding to residents' changes in condition with the appropriate emergency measures and progressive disciplinary action will be given where indicated. If the resident emergency has already occurred and the DON identifies an issue with the nurse's response after the fact, she will suspend the nurse from employment while an investigation is conducted. At the end of the investigation, the DON will review the facility policy and procedures for initiation of emergency measures with the nurse	

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	8:26 p.m. Called to Hickory Creek for difficult breathing and congestive heart failure. Upon arrival at Hickory Creek 61 year old man patient was laying in bed complaining of difficult breathing and chest tightness for about an hour." Interview with the Administrator on 3/24/11 at 1:10 p.m., indicated the nurse taking care of Resident #C was informed by the CNA on 3/9/11 at 7:45 p.m., Resident #C abdomen was distended and had stated he could not breath. The nurse was doing a treatment on another resident and finished the treatment or cleaned up the mess from the treatment and went to assess Resident #C. After her assessment she went to the nursing station and called the physician and then the ambulance but did not call 911. The administrator also indicated oxygen was not started or Resident #C and he was left lying flat in the bed.		and will render progressive disciplinary action as deemed appropriate. What measures will be put into place to ensure this practice does not recur and what QA will be put into place? The charge nurse will follow the written guidelines when dealing with an emergency situation and will document her interventions in the resident's chart. The charge nurse will indicate this change on the 24 hour report board as well as documenting the emergency measures initiated in the resident's medical record. The DON or MDS Coordinator will review the occurrence and related documentation to make sure that appropriate action was taken to handle the resident's emergency. If the DON or MDS Coordinator finds that an assessment has not been done or followed through as per policy, the DON will address the issue as indicated in question #2. How will the corrective action (s) be monitored to ensure the practice will not recur? The DON and/or MDS Coordinator will bring documentation for any resident who required emergency care to the next scheduled morning management meeting for	

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	155424	A. BUILDING 00 B. WING	03/25/2011

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	Interview with CNA #1 on 3/25/11 at 2:25 p.m., indicated she was in Resident #C's room when the ambulance arrived around on 3/9/11 around 8:30 p.m., and Resident #C did not have oxygen on or the head of his bed up until after the ambulance arrived. Interview with CNA #2 on 3/25/11 at 2:35 p.m., indicated the nurse had assessed Resident #C when she was in his room and he did not have any oxygen on before the ambulance arrived. A document titled "Attention all Nurses" dated 3/16/11 provided by the Administrator on 3/24/11 at 2:25 p.m., indicated the following: The following is guidance and expectations of when an emergency situation takes place. Responding to emergency situations: "- When a resident is experiencing signs/symptoms of distress a full head to toe assessment should be completed by the nurse		Interdisciplinary Team to review and make recommendations which will be followed through by the DON. The DON and/or MDS Coordinator will also bring this documentation and the results of any investigation that has been done due to the nurse's response to the emergency situation to the weekly IDT Standards of Care meetings and the monthly QA & A meeting for further review and recommendation. This process will continue on an ongoing basis.	

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	immediately including a full set of vital signs. - Finding should immediately by reported to the physician. - If the resident needs immediate intervention, call 9-1-1 and then notify MD of transfer to hospital. Do not wait for the MD to call back with an order to send to ER if resident's condition is dire. - While waiting for ambulance to arrive appropriate life saving measures should be implemented by the licensed nurse. Some of these measures are listed below: CPR if appropriate O2 (oxygen) if resident is in respiratory distress Continuous monitoring of vital signs Position the resident appropriately Stay with the resident at all times (an available staff member can call 9-1-1 if needed and also obtain necessary supplies). This list is not all inclusive and can not pertain to every emergency situation that may arise. You are to			

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	call 9-1-1 in an emergency and not (name of ambulance service) or (name of ambulance service)." This federal tag is related to Complaint IN00087586. 3.1-37(a)			