

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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W000000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>This visit was in conjunction with a PCR (post-certification revisit) survey to the investigation of complaint #IN00119541 completed on 12/11/12.</p> <p>Dates of Survey: 2/11, 2/12, 2/13, 2/14 and 2/25/13</p> <p>Facility number: 000614 Provider number: 15G068 AIM number: 100272120</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Keith Briner, Medical Surveyor III (2/11/13 to 2/14/13) Christine Colon, Medical Surveyor III (2/11/13 to 2/14/13) Susan Eakright, Medical Surveyor III (2/11/13 to 2/14/13) Claudia Ramirez-RN, Public Health Nurse Surveyor III (2/11/13 to 2/14/13)</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 3/4/13 by Ruth Shackelford, Medical Surveyor III.</p>	W000000	<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 Gaston desires this Plan of Correction to be considered the facilities Allegation of Compliance.</p>	
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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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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review for 10 of 10 sampled clients (#1, #2, #3, #4, #5, #6, #7, #8, #9 and #10) and for 57 additional clients (#11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, and #67), the facility's governing body failed to ensure the facility's environment and cookware in the dietary department was in good repair, and a client did not pay for prescription coverage in a Medicaid covered facility. The governing body failed to ensure the facility implemented its policy and procedures to prevent abuse and/or neglect of clients. The facility's governing body failed to ensure the facility conducted thorough investigations of all allegations of abuse, neglect and/or injuries of unknown source, to put in place corrective measures, and to complete investigations within a timely manner of 5 working days. The governing body failed to ensure clients participated in putting clothes away and/or assisted to make their beds.</p>	W000102	<p>W102 Condition - Governing Body - This facility has been diligent in its efforts to protect the welfare and dignity of all residents of the facility. Inherent in the philosophy of the ICF/MR regulations residents are to be allowed the freedom to move about in their home with as little restriction as possible. The facility has utilized numerous interventions to minimize the risk of injury to residents while still affording them the opportunity to move about freely in their home, the freedom to interact with peers who share their home and to afford them privacy and independence. The facility has also encouraged residents to have meaningful relationships with the staff. It is the facility's intent to encourage these normalized experiences but to keep safeguards in place that minimize the risk of injuries or events that could be viewed as possible violation of their rights. The facility will continue and re-new efforts to protect residents in all manners, but maintains that in protecting a residents right to make choices, that events can occur where residents will risk injury. #1. Please see response to W149, W156 and W104 related to clients with an injury,</p>	03/27/2013			

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	<p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition on Participation: Client Protections for clients #1, #2, #4, #5, #7, #8, #9, #10, #11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #57, #58, #60, #61, #62, #65 and #68. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect and/or abuse of clients in regard to a fractured neck, theft of clients' properties and in regard to preventing medications errors with a client. The governing body failed to ensure the facility implemented its policy and procedures to conduct thorough investigations in regard to all allegations of abuse, neglect and/or injuries of unknown source. The facility's governing body failed to ensure the facility implemented its policy and procedures to put in place corrective measures to prevent theft of clients' properties, and to ensure the results of an allegation of staff to client abuse were completed within 5 business days. The governing body failed to ensure the clients were allowed to participate in household tasks at the facility involving the clients' personal items/room. Please see W122.</p>		<p>medication error, thorough investigations, investigations of thefts, timely investigations and clients allowed to participate in household tasks. #2. Please see response to W149 related to client #11, Client #38, clients # 25, 29, 45, 60 and W154 related to clients #13, 18, 26, 28, 30, 33, 41, 45, 46, 50, 56, 58, 60 61, 62, 65 & 68. See response to W104 related to the environment and clients performing household tasks, W149 related in investigations, injury to client #11 and medication error for client #38, as well as thefts for #25, 29, 60, 65. W156 for late reporting related to client #57,</p>				

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	<p>2. The governing body failed to ensure the facility implemented its written policies and procedures to prevent neglect and/or abuse of client #11 in regard to an injury of unknown source (fractured neck) which resulted in a significant injury/paralysis of a client, to prevent client #38 from grabbing and taking others' medications to prevent potential harm of the client, and to prevent abuse/theft of clients' personal properties and possessions for clients #25, #29, #45, #60 and #65. The governing body failed to ensure the facility implemented its written policy and procedures to conduct and/or document thorough investigations in regard to allegations of neglect/abuse, injuries of unknown source, and/or client to client aggression/abuse for clients #11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #58, #60, #61, #62, #65 and #68. The governing body failed to ensure the facility's environment was not in need of repair, and/or failed to ensure a client did not pay for covered services for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58,</p>			

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	<p>#59, #60, #61, #62, #63, #64, #65, #66, and #67.</p> <p>The governing body failed to ensure the facility allowed each client the opportunity to put away their own clothing and make their own beds during active treatment opportunities for clients #1, #4, #5, #8 and #10.</p> <p>The governing body failed to ensure the facility conducted investigations and/or conducted thorough investigations in regard to client to client aggression/abuse, injuries of unknown source, medication errors involving a client grabbing medications, and in regard to a significant incident which left a client paralyzed due to an injury of unknown source for clients #11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #58, #60, #61, #62, #65 and #68. The governing body failed to ensure the facility completed an investigation in 5 working days and/or reported the results of the investigation to the administrator within the 5 day time frame involving client #57.</p> <p>The governing body failed to ensure the facility put in place corrective actions/measures to prevent continued theft of clients' properties for clients #25, #29, #45, #60 and #65. Please see W104.</p>						

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 10 of 10 sampled clients (#1, #2, #3, #4, #5, #6, #7, #8, #9 and #10) and for 57 additional clients (#11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, and #67), the facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility's environment and cookware in the dietary department was in good repair, and a client did not pay for prescription coverage in a Medicaid covered facility. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent abuse and/or neglect of clients. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations of all allegations of abuse, neglect and/or injuries of unknown source, to put in place</p>	W000104	<p>It is the policy of this facility to exercise general policy, budget and operating direction. ** What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. #1. For all clients of the facility, after looking at the can racks closely, it was discovered that there was no rust on them. Rather, there was some residue possibly caused by some type of tape. This residue has been removed and the can racks have been thoroughly cleansed. The metal cupcake pans that were pitted have been disposed of. They have not been used for several months. The cookie sheets have been replaced. The cookie sheets with built up debris and with pitting marks have been disposed of. The mixing bowls and the mixer itself have been thoroughly cleansed. #2. The light fixtures without covers located in the restroom by Program room D have been replaced. The floor tile in that restroom will be replaced. The privacy door in the women's restroom was being serviced during the survey. It has been repaired and is now in place. #3. For clients # 5, 29, 31, 39, 45, 54, & 66, the four walls in Program room D has</p>	03/27/2013

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	<p>corrective measures, and to complete investigations within a timely manner of 5 working days. The governing body failed to exercise general policy and operating direction over the facility to ensure clients participated in putting clothes away and/or assisted to make their beds.</p> <p>Findings include:</p>		<p>been cleaned thoroughly and no longer has a film. The 15 X 15 floor has been cleaned and no longer has any dirt build up in the corners. The wall with the blue paint has been re-painted and is no longer peeling. #4. An error was made by the insurance that provided Part D coverage for client # 5 and he was inadvertently charged for his coverage. This error was discovered and corrected. However, the client had not been reimbursed during the annual survey. Client # 5 has been reimbursed the monies owed him at this time. #5. Client # 11 suffered a fractured neck through unknown causes. The facility maintains that the incident was thoroughly investigated but we were not able to determine an absolute cause due to the client's inability to tell us what happened. On the morning of the incident, he was found lying in his bed with a superficial laceration on his head and a skin tear on his knee. He was not moving as normal. He was sent to the ER for assessment. He was admitted with a fracture. Our investigation showed that Client #11 was not neglected. Rather he was monitored frequently. He has a seizure disorder and could have had a seizure causing the fracture. There is nothing to indicate that he was not being cared for properly. There was a discrepancy in the statements</p>		

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			<p>from the witnesses, one employee who was interviewed a few days after the incident said she thought there were clothes on the floor. Other employees state that there were no clothes on the floor. Client # 11 is currently doing somewhat better. He is more alert than before. He is not able to walk due to the paralysis. He also had a history of chronic spinal issues including degenerative changes to joints and the spinal cord, disc herniation and narrowing of the spinal cord. Client # 38 suffered no ill effects from taking the wrong medication. He was monitored closely. Clients # 25, 29, 45, 60 and 65 had personal items stolen. Those items have been replaced. Clients # 13, 18, 25, 26, 28, 29, 30, 33, 35, 38, 41, 45, 46, 50, 56, 58, 60, 61, 62, 65, & 68 were all missing items.</p> <p>These items have all been replaced. #6. Clients #1, 4, 5, 8 and 10 have all been assessed as to the appropriateness of the decision to have the chores of putting clothes away and making their own beds added to their ISP (Individual support plan). Some of our clients are not able physically to do these chores. If they are able and it is determined that it would be beneficial, it will be added. #7. See response to W154. #8. Client # 57 has been assessed. She is doing fine with no ill effects. #9. All items that were stolen have been replaced.</p>		

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			<p>** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. #1. All clients can be affected. This residue has been removed and the can racks have been thoroughly cleansed. The metal cupcake pans that were pitted have been disposed of. They have not been used for several months. The cookie sheets have been replaced. The cookie sheets with built up debris and with pitting marks have been disposed of. The mixing bowls and the mixer itself have been thoroughly cleansed. #2. All clients could be affected. The light fixtures without covers located in the restroom by Program room D have been replaced. The floor tile in that restroom will be replaced. The privacy door in the women's restroom was being serviced during the survey. It has been repaired and is now in place. #3. All clients who go to Program room D could be affected. the four walls in Program room D has been cleaned thoroughly and no longer has a film. The 15 X 15 floor has been cleaned and no longer has any dirt build up in the corners. The wall with the blue paint has been re-painted and is no longer peeling. #4. All clients have the potential to be affected. However, the BOM is now in charge of monitoring the Part D</p>		

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			<p>premiums to assure that they are appropriate. #5. All clients have the potential to be affected. Any missing items will be replaced. Any injuries will continue to be thoroughly investigated with results sent to ISDH and BDDS as required. #6. All clients could be affected. All clients are being assessed for the appropriateness of adding or continuing these tasks on their ISP. #7. See response to W154. #8. All clients could be affected. Any time there is an allegation a thorough investigation will be conducted and the follow up will be completed within the 5 day time frame as required. #9. All clients have the potential to be affected. All TV's have been locked down and daily rounds are completed to assure that nothing is missing again. If something is found missing and immediate search will start and the local police and ISDH will be informed. The items will be replaced. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. #1. An audit has been developed to assist in assuring that all pans are clean with no pits. This audit tool will also monitor the condition of the can racks, shelves, pans and the mixer and mixing bowls 1 X weekly. #2. An audit tool has been developed to assist the Maintenance Supervisor in</p>	

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			<p>providing preventative maintenance. Every area of the facility will be audited for any maintenance needs at least one time monthly. Any needs found will be repaired/replaced as they are discovered. A separate maintenance book has been developed to assure compliance and track completion of these tasks. #3. The same audit tool developed for Maintenance will be utilized by the housekeeping supervisor in assuring that all areas in need of cleansing or repairs are completed timely. #4. The BOM keeps track of all of the prescription and other insurance cards so that she can check each client's information to assure there are no inappropriate charges. Before making any payments to insurance companies, the BOM will check with the pharmacy and the individual client/family to assure the charges are correct. No charges will be paid that cannot be verified. #5. The investigative process has been more formalized. It will include three categories for investigation. One person will be the lead investigator depending on what category it falls into. The three categories are; Unknown incident, Witnessed incidents, and Resident to Resident incidents. All staff will be in-serviced before March 26, 2013. #6. All clients will be assessed for the appropriateness of adding these</p>		

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			<p>tasks to their ISP. #7. See response to W154 #8. An in-service will be conducted before March 26 to inform all employees of the requirements to report anything that is suspicious in a timely manner. #9. TV's are now locked into place on their stands. Daily rounds are being completed and each resident has their inventory sheet updated with the appropriate personal items marled/ ** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what Quality Assurance program will be put into place. #1. The results of the audit tool will be presented during the QA meeting. It will be completed for at least 6 months. The results will be discussed and the QA committee will decide at the end of 6 months if the audit tool needs to continue or if we are in 100% compliance. #2. The maintenance book and the audit tool will be reviewed by the Maintenance Supervisor and the Administrator at least one time monthly. The results of the audits will be presented during the QA meetings with the Medical Director. These audits will continue for 6 months. If no further issues, the QA committee will make a recommendation as to it's continued use or not. #3. The results of the audit tool will be presented to the monthly QA meeting with the medical director. These audits will be ongoing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013
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	1. Observations of the facility kitchen, where meals are prepared for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43,		The housekeeping supervisor will meet with the Administrator weekly to go over any needs. #4. If there are any issues with billing it will be brought before the Administrator and the monthly QA committee. This will remain ongoing. #5. All incidents will be discussed during the daily IDT meeting. The QMRP's will be responsible to bring the incidents to the meeting and to provide any follow up. This will continue indefinitely. #6. The QMRP's will be responsible for the ISP programs and to assess for appropriateness by adding these tasks. #7. See response to W154. #8. All incidents will be brought before the QA committee for discussion. The Administrator will be responsible to assure all incidents are reported timely. #9. The results of the daily rounds tool will be discussed daily during the IDT meeting with the other Department Heads as well as during the monthly QA committee meeting with the Medical Director. This will continue indefinitely.		

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	<p>#44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, and #67 were conducted on 2/12/13 at 1:30 P.M.</p> <p>-Two of two (2 of 2) metal kitchen shelves in the dry storage area for cans were rusty and had paint finish peeling from the metal.</p> <p>-Four of four (4 of 4) metal cup cake pans were pitted, had baked built up debris in the corners, and the pans were worn.</p> <p>-Seven of seven (7 of 7) 25" (inch) by 18" cookie sheets had baked built up debris in the corners and the pans were pitted.</p> <p>-One of two (1 of 2) electric counter mixers had dried food debris inside the bowl, dried food to the sides of the mixer base, and dried food debris on the mixer blade. The mixer had paint peeling from the metal on the base of the mixer and the mixer bowl was pitted.</p> <p>On 2/12/13 at 2:05pm, DM (Dietary Manager) #33 stated the pitted pans and</p>			

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	<p>mixer were "dirty" and had dried food on the items. DM #33 stated the two shelves had worn finish and were "dirty." DM #33 indicated clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, and #67 had their food prepared inside the kitchen area daily.</p> <p>2. On 2/11/13 from 1:30pm until 2:32pm, on 2/11/13 from 3:20pm until 5:40pm, on 2/12/13 from 5:45am until 9:13am, and on 2/13/13 from 1pm until 1:40pm, observation at the main building hallway men's and women's restroom beside Program Room D (PRD) indicated the following: One of three (1 of 3) four foot long florescent light fixtures in the men's restroom was missing a light cover. Two of two (2 of 2) bathroom stalls in the men's restroom each had tile areas three feet by three feet (3' x 3') around each of the toilets which was worn, stained, and</p>			

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	<p>discolored. One of two (1 of 2) bathroom stalls inside the women's restroom was missing a stall door for privacy.</p> <p>3. On 2/11/13 from 1:30pm until 2:32pm, on 2/11/13 from 3:20pm until 5:40pm, on 2/12/13 from 5:45am until 9:13am, and on 2/13/13 from 1pm until 1:40pm, observation at the main building inside Program Room D (PRD) for clients #5, #29, #31, #39, #45, #54, and #66 indicated the following: Four of four (4 of 4) walls inside PRD had a film on the walls and the fifteen by fifteen feet floor had a dirt built up on the floor. One of four walls had blue paint which was peeling from the wall. Facility Employee (FE) #35 indicated on 2/13/13 at 1:40 pm that PRD was for clients who needed supervision not to eat inedible items.</p> <p>On 2/13/13 at 8:35am, the facility's maintenance records were requested and no maintenance records were available for review for the above maintenance needs.</p> <p>On 2/14/13 at 9:30am, the facility's maintenance records were requested and no maintenance records were available for</p>			

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	<p>review for the above maintenance needs.</p> <p>On 2/14/13 at 1:30pm, the facility's maintenance records were requested and no maintenance records were available for review for the above maintenance needs.</p> <p>4. A review of the facility's financial records was conducted on 2/12/13 at 1:50 P.M.. Review of client #5's personal financial record indicated the following: "12/3/12-Withdrawal (\$52.00)-8 month prescription coverage." Further review of client #5's personal financial record failed to indicate he had been reimbursed for the mentioned expenditure.</p> <p>An interview with the facility's Business Manager (BM) was conducted on 2/12/13 at 3:50 P.M.. When asked if client #5 paid for his 8 month prescription coverage on 12/3/12, the BM stated "Yes he did and we are working on getting him reimbursed." When asked if he should have paid for his prescription coverage, the BM stated "No." No documentation was provided to indicate when client #5 would be reimbursed for the mentioned expenditure.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility</p>						

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	<p>implemented its written policies and procedures to prevent neglect and/or abuse of client #11 in regard to an injury of unknown source (fractured neck) which resulted in a significant injury/paralysis of a client, to prevent client #38 from grabbing and taking others' medications to prevent potential harm of the client, and to prevent abuse/theft of clients' personal properties and possessions for #25, #29,#45, #60 and #65.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to conduct and/or document thorough investigations in regard to allegations of neglect/abuse, injuries of unknown source, and/or client to client aggression/abuse for clients #11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #58, #60, #61, #62, #65 and #68. Please see W149.</p> <p>6. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility allowed each client the opportunity to put away their own clothing and make their own beds during active treatment opportunities for clients #1, #4, #5, #8 and #10. Please see W137.</p>			

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	<p>7. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted investigations and/or conducted thorough investigations in regard to client to client aggression/abuse, injuries of unknown source, medication errors involving a client grabbing medications, and in regard to a significant incident which left a client paralyzed due to an injury of unknown source for clients #11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #58, #60, #61, #62, #65 and #68. Please see W154.</p> <p>8. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility completed an investigation in 5 working days and/or reported the results of the investigation to the administrator within the 5 day time frame involving client #57. Please see W156.</p> <p>9. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility put in place corrective actions/measures to prevent continued theft of clients' properties for clients #25, #29, #45, #60 and #65. Please see W157.</p>			

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	3.1-13(a) 3.1-13(r) 3.1-13(s)				

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 8 of 10 sampled clients (#1, #2, #4, #5, #7, #8, #9 and #10) and for 23 additional clients (#11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #57, #58, #60, #61, #62, #65 and #68). The facility failed to implement its policy and procedures to prevent neglect and/or abuse of clients in regard to a fractured neck, theft of clients' properties and in regard to preventing medication errors with a client. The facility failed to implement its policy and procedures to conduct thorough investigations in regard to all allegations of abuse, neglect and/or injuries of unknown source. The facility failed to implement its policy and procedures to put in place corrective measures to prevent theft of clients' properties, and to ensure the results of an allegation of staff to client abuse were completed within 5 business days. The facility failed to ensure clients were allowed to participate in household tasks at the facility involving the clients' personal items/room.</p> <p>Findings include:</p>	W000122	<p>W122 Condition - Client Protections - This facility has been diligent in its efforts to protect the welfare and dignity of all residents of the facility. Inherent in the philosophy of the ICF/MR regulations residents are to be allowed the freedom to move about in their home with as little restriction as possible. The facility has utilized numerous interventions to minimize the risk of injury to residents while still affording them the opportunity to move about freely in their home, the freedom to interact with peers who share their home and to afford them privacy and independence. The facility has also encouraged residents to have meaningful relationships with the staff. It is the facility's intent to encourage these normalized experiences but to keep safeguards in place that minimize the risk of injuries or events that could be viewed as possible violation of their rights. The facility will continue and re-new efforts to protect residents in all manners, but maintains that in protecting a residents right to make choices, that events can occur where residents will risk injury. #1. Please refer to W149 and W154 related to client #11 and client #38, 25, 29, 45, 60, 65. #2. Please refer to W104</p>	03/27/2013			

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	<p>1. The facility failed to implement its written policies and procedures to prevent neglect and/or abuse of client #11 in regard to an injury of unknown source (fractured neck) which resulted in a significant injury/paralysis of a client. The facility failed to implement its policy and procedures to prevent neglect of client #38 from grabbing and taking others' medications to prevent potential harm of the client, and to prevent abuse/theft of clients' personal properties and possessions for #25, #29, #45, #60 and #65. The facility failed to implement its written policy and procedures to conduct and/or document thorough investigations in regard to allegations of neglect/abuse, injuries of unknown source, and/or client to client aggression/abuse for clients #11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #58, #60, #61, #62, #65 and #68. Please see W149.</p> <p>2. The facility failed to ensure each client had the opportunity to put away their own clothing and make their own beds during active treatment opportunities for clients #1, #4, #5, #8 and #10. Please see W137.</p> <p>3. The facility failed to conduct investigations and/or to conduct thorough investigations in regard to client to client</p>		related to clients #1, 4, 5, 8, & 10. #3. Please refer to W154 related in investigations #4. Please refer to W104 related to timely investigations #5. Please refer to W149 related in investigations of theft.				

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	<p>aggression/abuse, injuries of unknown source, medication errors involving a client grabbing medications, and in regard to a significant incident which left a client paralyzed due to an injury of unknown source for clients #11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #58, #60, #61, #62, #65 and #68. Please see W154.</p> <p>4. The facility failed to complete an investigation in 5 working days and/or report the results of the investigation to the administrator within the 5 day time frame involving client #57. Please see W156.</p> <p>5. The facility failed to put in place corrective actions/measures to prevent continued theft of clients' properties for clients #25, #29, #45, #60 and #65. Please see W157.</p>						

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W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, record review, and interview for 5 of 10 sampled clients (clients #1, #4, #5, #8 and #10), the facility failed to ensure each client had the opportunity to put away their own clothing and make their own beds during active treatment opportunities.</p> <p>Findings include:</p> <p>1. On 2/11/13 from 1:30pm until 2:32pm, on 2/11/13 from 3:20pm until 5:40pm, on 2/12/13 from 5:45am until 9:13am, and on 2/13/13 from 1pm until 1:40pm, observations were conducted and during the observation times, clients #1, #4, #5, #8 and #10 were not observed to make their own beds or put away their own clothing. During the observation periods Laundry Aide (LA) #36 was observed to push a rack of clothing up/down the hallways, deliver clean laundry to each client's room, put hanging clothing into the clients' closets, put folding laundry into the clients' drawers, and make the clients' beds throughout the facility. On 2/12/13 at 6am, LA #36 stated clients</p>	W000137	<p>** What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Clients # 4, 5, 8, 1, and 10 have had their ISP's updated to indicate whether they are able to assist in putting their clothing away and making their beds. If it was determined in their ISP that this is part of their plan, they will be allowed and encouraged to do so. If not, then a reason will be given as to why. ** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents could be affected. All resident's ISP plans will be updated as they come up for review to determine exactly what they can do. Any changes will be reflected on the plan and in-services will be given to all staff to assure they are aware. ** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. All ISP plans will be updated as they come up for review. Any changes in whether a client can put his/her clothes away and make his/her own bed</p>	03/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
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	<p>#15, #44, and #46 were "the only" clients "allowed" to put away their personal clothing into closets and drawers. LA #36 indicated the Laundry and Housekeeping staff make the clients' beds each day in the facility. LA #36 indicated clients do not put away their clean clothing and do not make their beds in the facility. LA #36 stated "That's what we do."</p> <p>Client #4's record was reviewed on 2/13/13 at 11:35am. Client #4's 4/3/2011 CFA(Comprehensive Functional Assessment) indicated he can put his possessions away. Client #4's CFA indicated he "does not perform any chores independently such as making his bed...He can put clothes in drawers but not hang them up."</p> <p>Client #5's record was reviewed on 2/13/13 at 10:40am. Client #5's 5/8/2012 CFA indicated he can put away clothing and obtain his personal clothing. Client #5's CFA did not indicate if client #5 could make his bed.</p> <p>Client #8's record was reviewed on 02/12/13 at 2:00 PM. Client #8's 1/22/13 ISP did not indicate client #8 could make her bed or put away her clothes.</p> <p>Client #1's record was reviewed on</p>		<p>will be included in the ISP plan and all staff will be in-services. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place. The regularly scheduled meetings will address this issue. All clients will have their ISP updated during these meetings and this topic of whether they can or cannot put their own clothes away and/or make their bed will be discussed. The QMRP responsible for each client will be responsible for managing this and assuring the ISP is updated in this area. It will also be discussed during the QA meetings. This will be ongoing.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>2/13/13 at 2:43 PM. Client #1's ISP (Individual Support Plan) dated 7/31/12 did not indicate client #1 could make his bed or put his personal clothing items in drawers/closets.</p> <p>Client #10's record was reviewed on 2/13/13 at 9:34 AM. Client #10's ISP dated 8/23/12 did not indicate client #10 could make his bed or put his personal clothing items in drawers/closets.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #3 (Qualified Mental Retardation Professional) was completed. QMRP #3 indicated client #4 could assist with making his bed and putting his clothing away. QMRP #3 indicated client #4 was not allowed to put away his own clothing or make his bed.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #1 was completed. QMRP #1 indicated client #5 could assist staff to make his bed. QMRP #1 indicated client #5 could put away his own clothing with assistance. QMRP #1 indicated client #5 should have been prompted to assist with his personal possessions and was not. QMRP #1 indicated clients #1, #4, #5, #8 and #10 were not allowed to put away their clothing or to make their own beds.</p> <p>3.1-9(a)</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 7 additional clients (#11, #25, #29, #38, #45, #60 and #65), the facility neglected to implement its written policies and procedures to prevent neglect and/or abuse of client #11 in regard to an injury of unknown source (fractured neck) which resulted in a significant injury/paralysis of a client. The facility neglected to implement its policy and procedures to prevent neglect of client #38 from grabbing and taking others' medications to prevent potential harm of the client, and to prevent abuse/theft of clients' personal properties and possessions for #25, #29, #45, #60 and #65.</p> <p>Based on interview and record review for 22 additional clients (#11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #58, #60, #61, #62, #65 and #68), the facility neglected to implement its written policy and procedures to conduct and/or document thorough investigations in regard to allegations of neglect/abuse, injuries of unknown source, and/or client to client aggression/abuse.</p>	W000149	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. Client # 11 is still in the facility. He is non-ambulatory at this time. He has been placed in an area that is close to the "safety area" where there is heavier monitoring done by staff and where employees can assist him quickly if needed. He is up in geri-chair daily. #2. Client # 38 did not show any ill effects from the wrong medication. He was closely monitored. #3. Client # 65 and #25 had their personal property replaced. This facility initiated the following additional measures: *Replaced the combination locks. *Replaced the lock on the cabinet where the Wii is now located. *Locked all flat screen TV's when appropriate. *Random rounds are completed daily. *Security measures have also been initiated - added additional outside lighting on exterior of the building, police were requested to increase surveillance of the property, all windows are checked to assure they are closed and locked at least 5 X's weekly. #4. Clients #29, 45, and 60 have had their TV's replaced. #5. All clients who had property missing</p>	03/27/2013			

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	<p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's 6/27/12 reportable incident report indicated "At 7:00 am, [client #11] was found on his bed with one leg extended off of it and not moving very well. Nursing was called to assess [client #11] for any injury. The assessment revealed a small laceration to his right eyebrow and an abrasion to one knee. The areas were cleansed with soap and water and left open to air. It was also noted that [client #11] was not acting as usual. Neuro checks were initiated as well as a skin flow sheet. Because [client #11] was not responding as he usually does when assessments occur, he was sent to [name of hospital] Emergency Room (ER) for further assessment. [Client #11] was admitted to the hospital with a stable fracture of the sixth vertebrae. [Client #11] is independently ambulatory with an awkward gait. He gets up and down in chairs and gets in and out of bed independently. He has been assessed by Physical Therapy (PT) Services to determine need for any adaptive equipment to assist him in walking. None has been prescribed except to use a wheelchair to go to the other building due</p>		<p>have had the property replaced. A procedure has been changed regarding how to complete a thorough investigation, an audit is being done for safety in medication administration. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 1. All clients have the potential to be affected. An algorithm is being developed to assist any management staff who is charged with conducting an investigation for serious injuries. This algorithm will lead the employee to a thorough investigation by asking these questions: Have all employees involved been interviewed? Is there a discrepancy in the statements? Are there other minor injuries besides the serious injury? Is there a thorough accounting for the scene including how client was found and how the environment was set up? Any recent issues with safety for this client or any recent behaviors? Have we gotten a statement from the physician? #2. All clients could be affected. There is now a hydration cart available in the room located adjacent to the dining room where client #38 can access liquids from the time he arises until he goes to his class. An in-service will be conducted with all nursing personnel regarding the safe</p>		

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	<p>to the distance and edges of sidewalk. He frequently gets out of bed and changes his clothes. There is a bedside mat and he uses non-skid socks to further provide for his safety. Both measures were in place when this incident was noted. An investigation has been initiated to determine what might have happened. All staff that worked with [client #11] in the hours preceding the incident as well as all staff who were present the morning of the incident were interviewed. No one had any knowledge nor was that any indication of a fall (sic). Upon his return to the facility, [client #11] will become part of the facility's safety plan which involves very frequent monitoring throughout the night. In this manner, the facility can ensure that, if [client #11] gets out of bed, a staff member will be present to assist him...."</p> <p>A 7/5/12 follow-up report indicated "...Resident remains at [name of hospital] Transitional Care Unit at this time receiving physical therapy. MRI completed at [name of hospital], also shows a number of chronic conditions of the spine including: bone spurs, arthritis, several congenital degenerative changes to joints and the spinal cord, disc herniation, and narrowing of the spinal cord. In addition to his age as a factor in degenerative changes, [client #11] was</p>		<p>handling of medication administration. #3. All clients could be affected. All employees have been re-educated regarding misappropriation of property and how to report. #4. All clients could be affected. An in-service will be conducted to educate all personnel on misappropriation of property and how to thoroughly investigate. Security rounds will be conducted at least 5 X's weekly. #5. All clients could be affected. Re-education is being conducted, security rounds are being conducted, safety in medication administration is being monitored, and the algorithm will be used in the case of any serious injury to assure the investigation is thorough. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; 1. An algorithm is being developed to assist any management staff who is charged with conducting an investigation for serious injuries. This algorithm will lead the employee to a thorough investigation by asking these questions: Have all employees involved been interviewed? Is there a discrepancy in the statements? Are there other minor injuries besides the serious injury? Is there a thorough accounting for the scene including how client was found and how the environment was set up?</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>also a long term user of Dilantin to control his seizures. Dilantin may have contributed to the weakening of all bones and [client #11] now has a diagnosis of osteopenia. His use of Dilantin was discontinued in April 2009. Prior to this incident, [client #11] was able to fully participate in active treatment. He was able (sic) complete ADL's (adult daily living skills) with verbal/manual assist with out (sic) difficulty. There was no indication for increased risk of fracture. [Client #11's] primary care physician and his neurologist have indicated he could have potentially had a breakthrough seizure causing the injury on 6/27/12. We have investigated the cause of the injury sustained to [client #11]. This included inquiries of staff who worked with him in the hours prior to the injury being discovered. There is no one who witnessed [client #11] falling, but that possibility cannot be ruled out as he does rise from bed independently. A fall risk plan was in place at the time of the incident and all measures had been followed as written. According to the reports from staff working with [client #11] he was in bed as usual at 6:25 am. Staff saw him again about 7:00 am. He was still in bed but had changed positions and was lying with one leg off the bed...."</p> <p>A 7/12/12 follow-up report indicated</p>		<p>Any recent issues with safety for this client or any recent behaviors? Have we gotten a statement from the physician? #2. All nurses have been re-educated regarding the safety of medication administration. The DON will audit to assure that all nurses are providing medications in a safe manner. #3. All employees have been re-educated regarding misappropriation of property and how to report timely. The security rounds will continue at least 5 X's weekly to assure that nothing is missing and that the building is secure. #4. All employees have been re-educated regarding misappropriation of property and how to report timely. The security rounds will continue at least 5 X's weekly to assure that nothing is missing and that the building is secure. #5. An algorithm is being developed to assist any management staff who is charged with conducting an investigation for serious injuries. This algorithm will lead the employee to a thorough investigation by asking these questions: Have all employees involved been interviewed? Is there a discrepancy in the statements? Are there other minor injuries besides the serious injury? Is there a thorough accounting for the scene including how client was found and how the environment was set up? Any recent issues with safety for</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>client #11 was discharged back to the facility on 7/11/12. The 7/12/12 follow-up report indicated "...Upon his return to the facility included a room change which involved him moving to a bedroom in closer proximity to the nurses and near others in need more intensive monitoring by staff (sic)...." The follow-up report indicated client #11 had a bedside mat, padded head board, hoyer lift, a fall risk assessment, monitored seizures and medications. The follow-up report indicated client #11 also had a repositioning chair and a pressure relieving mattress.</p> <p>The facility's 6/27/12 and/or 7/2/12 witness statements indicated some staff indicated there were clothes on the floor of client #11's bedroom the morning of 6/27/12 and some staff indicated there were no clothes laying around on the floor on 6/27/12. The staff witness statements indicated the following (not all inclusive):</p> <p>-Staff #46's 6/29/12 hand written statement indicated "Wednesday morning I went into [client #11's] room- about 6:15 AM. I was helping get [client #47] into the chair. I didn't notice anything unusual in the room. The floor area was clear, nothing anyone could fall over, floor mats were in place. [Client #11] was not sitting up in his bed. We left the</p>		<p>this client or any recent behaviors? Have we gotten a statement from the physician? **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place; #1. All investigations will be discussed during the morning IDT meeting. The results will be brought before the QA committee and the Medical Director to assure that the investigation is thorough and complete. This will be ongoing. #2. The results of the audit will be brought to the monthly QA committee meeting. The DON is responsible. This audit tool will be completed 1 X weekly for the first 1 month. If no further problems, then it will be completed 1 X every two weeks for 3 months. If there is 100% compliance after 3 months, the QA committee will decide if it should continue. #3. The results of the daily security rounds will be discussed during monthly QA committee meetings. The rounds will be ongoing. #4. The results of the daily security rounds will be discussed during monthly QA committee meetings. The rounds will be ongoing. #5. Results of all of the audits and security checks will be brought before the QA committee monthly. These will be ongoing.</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>room about 6:23 AM."</p> <p>-Staff #46's typed 6/29/12 witness statement indicated "...[Staff #46] stated there was a lot of things ([client #11's] clothes) on the floor when she was in his room."</p> <p>-Staff #48's 7/2/12 hand written witness statement indicated "I entered [client #11's] room in between 6:30 a.m.-7:00 a.m. At that time I was trying to get shorts on him and didn't notice the cut to his head. [Client #11] acted like he didn't want to get up so I moved on to assist another resident. Sometime after I passed by [client #11's] room, again and that's when I came back in after another employee asked me if I had seen the cut, I went in and looked and then I went to get a nurse."</p> <p>-Staff #48's 7/2/12 typed witness statement indicated staff #48 indicated she had first seen client #11 at 7:00 AM as staff #48 had not been in the client's room prior to that. Staff #48's typed witness statement indicated client #11 had "...Two to three pairs of pants on the floor by his mat and the closet door was slightly ajar. These were picked up. [Staff #48] stated that she tried to put a pair of shorts on him. [Client #11] grunted as he normally does. She did not</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>notice any injury or sense that anything was wrong. She went back to the room after [staff #47] pointed out that something was wrong with [client #11]. It was at this time that she went to get the nurse to assess [client #11]."</p> <p>-Staff #47's hand written witness statement indicated "On 6/27/12 at 7:00 am I went into the room to get [client #11] up and had not been in that room or seen any one go in or out of that room tell (sic) 7:00 am and saw that [client #11] was not up asked [staff #48] why he was not up she sead (sic) hed (sic) didn't want to get up saw a injury asked her if she saw it she sead (sic) yes but it looked old so I seed (sic) for her to get the nurse (sic)."</p> <p>-Staff #47's undated typed statement indicated "...He indicated he did not see anyone go into [client #11's] room prior to finding him at 7:00 am. He called [staff #48] into the room and asked her if she had seen [client #11's] injury. She stated she had not. There were no clothes on the floor at this time, according to [staff #47]. [Staff #47] told [staff #48] to get [LPN #1] who came to assess him."</p> <p>-Staff #49's undated typed witness statement indicated staff #49 walked with client #11 to the bathroom at 3:30 AM, 5:00 AM and at 6:15 AM on 6/27/12.</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>Staff #49's typed witness statement indicated no clothes were on client #11's floor when the staff was with client #11 in his bedroom. The undated typed witness statement indicated "...He (client #11) was not up at 6:25am when [staff #49] left the room."</p> <p>The facility's undated investigation indicated "We have investigated the cause of the injury sustained by [client #11]. This included inquiries with staff who worked with him in the hours prior to the fall. There is no one who witnesses [client #11] falling, but that possibility cannot be ruled out." The facility's undated investigation neglected to include the following:</p> <ul style="list-style-type: none"> -an interview by LPN #1 who assessed client #11 on 6/27/12 -to investigate the discrepancy of the above mentioned staff statements -to include a thorough layout/investigation of client #11's environment/room -to include how the client received a laceration to eyebrow/knees -to indicate what position (back or stomach) the client was found laying in 				

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	<p>- to include any recent health issues, falls and/or seizures client #11 had experienced in the past months.</p> <p>-to look at possible client to client incidents of aggression and/or client #11's roommates for possible cause.</p> <p>-to include interviews with clients in regard to incident and/or staff treatment of clients</p> <p>-to include doctor/medical professional statements and/or interviews.</p> <p>Client #11's record was reviewed on 2/13/13 at 2:50 PM. Client #11's 7/11/13 admitting orders/hospital records indicated client #11's diagnoses included, but were not limited to, Cervical Myelopathy (degenerative cervical deterioration or trauma) and "Fx (fracture) C 6" of the client's cervical spine.</p> <p>Client #11's 6/27/12 History and Physical (H & P) indicated "...HISTORY OF PRESENT ILLNESS: The patient was found this morning at the residence of Hickory Creek, a care facility for the mentally retarded. He was lying apparently on his back, halfway on and halfway off of his bed. He was noted to have a laceration to his right brow but</p>			

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	<p>was not moving. He was brought to the emergency room. He has been found to have a fracture of the body of C6. There is no neurological impairment. The patient is admitted for observation purposes...." The H & P indicated client #11 had a history of a fracture to his hip and ankle. The 6/27/12 H & P indicated "...He requires assistance for all activities of daily living...He has no recent seizure activity, Events related to his fall were unobserved...." The H& P indicated client #11 was not walking/ambulatory at the time of the exam.</p> <p>Client #11's Nurses Notes indicated the following (not all inclusive):</p> <p>-6/27/12 at 7 AM, "Staff reported resident not wanting to get out of bed, upon assessment resident laying ob bed (on back) (with) one leg (L (left) off on floor. (T) (temperature) 95.6, (P) (pulse) 56 (R) (respirations) 20 even/unlabored, BP (blood pressure) 154/58, Sp 0s (oxygen level) 98% RA PEARL (brisk).</p> <p>Laceration to (R) (right) eyebrow noted 1 cm (centimeter) x (by) 0.3 cm area cleansed (with) soap et (and) water et left open to air. Resident responded to pain by yelling out. (L) leg rotated outward et very superficial abrasion noted to (L) knee measuring 1.5 cm x 0.5 cm.</p> <p>Resident not acting like himself, not</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>moving extremities when stimulated, Extremities flaccid. Alert to self/name. Pedal pulses in both (+) (positive-present) in both feet 0 (zero) S/S (signs/symptoms) seizure, 0 S/S HA (headache), or 0 emesis noted.</p> <p>-6/27/12 at 7:10 AM, "...Slipper socks were on patient et mat at bedside (at 7 AM)."</p> <p>-6/27/12 at 7:13 AM, "(911 called d/t (due to) 0 response from [name of doctor]...."</p> <p>-7/3/12 at 9:40 AM Nurse spoke with the case manager at the hospital regarding client #11's needs. The note indicated "...It was determined per [name of case worker] report, surgery was not an option et he requires a soft neck back et therapy. Option to transfer to TCU (Transitional Care Unit) for intensive therapy for a few days then discharge back to HCG (Hickory Creek Gaston)."</p> <p>-7/3/12 at 9:45 AM, "Consulted/updated...Intensive therapy BID (two times a day) ordered vs (versus) option of transition care." Another 7/3/12 note at 9:50 AM indicated client #11 would return to Hickory Creek once the client completed "Intensive therapy."</p> <p>-7/11/12 Client #11 returned to the</p>						

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	<p>facility. Client #11 was no longer able to void on own and required a straight catheter.</p> <p>Client #11's January 2012 to May 2012 indicated client #11 had no seizure activity. Client #11's 7/11/12 progress note indicated "[Client #11] is seen after being hospitalized with a serious cervical myelopathy after suffering a body of C6 fracture. This patient is nonverbal. He has very limited motion of his extremities and torso. He does have some function of his left arm...Assessment/serious cervical myleopathy with body of C6 fracture...." A 7/6/12 note indicated "...He is cathed for urine on a regular basis...." Client #11's 8/15/12 physician's progress note indicated "...Nurses also tell me that he has developed some function of his lower extremities at least able to use his pelvis to contact his legs. Objective/patient is awake and alert. He is noted to have some function of his right upper extremity at least to the level of the wrist. He does move his lower extremities symmetrically...."</p> <p>Client #11's 8/30/12 physician's order indicated "PT clarification: Discharge skilled PT Services as per pt reach the highest functional outcome (with) PT, pt progress plateau to recommend restoration program 2-3x/week to increase</p>						

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	<p>ROM (range of motion)...and improved sitting balance...."</p> <p>Client #11's Social Service Progress Notes indicated the following (not all inclusive):</p> <p>-7/26/12 "...Res (resident) uses jeri chair for mobility now. Res needs assist (with) Tsing (transferring) & (and) his ADLs. Res is a fall risk. Res resides in Rm #11...."</p> <p>-8/21/12 "...Res continues to have difficulties moving his extremities. Staff are feeding Res...."</p> <p>A 6/28/12 QMRP (Qualified Mental Retardation Professional) Needs Oriented Progress Note indicated: Response to Nurse Note dated 6-27-12: "[Client #11] was found with one leg off the bed in his bedroom and not acting as usually (sic). He sustained a small laceration to his right eyebrow. [Client #11] usually gets out of bed independently. He is independently ambulatory but has an awkward gait. He wears non-skid socks to help his stability while he is walking. [Client #11] may lose his balance at times due to his gait but not often. There is no evidence of a fall but that possibility cannot be ruled out. It appears that [client #11] may have hit his head on the</p>						

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	<p>headboard or some other object on his bed causing the injury...[Client #11] will be placed in the safety group which is a group of residents that require more intensive monitoring when they are in bed....."</p> <p>Client #11's 3/22/12 Individual Support Plan indicated client #11 was independent in ambulation and was able to sit on the toilet without staff prior to the 6/27/12 incident. Client #11's ISP did not indicate the client had experienced any seizures in the past year.</p> <p>Client #11's undated Initial Care Plan (readmission) indicated client #11's "Primary Admitting Diagnosis or Problem: Hx (history)-C6 Fx, paralysis or upper/lower extremities...."</p> <p>Interview with LPN #1 on 2/14/13 at 9:16 AM indicated client #11 had a small headboard at the end of his bed. LPN #1 indicated the client had an Armoire that was about 6 feet tall next to his bed. LPN #1 indicated client #11 was in a different room prior to the 6/27/12 incident. LPN #1 indicated she was the nurse who assessed the client on 6/27/12. LPN #1 indicated client #11 was laying on his back with one leg off the bed. LPN #1 indicated client #11 had a laceration above his eyebrow. LPN #1 stated "There</p>						

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	<p>was one spot of blood on bed. None else." LPN #1 indicated there was no blood found any place else in the client's room. When asked if client #11 experienced seizures, LPN #1 stated "Can't ever remember him having a seizure." LPN #1 indicated client #11 was not having any falls prior to the incident. LPN #1 indicated it was determined the client probably had a seizure which caused the fracture.</p> <p>Interview with QMRP #1, #2, #3, #4 and administrative staff #1 on 2/14/13 at 10:00 AM indicated the facility conducted an investigation into client #11's injury of unknown source. Administrative staff #1 provided no additional information/documentation in regard to client #11's injury of unknown source. QMRP #1 stated client #11's doctor indicated the client "may have had a significant health status change like a stroke." QMRP #1 indicated the facility did not know how client #11 fractured his neck. QMRP #1 and administrative staff #1 indicated the facility moved client #11 to another hall to be monitored closer at night. QMRP #1 was not aware of any falls with client #11 prior to 6/27/12. QMRP #1 indicated client #11 utilized a wheelchair for ambulation as the client could no longer walk.</p>						

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	<p>2. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-5/16/12 "Medication error report of 5/16/12 at 7:15 am. During medication administration [client #38] grabbed a cup off the med cart as the nurse had turned to assist another resident in need if immediate nursing care. The cup contained medications intended for another resident and [client #38] inadvertently consumed the medications: Miralax (stool softener) 17mg (milligrams), Klonopin 0.5mg (antipsychotic), Sertraline 50mg (behavior). [Name of doctor] was immediately notified and noted [client #38] may be more sedated and to hold his Mellaril (antipsychotic) and risperdal (sic) (antipsychotic) for the day. Correct medication given to other resident. Resident was closely clinically monitored by licensed nursing staff (sic). There were no ill effects from the medications, resident as per usual (sic). Resident has a behavior program to address stealing (usually food or drink) in addition to behavioral medications...Nurse involved received an inservice on medication administration...."</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	-5/20/12 "Medication error report of 5/20/12 at 7:10 am. During medication administration [client #38] took a cup off the med cart as the nurse turned to assist another resident in need of nursing care. The cup contained medications intended for another resident and [client #38] inadvertently (sic) consumed the medications: Miralax 17mg, Klonopin 0.5 mg, Sertraline 50mg. [Name of doctor] was immediately notified and instructed to monitor. Resident was closely monitored by licensed nursing staff. Correct medication given to other resident. They (sic) were no ill effects from the medications, resident as per usual (sic). Resident has a behavior program to address stealing (usually food or drink) in addition to behavioral medications. [Client #38's] behavioral medications and data was reviewed by [name of nurse practitioner], of [name of company] on 5/19/12 and orders received for increase upon approval. In addition, there has been a program change to address this transitional time in the am. [Client #38] will cross to training center by 7:15 am upon finishing breakfast to encourage less access to medication cart and decrease desire to seek out nursing for fluids. The nurse involved has been re-inserviced on medication administration with a focus on the 5 rights and errors related to distractions and the				

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	<p>ICF/MR (Intermediate Care facility/Mental Retardation) population. In, (sic) addition to the training, the nurse has received disciplinary action. Will continue to monitor and treat healthcare needs as they arise."</p> <p>The facility neglected to conduct and/or document an investigation in regard to the above mentioned medication errors involving client #38 as no additional information/investigation was included with the above mentioned reportable incident reports.</p> <p>Client #38's record was reviewed on 2/13/13 at 5:07 PM. Client #38's 4/29/11 Behavior Intervention Plan (BIP) indicated client #38's diagnoses included, but were not limited to, Severe Mental Retardation and Impulse Control Disorder. Client #38's BIP indicated the client demonstrated the behavior of "Stealing (Usually Food or Drink) which was defined as "Taking others people's pop or food and eating it. May go into a restricted area such as office to steal pop/food." Client #38's 4/29/11 BIP indicated the facility neglected to revise and/or address client #38's taking of medications as indicated by the facility's 5/16/12 and 5/20/12 reportable incident reports.</p>						

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	<p>Interview with LPN #1, Administrative staff #1 and Qualified Mental Retardation Professional (QMRP) #1 on 2/14/13 at 10:00 AM indicated client #38 would take others food, drink and medications. LPN #1 indicated LPN #3 was involved in both of the medication incidents with client #38. When asked how client #38 was able to grab medication off a medication cart, LPN #1 stated "He's quick." LPN #1 indicated LPN #3 was restrained in regard to medication administration. QMRP #1 and LPN #1 indicated staff would try to redirect client #38 away from the medication cart. LPN #1 and QMRP #1 indicated the client had a behavior program for stealing. QMRP #1 indicated client #38's 4/29/11 BIP neglected to specifically address client #38's behavior of grabbing/taking others medications. The facility did not provide documentation LPN #3 was restrained/re-inserviced in regard to medication administration. Administrative staff #1, QMRP #1 and LPN #1 indicated the facility did not document/conduct an investigation of the May 2012 Medication errors with client #38.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's reportable incident reports and/or</p>			

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	<p>investigations indicated the following:</p> <p>-5/27/12 "At approximately 7:30 pm [client #65] told staff that her game system and her portable DVD was (sic) missing from her bedroom. Staff were instructed to search for the missing items. [Client #65] does use the games in different locations and will offer for some of her peers to use things that belong to her. At the time of submitting tis (sic) report the items have not yet been found. Further search will continue. The [name of police department] have been notified and will investigate the reported missing items. [Client #65] has her own bedroom and no person was seen entering her room. The facility will continue to investigate and search for recovery of the missing items."</p> <p>The facility's 6/4/12 follow-up report indicated the facility was not able to locate the missing items. The follow-up report indicated the facility replaced the items and client #65 was given a new combination lock for her closet. The report indicated "...She has been instructed to not allow staff to watch her open the closet door when she is entering the combination. We continue to work with [name of police department] who is investigating the missing property...." The 6/4/12 follow-up report indicated</p>						

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	<p>facility staff had been retrained in regard to "misappropriation of property."</p> <p>-5/27/12 "[Client #25] approached a staff member indicating that her wii was missing from her room. The Administrator was notified and requested that a search of other areas in [client #25's] home be made to see if she had misplaced it. At the time of this report the wii had not yet been located. The [name of police] were contacted and have started a report and will conduct an investigation. We will continue to look to at locations in the home where the wii may have been misplaced (sic)."</p> <p>The facility's 6/4/12 follow-up report indicated "The [name of police] are investigating the missing wii. The facility has also been questioning staff who worked on 5/27/12. At this time no one was seen to enter [client #25's] room or have possession of her wii. The Wii has been replaced by the facility and [client #25] has a new lock for her closet with no other key available to staff...2. Staff that work with [client #25] are being re-trained as it relates to misappropriation of property...."</p> <p>The facility's undated investigation indicated the police department had interviewed 3 facility staff in regard to the</p>						

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	<p>theft of the clients' items. The undated investigation indicated "...Findings: There is no evidence to prove anyone person took the property of either resident as of 5/30/12. It is believed that [clients #25 and #65] rarely leave their supplies un-locked. [Client #65] uses a combination lock and it is possible she may have forgot to lock her closet, but that is unusual. [Client #65] may have opened with a staff present, who then found out her combination. Her combination lock was changed and very few people on the management team have the new combination including [client #65]. [Client #65] has been instructed in the future to ask staff to leave the room or turn their backs while she opens her closet in the future. The combination will also be changed at varied intervals in the future. [Client #25] always uses a key that she wears around her neck to the closet where her wii was located. There was only one other key that was available for staff in case [client #25] was to lose her key. A new lock has been put in place and the spare key will be locked up in a manager's office." The facility's investigation indicated the facility neglected to interview any clients in regard to the missing items and/or knowledge of staff taking the items.</p> <p>The facility's inservice training records</p>						

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	were reviewed on 2/14/13 at 12:30 PM. The facility's 6/4/12 Meeting/Seminar Attendance Sign-In sheet indicated facility staff were trained in regard to "Misappropriation Of Property." An attached undated memo indicated "ALL STAFF MUST BE AWARE THAT IT IS NEVER APPROPRIATE TO USE A RESIDENT PROPERTY, TO BORROW IT, OR TO REMOVE IT FROM THE FACILITY PREMISES. AT TIMES A RESIDENT MAY OFFER YOU THE USE OF THEIR PROPERTY OR EVEN ASK YOU OR ANOTHER RESIDENT TO TAKE IT. IT IS NEVER OKAY TO USE THIS AS IT MAY BE CONSIDERED MISAPPROPRIATION OF PROPERTY. IF YOU ARE FOUND TO TAKE THINGS THAT BELONG TO A RESIDENT YOU CAN BE TERMINATED IF IT IS DETERMINED THAT YOU DID THIS AND FORMAL CRIMINAL CHARGES MAY BE PURSUED. RECENTLY WE HAD A WII, A PORTABLE DVD PLAYER, AND A DS GAME THAT WAS (sic) REPORTED MISSING BY FACILITY RESIDENTS. WE ARE WORKING WITH THE LOCAL POLICE DEPARTMENT TO INVESTIGATE THIS. IF YOU HAVE ANY INFORMATION REGARDING THE DISAPPEARANCE OF ANY OF THESE ITEMS YOU NEED TO						

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	<p>NOTIFY THE ADMINISTRATOR IMMEDIATELY. ALL RESIDENT POSSESSIONS SHOULD REMAIN WITH THE RESIDENT IN THEIR HOME. IF YOU ARE AWARE THAT A RESIDENT HAS NOT SECURED A VALUABLE ITEM ASSIST THEM TO LOCK THE ITEM UP."</p> <p>The facility neglected to put in place any additional measures to prevent theft of clients' personal possessions/items.</p> <p>Interview with administrative staff #1, QMRP #1, #2, #3 and #4 on 2/14/13 at 10:00 AM indicated client #25 and #65's items were taken/stolen as the items were not found. Administrative staff #1 indicated clients #25 and #65's items were replaced by the facility on 6/4/12 (client #25) and on 6/31/12 (sic) (client #65). Administrative staff #1 indicated neither the facility nor the police were able to determine who took the clients' personal possessions. Administrative staff #1 and QMRP did not provide any additional information in regard to client interviews conducted during the facility's investigation. Administrative staff #1 indicated the facility neglected to put in place any additional corrective measures to prevent the theft of clients' personal items, who resided at the facility.</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>4. The facility's records were reviewed on 2/12/13 at 12:15pm and on 2/12/13 at 2:30pm. A review of the BDDS (Bureau of Developmental Disability Services) reports from 7/1/2012 through 8/31/2012 indicated the following:</p> <p>-Three BDDS reports on 7/16/12 for incidents on 7/15/12 at 12:57pm, for clients #29, #45, and #60 indicated "Staff to nursing that resident's television was missing" from clients #29, #45, and #60's bedrooms in the main building at the facility. The reports indicated the police were notified and the police and facility had begun an investigation. The reports indicated the staff will be retrained on misappropriation of property.</p> <p>-Follow up reports for client #29, #45, and #60's 7/15/12 incident indicated the police continued their investigation. The reports indicated the police determined the televisions were removed from client #29, #45, and #60's bedrooms at the facility "on the evening of 7/15/12" and no determination had been made for who took the televisions. The follow up reports indicated client #29, #45, and #60's televisions had been replaced and secured on the television stands inside their bedrooms. The reports indicated outside facility lighting had been installed, staff had been inserviced on</p>						

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	<p>misappropriation of property, and "random checks" were being completed to ensure the televisions were in place.</p> <p>On 2/14/13 at 1:40pm, the investigation for the three (3) 7/15/12 incidents was reviewed. The investigation indicated the missing televisions belonged to clients #29, #45, and #60. The investigation indicated the televisions were reported as missing on "7/15/12 around 10:00 in the morning." The investigation indicated the Director of Nursing "started collecting statements" from staff and had twenty-two (22) completed. The investigation indicated "the police" determined the "TV's likely came up missing between 9pm and 10pm on Saturday night" and could not "determine who took the TV." The investigation neglected to include how the facility was going to complete "random" security checks or what areas would be checked. No client interviews were available for review. No staff witness statements were available for review. A written summary of the statements taken by the Director of Nursing were reviewed and these summaries were completed by the facility's administrative staff.</p> <p>On 2/14/13 at 1:15pm, a review of the facility's 8/29/12 inservice training for "Misappropriation of Resident Property"</p>						

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	<p>was conducted. The inservice indicated a written note "All staff must be aware that it is never appropriate to use, borrow, or remove a resident's property from the facility...." The inservice training indicated three (3) clients had televisions reported as missing.</p> <p>On 2/14/13 at 1:35pm, a review of the facility's undated inservice training for "Misappropriation of Resident Property" indicated additional training on the same information as 8/29/12 was completed from 7/16/12 until 8/7/12.</p> <p>On 2/13/13 at 1pm, observation was completed of client #29, #45, and #60's bedrooms at the main building. Each bedroom had an unlabeled television anchored to the wall with a secure cable and each television did not indicate a client name on each television.</p> <p>On 2/14/13 at 1:15pm, a review was completed of a 7/19/12 receipt for three (3) 19" televisions which the facility purchased.</p> <p>On 2/14/13 at 1:15pm, and on 2/14/13 at 1:40pm, the Administrator provided a review of the "Security Checks" sheets. Each "Security Check" sheet was one sheet per month, had initials on the page for each day of the month, and neglected</p>						

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	<p>to indicate the time the security checks were completed and neglected to indicate what area was checked.</p> <p>On 2/14/13 at 1:50pm, an interview with Administrative Staff (AS) #5 and record review of client #29, #45, and #60's "Inventory of Personal Items" was conducted. AS #5 and client #29, #45, and #60's personal inventory sheets neglected to indicate the replacement of their televisions on 7/19/12 and each inventory sheet was signed by Social Service Staff #40 and AS #5.</p> <p>On 2/12/13 at 2:30pm, on 2/13/13 at 8:35am, and on 2/14/13 at 9:30am, an interview was completed with the Administrator. The Administrator indicated he was locating information of the investigation for the incident on 7/15/12 for client #29, #45, and #60's missing TV's. On 2/14/13 at 9:30am, the Administrator indicated no further information was available for review of the 7/15/12 incidents.</p> <p>The facility's policies and procedures were reviewed on 2/11/13 at 1:42 PM. The facility's 9/10 policy entitled Resident Mistreatment, Neglect, Abuse & Misappropriation of Property indicated "Resident will be free from mistreatment, neglect, abuse, misappropriation of</p>						

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	<p>resident funds and property,...." The facility's 9/10 policy indicated "Neglect" Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents...Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The facility's 9/10 policy and procedure indicated "...K. If the alleged violation is verified, appropriate corrective action is taken, including measures to prevent further abuse, neglect, or misappropriation of resident property...."</p> <p>5. The facility's policies and procedures were reviewed on 2/11/13 at 1:42 PM. The facility's 9/10 policy entitled Resident Mistreatment, Neglect, Abuse & Misappropriation of Property indicated "...J. Investigation: All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law...All allegations</p>						

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	<p>will be thoroughly investigated...."</p> <p>The facility neglected to conduct investigations and/or to conduct thorough investigations in regard to client to client aggression/abuse, injuries of unknown source, medication errors involving a client grabbing medications, and in regard to a significant incident which left a client paralyzed due to an injury from an unknown source for clients #11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #58, #60, #61, #62, #65 and #68. Please see W154.</p> <p>3.1-9(b) 3.1-28(a) 3.1-28(d)</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 20 of 38 allegations of abuse, neglect, injuries of unknown source reviewed, the facility failed to conduct investigations and/or to conduct thorough investigations in regard to client to client aggression/abuse, injuries of unknown source, medication errors involving a client grabbing medications, and in regard to a significant incident which left a client paralyzed due to an injury of unknown source for clients #11, #13, #18, #25, #26, #28, #29, #30, #33, #35, #38, #41, #45, #46, #50, #56, #58, #60, #61, #62, #65 and #68.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's 6/27/12 reportable incident report indicated "At 7:00 am, [client #11] was found on his bed with one leg extended off of it and not moving very well. Nursing was called to assess [client #11] for any injury. The assessment revealed a small laceration to his right eyebrow and an abrasion to one knee. The areas were cleansed with soap and</p>	W000154	<p>** What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. Please see response to W149 related to client #11 #2. Please see response to W149 related to client #38 #3. Please see response to W149 related to clients #35 and #65 #4 Client # 68, # 13 and #56 are all fine. They were monitored and assessed for injury during the time of each incident. #5. Clients #41 and #50 are both fine today with no negative effects from the incidents that occurred. #6. Clients 61, 58, 35, 33, 38, 46, 62, 18, 61, 26 are all fine and have suffered no ill effects from the resident to resident altercations. #7. Please see response to W149 related to clients 29, 45 and 60. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; #1. Please see response to W149 related to client #11 #2. Please see response to W149 related to client #38 #3. Please see response to W149 related to clients #35 and #65 #4. All clients have the potential to be affected. There is a behavior management plan in place for</p>	03/27/2013			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	water and left open to air. It was also noted that [client #11] was not acting as usual. Neuro checks were initiated as well as a skin flow sheet. Because [client #11] was not responding as he usually does when assessments occur, he was sent to [name of hospital] Emergency Room (ER) for further assessment. [Client #11] was admitted to the hospital with a stable fracture of the sixth vertebrae. [Client #11] is independently ambulatory with an awkward gait. He gets up and down in chairs and gets in and out of bed independently. He has been assessed by Physical Therapy (PT) Services to determine need for any adaptive equipment to assist him in walking. None has been prescribed except to use a wheelchair to go to the other building due to the distance and edges of sidewalk. He frequently gets out of bed and changes his clothes. There is a bedside mat and he uses non-skid socks to further provide for his safety. Both measures were in place when this incident was noted. An investigation has been initiated to determine what might have happened. All staff that worked with [client #11] in the hours preceding the incident as well as all staff who were present the morning of the incident were interviewed. No one had any knowledge nor was that any indication of a fall (sic)...."		client #30 that has been revised that addresses the antecedent to the biting behavior as well as a reward system for addressing appropriate behavior. #5. All clients have the potential to be affected. The investigative process has been more formalized. It will include three categories for investigation. One person will be the lead investigator depending on what category it falls into. The three categories are; Unknown incident, Witnessed incidents, and Resident to Resident incidents. All staff will be in-serviced before March 26, 2013. #6. All clients have the potential to be affected. In-services will be conducted regarding resident to resident altercations and how to intervene. The investigative process has been more formalized. It will include three categories for investigation. One person will be the lead investigator depending on what category it falls into. The three categories are; Unknown incident, Witnessed incidents, and Resident to Resident incidents. All staff will be in-serviced before March 26, 2013. #7. Please see response to W149 related to clients 29, 45 and 60. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; #1. Please see response to W149 related to client #11 #2. Please see				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	A 7/5/12 follow-up report indicated "...Resident remains at [name of hospital] Transitional Care Unit at this time receiving physical therapy. MRI completed at [name of hospital], also shows a number of chronic conditions of the spine including: bone spurs, arthritis, several congenital degenerative changes to joints and the spinal cord, disc herniation, and narrowing of the spinal cord. In addition to his age as a factor in degenerative changes, [client #11] was also a long term user of Dilantin to control his seizures. Dilantin may have contributed to the weakening of all bones and [client #11] now has a diagnosis of osteopenia. His use of Dilantin was discontinued in April 2009. Prior to this incident, [client #11] was able to fully participate in active treatment. He was able (sic) complete ADL's (adult daily living skills) with verbal/manual assist with out (sic) difficulty. There was no indication for increased risk of fracture. [Client #11's] primary care physician and his neurologist have indicated he could have potentially had a breakthrough seizure causing the injury on 6/27/12. We have investigated the cause of the injury sustained to [client #11]. This included inquiries of staff who worked with him in the hours prior to the injury being discovered. There is no one who witnessed [client #11] falling, but that		response to W149 related to client #38 #3. Please see response to W149 related to clients #35 and #65 #4. An re-education will be completed to inform staff of the changes in the behavior plans. The focus will be on the antecedent to the behavior in an effort to prevent it in the future. #5. The investigative process has been more formalized. It will include three categories for investigation. One person will be the lead investigator depending on what category it falls into. The three categories are; Unknown incident, Witnessed incidents, and Resident to Resident incidents. All staff will be in-serviced before March 26, 2013. 6. The investigative process has been more formalized. It will include three categories for investigation. One person will be the lead investigator depending on what category it falls into. The three categories are; Unknown incident, Witnessed incidents, and Resident to Resident incidents. All staff will be in-serviced before March 26, 2013. #7. Please see response to W149 related to clients 29, 45 and 60. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place; #1. Please see response to W149 related to client #11 #2. Please see response to W149 related to				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>possibility cannot be ruled out as he does rise from bed independently. A fall risk plan was in place at the time of the incident and all measures had been followed as written. According to the reports from staff working with [client #11] he was in bed as usual at 6:25 am. Staff saw him again about 7:00 am. He was still in bed but had changed positions and was lying with one leg off the bed...."</p> <p>The facility's 6/27/12 and/or 7/2/12 witness statements indicated some staff indicated there were clothes on the floor of client #11's bedroom the morning of 6/27/12 and some staff indicated there were no clothes laying around on the floor on 6/27/12. The staff witness statements indicated the following (not all inclusive):</p> <p>-Staff #46's 6/29/12 hand written statement indicated "Wednesday morning I went into [client #11's] room- about 6:15 AM. I was helping get [client #47] into the chair. I didn't notice anything unusual in the room. The floor area was clear, nothing anyone could fall over, floor mats were in place. [Client #11] was not sitting up in his bed. We left the room about 6:23 AM."</p> <p>-Staff #46's typed 6/29/12 witness statement indicated "...[Staff #46] stated there was a lot of things ([client #11's]</p>		<p>client #38 #3. Please see response to W149 related to clients #35 and #65 #4. Any and all incidents of aggression will be brought before the daily meeting as well as during the QA committee meetings held monthly. #5. All incidents will be discussed during the daily IDT meeting. The incidents will also be discussed during monthly QA committee meetings. This will be ongoing. #6. All incidents will be discussed during the daily IDT meeting. The incidents will also be discussed during monthly QA committee meetings. This will be ongoing. #7. Please see response to W149 related to clients 29, 45 and 60.</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>clothes) on the floor when she was in his room."</p> <p>-Staff #48's 7/2/12 hand written witness statement indicated "I entered [client #11's] room in between 6:30 a.m.-7:00 a.m. At that time I was trying to get shorts on him and didn't notice the cut to his head. [Client #11] acted like he didn't want to get up so I moved on to assist another resident. Sometime after I passed by [client #11's] room, again and that's when I came back in after another employee asked me if I had seen the cut, I went in and looked and then I went to get a nurse."</p> <p>-Staff #48's 7/2/12 typed witness statement indicated staff #48 indicated she had first seen client #11 at 7:00 AM as staff #48 had not been in the client's room prior to that. Staff #48's typed witness statement indicated client #11 had "...Two to three pairs of pants on the floor by his mat and the closet door was slightly ajar. These were picked up. [Staff #48] stated that she tried to put a pair of shorts on him. [Client #11] grunted as he normally does. She did not notice any injury or sense that anything was wrong. She went back to the room after [staff #47] pointed out that something was wrong with [client #11]. It was at this time that she went to get the</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>nurse to assess [client #11]."</p> <p>-Staff #47's hand written witness statement indicated "On 6/27/12 at 7:00 am I went into the room to get [client #11] up and had not been in that room or seen any one go in or out of that room tell (sic) 7:00 am and saw that [client #11] was not up asked [staff #48] why he was not up she sead (sic) hed (sic) didn't want to get up saw a injury asked her if she saw it she sead (sic) yes but it looked old so I seed (sic) for her to get the nurse (sic)."</p> <p>-Staff #47's undated typed statement indicated "...He indicated he did not see anyone go into [client #11's] room prior to finding him at 7:00 am. He called [staff #48] into the room and asked her if she had seen [client #11's] injury. She stated she had not. There were no clothes on the floor at this time, according to [staff #47]. [Staff #47] told [staff #48] to get [LPN #1] who came to assess him."</p> <p>-Staff #49's undated typed witness statement indicated staff #49 walked with client #11 to the bathroom at 3:30 AM, 5:00 AM and at 6:15 AM on 6/27/12. Staff #49's typed witness statement indicated no clothes were on client #11's floor when the staff was with client #11 in his bedroom. The undated typed witness statement indicated "...He (client #11)</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>was not up at 6:25am when [staff #49] left the room."</p> <p>The facility's undated investigation indicated "We have investigated the cause of the injury sustained by [client #11]. This included inquiries with staff who worked with him in the hours prior to the fall. There is no one who witnesses [client #11] falling, but that possibility cannot be ruled out." The facility's undated investigation failed to include the following:</p> <ul style="list-style-type: none"> -an interview by LPN #1 who assessed client #11 on 6/27/12 -to investigate the discrepancy of the above mentioned staff statements -to include a thorough layout/investigation of client #11's environment/room -to include how the client received a laceration to eyebrow/knees -to indicate what position (back or stomach) the client was found laying in - to include any recent health issues, falls and/or seizures client #11 had experienced in the past months. 						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>-to look at possible client to client incidents of aggression and/or client #11's roommates for possible cause.</p> <p>-to include interviews with clients in regard to incident and/or staff treatment of clients</p> <p>-to include doctor/medical professional statements and/or interviews.</p> <p>Interview with LPN #1 on 2/14/13 at 9:16 AM indicated client #11 had a small headboard at the end of his bed. LPN #1 indicated the client had an Armoire that was about 6 feet tall next to his bed. LPN #1 indicated client #11 was in a different room prior to the 6/27/12 incident. LPN #1 indicated she was the nurse who assessed the client on 6/27/12. LPN #1 indicated client #11 was laying on his back with one leg off the bed. LPN #1 indicated client #11 had a laceration above his eyebrow. LPN #1 stated "There was one spot of blood on bed. None else." LPN #1 indicated there was no blood found any place else in the client's room. When asked if client #11 experienced seizures, LPN #1 stated "Can't ever remember him having a seizure." LPN #1 indicated client #11 was not having any falls prior to the incident. LPN #1 indicated it was determined the client probably had a</p>						

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	<p>seizure which caused the fracture.</p> <p>Interview with QMRP #1, #2, #3, #4 and administrative staff #1 on 2/14/13 at 10:00 AM indicated the facility conducted an investigation into client #11's injury of unknown source. Administrative staff #1 provided no additional information/documentation in regard to client #11's injury of unknown source. QMRP #1 stated client #11's doctor indicated the client "may have had a significant health status change like a stroke." QMRP #1 indicated the facility did not know how client #11 fractured his neck.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-5/16/12 "Medication error report of 5/16/12 at 7:15 am. During medication administration [client #38] grabbed a cup off the med cart as the nurse had turned to assist another resident in need if immediate nursing care. The cup contained medications intended for another resident and [client #38] inadvertently consumed the medications: Miralax (stool softener) 17mg (milligrams), Klonopin 0.5mg</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>(antipsychotic), Sertraline 50mg (behavior). [Name of doctor] was immediately notified and noted [client #38] may be more sedated and to hold his Mellaril (antipsychotic) and risperdal (sic) (antipsychotic) for the day. Correct medication given to other resident. Resident was closely clinically monitored by licensed nursing staff (sic). There were no ill effects from the medications, resident as per usual (sic)...."</p> <p>-5/20/12 "Medication error report of 5/20/12 at 7:10 am. During medication administration [client #38] took a cup off the med cart as the nurse turned to assist another resident in need of nursing care. The cup contained medications intended for another resident and [client #38] inavertantly (sic) consumed the medications: Miralax 17mg, Klonopin 0.5 mg, Sertraline 50mg. [Name of doctor] was immediately notified and instructed to monitor. Resident was closely monitored by licensed nursing staff. Correct medication given to other resident. They (sic) were no ill effects from the medications, resident as per usual (sic)...."</p> <p>The facility failed to conduct and/or document an investigation in regard to the above mentioned medication errors involving client #38 as no additional</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>information/investigation was included with the above reportable incident reports.</p> <p>Interview with LPN #1, Administrative staff #1 and Qualified Mental Retardation Professional (QMRP) #1 on 2/14/13 at 10:00 AM indicated client #38 would take others food, drink and medications. LPN #1 indicated LPN #3 was involved in both of the medication incidents with client #38. When asked how client #38 was able to grab medication off a medication cart, LPN #1 stated "He's quick." Administrative staff #1, QMRP #1 and LPN #1 indicated the facility did not document/conduct an investigation of the May 2012 Medication errors with client #38.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-5/27/12 "At approximately 7:30 pm [client #65] told staff that her game system and her portable DVD was (sic) missing from her bedroom. Staff were instructed to search for the missing items. [Client #65] does use the games in different locations and will offer for some of her peers to use things that belong to her. At the time of submitting tis (sic)</p>						

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	<p>report the items have not yet been found. Further search will continue. The [name of police department] have been notified and will investigate the reported missing items. [Client #65] has her own bedroom and no person was seen entering her room. The facility will continue to investigate and search for recovery of the missing items."</p> <p>The facility's 6/4/12 follow-up report indicated the facility was not able to locate the missing items. The follow-up report indicated the facility replaced the items.</p> <p>-5/27/12 "[Client #25] approached a staff member indicating that her wii was missing from her room. The Administrator was notified and requested that a search of other areas in [client #25's] home be made to see if she had misplaced it. At the time of this report the wii had not yet been located. The [name of police] were contacted and have started a report and will conduct an investigation. We will continue to look to at locations in the home where the wii may have been misplaced (sic)."</p> <p>The facility's 6/4/12 follow-up report indicated "The [name of police] are investigating the missing wii. The facility has also been questioning staff who</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>worked on 5/27/12. At this time no one was seen to enter [client #25's] room or have possession of her wii. The Wii has been replaced by the facility and [client #25] has a new lock for her closet with no other key available to staff...."</p> <p>The facility's undated investigation indicated the police department had interviewed 3 facility staff in regard to the theft of the clients' items. The undated investigation indicated "...Findings: There is no evidence to prove anyone person took the property of either resident as of 5/30/12. It is believed that [clients #25 and #65] rarely leave their supplies un-locked. [Client #65] uses a combination lock and it is possible she may have forgot to lock her closet, but that is unusual. [Client #65] may have opened with a staff present, who then found out her combination. Her combination lock was changed and very few people on the management team have the new combination including [client #65]. [Client #65] has been instructed in the future to ask staff to leave the room or turn their backs while she opens her closet in the future. The combination will also be changed at varied intervals in the future. [Client #25] always uses a key that she wears around her neck to the closet where her wii was located. There was only one other key that was available</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>for staff in case [client #25] was to lose her key. A new lock has been put in place and the spare key will be locked up in a managers office." The facility's investigation indicated the facility failed to interview any clients in regard to the missing items and/or knowledge of staff taking the items.</p> <p>Interview with administrative staff #1, QMRP #1, #2, #3 and #4 on 2/14/13 at 10:00 AM indicated client #25 and #65's items were taken/stolen as the items were not found. Administrative staff #1 indicated clients #25 and #65's items were replaced by the facility on 6/4/12 (client #25) and on 6/31/12 (sic) (client #65). Administrative staff #1 indicated neither the facility nor the police were able to determine who took the clients' personal possessions. Administrative staff #1 and QMRP did not provide any additional information in regard to client interviews conducted during the facility's investigation.</p> <p>4. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-2/1/13 "[Client #30] came out of the classroom and went up to [client #56]</p>						

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	<p>while [client #56] was sitting at the activity table in his own classroom and bit [client #56] on the left shoulder. The bite did not break the skin and left a small pink discoloration on [client #56's] shoulder. [Client #30] was redirected back to his classroom where comfort measures were taken. He was monitored by staff and efforts made to engage him in appropriate activity following the incident. [Client #56] was given comfort from the nurse and the staff who were working with him. The area was cleansed with water and peroxide and ice applied....[Client #30] has a behavior intervention plan to address biting...."</p> <p>-10/25/12 "[Client #30] was in classroom, he walked out of class while staff was dealing with another resident behavior at the time and attempted to bite [client #13]. Staff immediately separated the residents, [client #30] was taken to a quiet area. Nursing was notified and assessed the area. Nursing noted discoloration and abrasion to right shoulder blade area (to client #13). The area was cleansed with soap and water. [Client #13] was comforted by staff. [Name of doctor] was notified with orders for an antibiotic (for client #13). [Client #30] has a behavior program for biting...."</p> <p>-2/18/12 "[Client #30] had been</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>presenting maladaptive behaviors in the classroom. He had calmed down and was sitting quietly in a chair. [Client #30] bent down and bit [client #68] on the left shoulder. Staff immediately intervened and separated residents. Nursing was notified, assessed red area with superficial open areas to shoulder. Area was cleansed and bandage applied....[Client #30] has a behavior intervention plan to address biting,...."</p> <p>Client #30's record was reviewed on 2/13/13 at 4:33 PM. Client #30's 2/8/11 Behavior Intervention Plan (BIP) indicated client #30 demonstrated physical aggression defined as "BITING OTHER PEOPLE." Client #30's 2/8/11 BIP indicated "To Prevent Biting</p> <ol style="list-style-type: none"> Staff will be with [client #30] at all times when he is out of his bedroom. Day staff will begin working with [client #30] at 6:00 AM...4. [Client #30] will wear a helmet with a face mask except for: a) In his bedroom, b) In his classroom, c) While seated in the dining room, d) In the shower." Client #30's 2/8/11 BIP indicated client #30 required "Close supervision by staff even with helmet." <p>The facility failed to conduct an investigation in regard to client #30's client to client physical aggressive/abuse</p> 						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>incidents to ensure client #30 was supervised/monitored as specified in the client's 2/8/11 BIP, and/or to ensure the client's BIP was implemented as written.</p> <p>Interview with QMRP #2 on 2/14/13 at 12:30 PM indicated client #30 had a behavior intervention plan for biting. QMRP #2 stated on 2/1/13, "There was mix up between staff" in regard to monitoring/supervising client #30. QMRP #2 did not provide any additional documentation of an investigation for the 2/1/13, 10/25/12 and/or 2/18/12 incidents of client to client aggression/abuse incidents for neglect regarding staff supervision/monitoring/implementation of the client's BIP.</p> <p>5. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's reportable incident reports and/or investigations indicated the following injuries of unknown origin:</p> <p>-12/29/12 "[Client #41] found sitting on floor in bedroom near bathroom, with red laceration to right eyebrow area. Nursing cleans the area off with soap and water and bleeding stopped. [Client #41] sent to the ER (emergency room) for evaluation. Returned to facility with 3 sutures to right eyebrow and orders to</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>remove sutures after 5 days....4. Injury investigation initiated to determine likely cause...."</p> <p>The facility's 1/4/13 follow-up report indicated "Upon completion of injury investigation regarding laceration to right eyebrow, the injury was determined to likely be caused from [client #41] bumping his eye on the corner of the wardrobe that is beside his bed...." The facility's 1/4/13 follow-up report did not indicate any additional documentation in regard to who was interviewed and/or how the facility determined the cause.</p> <p>-6/28/12 "Staff reported purple discoloration to upper right arm. No treatment was necessary,...Injury investigation initiated to determine likely cause. Extremities are prone to bumps and bruises in the course of normal everyday activity. [Client #50] has a tendency to grab objects and peers in her environment...."</p> <p>The facility's 7/6/12 follow-up report indicated "Upon completion of injury investigation regarding discoloration to upper right arm. (sic) The (sic) cause was determined to be from [client #50] bumping her arm on an object in her environment. She does walk throughout the facility with the aid of a walker and</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>does not always watch for objects in her environment. She also puts herself through crowded and/or small spaces. [Client #50] does grab at objects and peers in her environment. Though no staff witnessed another resident grabbing her it is possible that she was grabbed by another resident after she had grabbed them...1. Injury investigation completed with cause determined...."</p> <p>The facility's undated Injury Inquiry form indicated "IS INJURY SUPERFICIAL IN NATURE? No. 8 cm (centimeter) x (by) 10cm purple discoloration to right upper arm. 2.2 cm discoloration left lower arm, 3 cm x 1.3 cm discoloration to right lower arm, 1 cm x 2 cm, 1.5 cm x 1.5 cm, and 1cm x 1cm, 1 cm x 1.5 cm discoloration to right upper arm, and 1cm x 1.5 cm discoloration noted to let upper arm."</p> <p>The undated Injury Inquiry form indicated facility staff were interviewed in regard to client #50's injuries. The facility's investigation did not indicate any of the interviewed staff witnessed how client #50 received the above injuries. The facility's investigation indicated facility staff only indicated how client #50 might have received the injuries. The undated Injury Inquiry also indicated the facility did not interview any clients and/or document any behaviors which would have accounted for client #50's multiple</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>bruises to both arms.</p> <p>Interview with administrative staff #1, QMRP #1, #2, #3 and #4 on 2/14/13 at 10:00 AM indicated the facility conducted investigations of the above mentioned incidents. QMRP #1, #2, #3 and #4 indicated the facility documented the investigations on Injury Inquiry forms. Administrative staff #1 and QMRP #1, #2, #3 and/or #4 did not provide an Injury Inquiry form for client #41's injury of unknown origin. QMRP #1 and #2 indicated they did not have any more documentation in regard to client #50's incident. QMRP #2 indicated client #2 received the injuries from bumping into an object.</p> <p>6. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's reportable incident reports indicated the following client to client incidents of aggression/abuse:</p> <p>-10/7/12 "In class room [client #61] wheeled himself in his wheelchair to [client #58] and hit him in the face. [Client #61] then struck [client #58] in the forehead. He also scratched his forehead causing some minor bleeding...."</p> <p>-9/25/12 "[Client #35] was sitting in a</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>chair in the classroom when another resident (unidentified) suddenly got up from his chair, went to her, and pulled on her arm to pull her out of the chair she was sitting in. In doing so, she went to the floor landing on her right elbow. She sustained an open area 0.5 cm by 1.5 cm, a 2 cm by 0.5 cm blue discoloration, and a 2 cm by 2 cm hematoma to her right elbow...."</p> <p>-9/13/12 "[Client #33] was agitated in class, [client #38] walked past him and [client #33] grabbed [client #38's] arm and scratched him. Staff immediately intervened and separated the residents. Nursing assessed 4 superficial scratches on right forearm (of client #38)...."</p> <p>-6/3/12 "1. [Client #46] hit [client #62] at the desk where the telephone is kept. It was unknown if it was over the telephone or not. 2. A little time passed and then [client #62] sought out [client #46] and hit and scratched her in the hall outside her room. There was an area noted on [client #46] to her right face of 3cm another area to right face 4cm; an area to her right chest 8cm; and an area to right chest of 5cm of superficial scratches...."</p> <p>-5/15/12 "[Client #61] had a coloring book that [client #18] wanted. [Client #18] grabbed [client #61] on the back of</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>the neck causing him to fall out of his chair. Staff immediately intervened and separated residents...." The reportable incident report indicated client #61 had scratches to his back of of his neck and ankle.</p> <p>-5/4/12 "[Clients #26 and #28] were in class. [Client #58] hit [client #26] in the face (with no injury noted), and [client #26] then scratched [client #58] near the left eye...."</p> <p>The above mentioned reportable incident reports did not indicate the facility conducted investigations in regard to the client to client abuse/aggressive incidents.</p> <p>Interview with administrative staff #1, QMRP #1, #2, #3 and #4 indicated client to client incidents of aggression/abuse were to be investigated by the QMRPs. QMRP #1, #2, #3 and #4 indicated the investigations were documented on Resident to Resident Investigative Questionnaires. QMRP #1, #2, #3, #4 and administrative staff #1 did not provide any documentation of an investigation for the above mentioned client to client incidents of aggression/abuse.</p> <p>7. The facility's records were reviewed on 2/12/13 at 12:15pm and on 2/12/13 at</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2013
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	<p>2:30pm. A review of the BDDS (Bureau of Developmental Disability Services) reports from 7/1/2012 through 8/31/2012 indicated the following:</p> <p>-Three BDDS reports on 7/16/12 for incidents on 7/15/12 at 12:57pm, for clients #29, #45, and #60 indicated "Staff to nursing that resident's television was missing" from clients #29, #45, and #60's bedrooms in the main building at the facility. The reports indicated the police were notified and the police and facility had begun an investigation. The reports indicated the staff will be retrained on misappropriation of property.</p> <p>-Follow up reports for client #29, #45, and #60's 7/15/12 incident indicated the police continued their investigation. The reports indicated the police determined the televisions were removed from client #29, #45, and #60's bedrooms at the facility "on the evening of 7/15/12" and no determination had been made for who took the televisions. The follow up reports indicated client #29, #45, and #60's televisions had been replaced and secured on the television stands inside their bedrooms. The reports indicated outside facility lighting had been installed, staff had been inserviced on misappropriation of property, and "random checks" were being completed to</p>			

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	<p>ensure the televisions were in place.</p> <p>On 2/14/13 at 1:40pm, the investigation for the three (3) 7/15/12 incidents was reviewed. The investigation indicated the missing televisions belonged to clients #29, #45, and #60. The investigation indicated the televisions were reported as missing on "7/15/12 around 10:00 in the morning." The investigation indicated the Director of Nursing "started collecting statements" from staff and had twenty-two (22) completed. The investigation indicated "the police" determined the "TV's likely came up missing between 9pm and 10pm on Saturday night" and could not "determine who took the TV." The investigation did not include how the facility was going to complete "random" security checks or what areas would be checked. No client interviews were available for review. No staff witness statements were available for review. A written summary of the statements taken by the Director of Nursing were reviewed and these summaries were completed by the facility's administrative staff.</p> <p>On 2/12/13 at 2:30pm, on 2/13/13 at 8:35am, and on 2/14/13 at 9:30am, an interview was completed with the Administrator. The Administrator indicated was locating information of the</p>				

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	<p>investigation for the incident on 7/15/12 for client #29, #45, and #60's missing TV's. On 2/14/13 at 9:30am, the Administrator indicated no further information was available for review of the 7/15/12 incidents.</p> <p>3.1-28(d)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review for 1 of 23 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to complete an investigation in 5 working days and/or report the results of the investigation to the administrator within the 5 day time frame involving client #57.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's 2/4/13 reportable incident report indicated "An investigation is in progress related to an observation by a nurse. She was walking past a resident room and through the open door she saw [housekeeping staff #3] a housekeeper, with his hand on top of the head of [client #57] a resident of the facility. [Client #57] was sitting in her wheelchair at the time with her back to the door of her room. The male employee was standing in front of her and was observed to readjust his trousers. Because [client #57] was sitting between the employee and the doorway, the nurse</p>	W000156	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; Client #57 is fine with no negative effects. Unfortunately there are times when an investigation may take longer to finalize than the 5 working days allotted. There was a follow up report submitted to state officials within the 5 working days on 2-13-13. However, we were not able to determine a resolution at that time. The employee remained suspended and another follow up was sent to the state officials on 2/20/13 to update. At that time the employee returned to work. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents could be affected. This facility will continue to report according to guidelines and will give an honest and thorough report within 5 working days of any incident. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Administrator will be responsible</p>	03/27/2013			

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	<p>could not see what the employee was doing. The employee was questioned and indicated that his trousers had come partially unzipped, and he was just zipping them up. He further explained that the pants did not fit him very well and became partially unzipped frequently when he wore them. The nurse reported her observation to the administrator immediately and they both checked the resident, finding no evidence of any injury or any other sign or symptom of inappropriate or unusual activity. This resident was acting as usual with no signs of distress. Due to the unusual nature of the interaction the employee has been suspended and a thorough investigation has been initiated. The [name of police] department has been contacted to investigate the incident. [Housekeeping staff #3] will remain off work until the investigation is completed."</p> <p>Review of the facility's 2/4/13 to 2/13/13 witness statements/investigation indicated the facility was still conducting an investigation into the 2/4/13 allegation of possible abuse with housekeeping staff #3 as of 2/14/13.</p> <p>Interview with administrative staff #1 on 2/14/13 at 10:00 AM indicated the police were still conducting their investigation and the facility had not completed its</p>		<p>to assure that all incidents are reported timely. All incidents will be discussed during the morning IDT meeting with appropriate follow up done. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place; All incidents will be discussed during the morning IDT meetings. A synopsis of all incidents will be brought before the monthly QA committee meetings by the Administrator. It will be ongoing.</p>				

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	<p>investigation. Administrative staff #1 indicated he had not found anyone to indicate they had seen and/or witnessed housekeeping staff #3 being inappropriate with any of the clients at the facility. Administrative staff #1 indicated the housekeeping staff did have a problem with his clothing, at times, not being zipped.</p> <p>3.1-28(e)</p>			

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, interview and record review for 5 of 38 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to put in place corrective actions/measures to prevent continued theft of clients' properties for clients #25, #29, #45, #60 and #65.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-5/27/12 "At approximately 7:30 pm [client #65] told staff that her game system and her portable DVD were missing from her bedroom. Staff were instructed to search for the missing items. [Client #65] does use the games in different locations and will offer for some of her peers to use things that belong to her. At the time of submitting tis (sic) report the items have not yet been found. Further search will continue. The [name of police department] have been notified and will investigate the reported missing</p>	W000157	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. Please refer to W149 related to clients # 65 and 25 missing property. #2 Please refer to W149 related to clients #29, 45, & 60 related to missing property. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; #1. Please refer to W149 related to clients # 65 and 25 missing property. #2 Please refer to W149 related to clients #29, 45, & 60 related to missing property. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; #1. Please refer to W149 related to clients # 65 and 25 missing property. #2 Please refer to W149 related to clients #29, 45, & 60 related to missing property. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place; #1. Please refer to W149 related to clients # 65 and 25 missing property. #2 Please refer to W149 related to clients #29, 45, & 60 related to missing property.</p>	03/27/2013			

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	<p>items. [Client #65] has her own bedroom and no person was seen entering her room...."</p> <p>The facility's 6/4/12 follow-up report indicated the facility was not able to locate the missing items. The follow-up report indicated the facility replaced the items and client #65 was given a new combination lock for her closet. The report indicated "...She has been instructed to not allow staff to watch her open the closet door when she is entering the combination. We continue to work with [name of police department] who is investigating the missing property...."</p> <p>The 6/4/12 follow-up report indicated facility staff had been retrained in regard to "misappropriation of property."</p> <p>-5/27/12 "[Client #25] approached a staff member indicating that her wii was missing from her room. The Administrator was notified and requested that a search of other areas in [client #25's] home be made to see if she had misplaced it. At the time of this report the wii had not yet been located. The [name of police] were contacted and have started a report and will conduct an investigation. We will continue to look to at locations in the home where the wii may have been misplaced (sic)."</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>The facility's 6/4/12 follow-up report indicated "The [name of police] are investigating the missing wii. The facility has also been questioning staff who worked on 5/27/12. At this time no one was seen to enter [client #25's] room or have possession of her wii. The Wii has been replaced by the facility and [client #25] has a new lock for her closet with no other key available to staff...2. Staff that work with [client #25] are being re-trained as it relates to misappropriation of property...."</p> <p>The facility's undated investigation indicated the police department had interviewed 3 facility staff in regard to the theft of the clients' items. The undated investigation indicated "...Findings: There is no evidence to prove anyone person took the property of either resident as of 5/30/12. It is believed that [clients #25 and #65] rarely leave their supplies un-locked. [Client #65] uses a combination lock and it is possible she may have forgot to lock her closet, but that is unusual. [Client #65] may have opened with a staff present, who then found out her combination. Her combination lock was changed and very few people on the management team have the new combination including [client #65]. [Client #65] has been instructed in the future to ask staff to leave the room or</p>				

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	<p>turn their backs while she opens her closet in the future. The combination will also be changed at varied intervals in the future. [Client #25] always uses a key that she wears around her neck to the closet where her wii was located. There was only one other key that was available for staff in case [client #25] was to lose her key. A new lock has been put in place and the spare key will be locked up in a manager's office."</p> <p>The facility's inservice training records were reviewed on 2/14/13 at 12:30 PM. The facility's 6/4/12 Meeting/Seminar Attendance Sign-In sheet indicated facility staff were trained in regard to "Misappropriation Of Property." An attached undated memo indicated "ALL STAFF MUST BE AWARE THAT IT IS NEVER APPROPRIATE TO USE A RESIDENT PROPERTY, TO BORROW IT, OR TO REMOVE IT FROM THE FACILITY PREMISES. AT TIMES A RESIDENT MAY OFFER YOU THE USE OF THEIR PROPERTY OR EVEN ASK YOU OR ANOTHER RESIDENT TO TAKE IT. IT IS NEVER OKAY TO USE THIS AS IT MAY BE CONSIDERED MISAPPROPRIATION OF PROPERTY. IF YOU ARE FOUND TO TAKE THINGS THAT BELONG TO A RESIDENT YOU CAN BE TERMINATED IF IT IS DETERMINED</p>						

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	<p>THAT YOU DID THIS AND FORMAL CRIMINAL CHARGES MAY BE PURSUED. RECENTLY WE HAD A WII, A PORTABLE DVD PLAYER, AND A DS GAME THAT WAS (sic) REPORTED MISSING BY FACILITY RESIDENTS. WE ARE WORKING WITH THE LOCAL POLICE DEPARTMENT TO INVESTIGATE THIS. IF YOU HAVE ANY INFORMATION REGARDING THE DISAPPEARANCE OF ANY OF THESE ITEMS YOU NEED TO NOTIFY THE ADMINISTRATOR IMMEDIATELY. ALL RESIDENT POSSESSIONS SHOULD REMAIN WITH THE RESIDENT IN THEIR HOME. IF YOU ARE AWARE THAT A RESIDENT HAS NOT SECURED A VALUABLE ITEM ASSIST THEM TO LOCK THE ITEM UP."</p> <p>The facility facility failed to put in place any additional measures to prevent theft of clients' personal possessions/items.</p> <p>Interview with administrative staff #1, QMRP #1, #2, #3 and #4 on 2/14/13 at 10:00 AM indicated client #25 and #65's items were taken/stolen as the items were not found. Administrative staff #1 indicated clients #25 and #65's items were replaced by the facility on 6/4/12 (client #25) and on 6/31/12 (sic) (client #65).</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>Administrative staff #1 indicated neither the facility nor the police were able to determine who took the clients' personal possessions. Administrative staff #1 indicated the facility failed to put in place any additional corrective measures to prevent the theft of clients' personal items, who resided at the facility.</p> <p>2. The facility's records were reviewed on 2/12/13 at 12:15pm and on 2/12/13 at 2:30pm. A review of the BDDS (Bureau of Developmental Disability Services) reports from 7/1/2012 through 8/31/2012 indicated the following:</p> <p>-Three BDDS reports on 7/16/12 for incidents on 7/15/12 at 12:57pm, for clients #29, #45, and #60 indicated "Staff to nursing that resident's television was missing" from clients #29, #45, and #60's bedrooms in the main building at the facility. The reports indicated the police were notified and the police and facility had begun an investigation. The reports indicated the staff will be retrained on misappropriation of property.</p> <p>-Follow up reports for client #29, #45, and #60's 7/15/12 incident indicated the police continue their investigation. The reports indicated the police determined the televisions were removed from client #29, #45, and #60's bedrooms at the</p>						

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	<p>facility "on the evening of 7/15/12" and no determination had been made for who took the televisions. The follow up reports indicated client #29, #45, and #60's televisions had been replaced and secured on the television stands inside their bedrooms. The reports indicated outside facility lighting had been installed, staff had been inserviced on misappropriation of property, and "random checks" were being completed to ensure the televisions were in place.</p> <p>On 2/14/13 at 1:40pm, the investigation for the three (3) 7/15/12 incidents was reviewed. The investigation indicated the missing televisions belonged to clients #29, #45, and #60. The investigation indicated the televisions were reported as missing on "7/15/12 around 10:00 in the morning." The investigation indicated the Director of Nursing "started collecting statements" from staff and had twenty-two (22) completed. The investigation indicated "the police" determined the "TV's likely came up missing between 9pm and 10pm on Saturday night" and could not "determine who took the TV." The investigation did not include how the facility was going to complete "random" security checks or what areas would be checked.</p> <p>On 2/14/13 at 1:15pm, a review of the</p>						

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	<p>facility's 8/29/12 inservice training for "Misappropriation of Resident Property" was conducted. The inservice indicated a written note "All staff must be aware that it is never appropriate to use, borrow, or remove a resident's property from the facility...." The inservice training indicated three (3) clients had televisions reported as missing.</p> <p>On 2/14/13 at 1:35pm, a review of the facility's undated inservice training for "Misappropriation of Resident Property" indicated additional training of the same information as 8/29/12 was completed from 7/16/12 until 8/7/12.</p> <p>On 2/13/13 at 1pm, observation was completed of client #29, #45, and #60's bedrooms at the main building. Each bedroom had an unlabeled television anchored to the wall with a secure cable and each television did not indicate a client name on each television.</p> <p>On 2/14/13 at 1:15pm, and on 2/14/13 at 1:40pm, the Administrator provided a review of the "Security Checks" sheets. Each "Security Check" sheet was one sheet per month, had initials on the page for each day of the month, and did not indicate the time the security checks were completed and did not indicate what area was checked.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>On 2/14/13 at 1:50pm, an interview with Administrative Staff (AS) #5 and record review of client #29, #45, and #60's "Inventory of Personal Items" was conducted. AS #5 and client #29, #45, and #60's personal inventory sheets did not indicate the replacement of their televisions on 7/19/12 and each inventory sheet was signed by Social Service Staff #40 and AS #5.</p> <p>3.1-28(e)</p>			
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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 10 sampled clients (clients #3 and #8) and 2 additional clients (clients #16 and #38) to ensure staff who worked with clients received client specific training (clients #3, #8 and #16) and retraining related to medication errors (client #38).</p> <p>Findings include:</p> <p>1. Observations were conducted in the facility on 02/12/13 from 2:00 PM until 4:30 PM. During the observation times staff #22 was interacting with members of the "Retirement Group." Clients #3 and #8 were members of the retirement group. Clients #3 and #8 joined the group at 3:30 PM.</p> <p>On 02/12/13 at 4:08 PM staff #22 was interviewed. Staff #22 stated she was normally in the kitchen, but had been restricted to light duty and had been assigned to, "interact with them." When asked if she had been trained on the specifics of each client in her care,</p>	W000189	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. There were no residents affected. #2. Client # 38 was monitored closely and showed no signs of problems after this incident. #3. Client #16 showed no ill effects from this. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; #1. All clients could be affected. The training for any employee who works directly with a client will be completed prior to working with them. This training will be documented in their employee file. #2. All clients could be affected. All nurses have been re-educated regarding safety with medication administration. LPN # 3 has been re-educated regarding the incident mentioned. #3. All clients could be affected. The bus driver has been trained regarding proper procedures when he is in the dining room. An in-service will be conducted with all staff regarding the dining room and proper handling of food. **What measures will be put into place or what systemic changes</p>	03/27/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>utilizing each client's ISPs and BSPs she indicated she did not have any client specific training.</p> <p>On 02/14/13 at 11:50 AM QMRP #3 was interviewed. QMRP #3 indicated any staff working with the clients should have client specific training.</p>		<p>the facility will make to ensure that the deficient practice does not recur; #1. The QMRP will be responsible to re-educate any employees who are not already trained to work with the population who for any reason are assigned to that type of work. #2. All nurses were re-educated to address safety with medication administration. The DON will audit the med cart daily to assure it is safe. #3. All employees will be re-educated regarding the dining room and proper handling of food. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place; #1. At the daily meetings, we will discuss any employee who is on light duty to assure that they have been educated regarding where they are working. This will be discussed during the QA meeting. The Administrator will be responsible. #2. The DON will discuss the results of the audit regarding safe administration of medications. This audit will be conducted 5 X's weekly for one month. If no further issues, then it will be conducted 1 X weekly for 3 months. After that time, if in 100% compliance, the QA committee will recommend further auditing or not. #3. During administrative rounds, the dining rooms will be observed for proper food handling by all</p>		

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	<p>2. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-5/16/12 "Medication error report of 5/16/12 at 7:15 am. During medication administration [client #38] grabbed a cup off the med cart as the nurse had turned to assist another resident in need if immediate nursing care. The cup contained medications intended for another resident and [client #38] inadvertently consumed the medications: Miralax (stool softener) 17mg (milligrams), Klonopin 0.5mg (antipsychotic), Sertraline 50mg (behavior). [Name of doctor] was immediately notified and noted [client #38] may be more sedated and to hold his Mellaril (antipsychotic) and risperdal (sic) (antipsychotic) for the day. Correct medication given to other resident. Resident was closely clinically monitored by licensed nursing staff (sic). There were no ill effects from the medications, resident as per usual (sic)...Nurse involved received an inservice on medication administration...."</p>		employees. The results of these rounds will be discussed during the QA meetings by the Administrator.				

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	<p>-5/20/12 "Medication error report of 5/20/12 at 7:10 am. During medication administration [client #38] took a cup off the med cart as the nurse turned to assist another resident in need of nursing care. The cup contained medications intended for another resident and [client #38] inavertantly (sic) consumed the medications: Miralax 17mg, Klonopin 0.5 mg, Sertraline 50mg. [Name of doctor] was immediately notified and instructed to monitor. Resident was closely monitored by licensed nursing staff. Correct medication given to other resident. They (sic) were no ill effects from the medications, resident as per usual (sic)...The nurse involved has been re-inserviced on medication administration with a focus on the 5 rights and errors related to distractions and the ICF/MR (Intermediate Care facility/Mental Retardation) population. In, (sic) addition to the training, the nurse has received disciplinary action. Will continue to monitor and treat healthcare needs as they arise."</p> <p>Interview with LPN #1, Administrative staff #1 and Qualified Mental Retardation Professional (QMRP) #1 on 2/14/13 at 10:00 AM indicated client #38 would take others food, drink and medications. LPN #1 indicated LPN #3 was involved in both</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>of the medication incidents with client #38. When asked how client #38 was able to grab medication off a medication cart, LPN #1 stated "He's quick." LPN #1 indicated LPN #3 was retrained in regard to medication administration. The facility did not provide documentation LPN #3 was retrained/re-inserviced in regard to medication administration.</p> <p>3. A morning observation was conducted at the facility on 2/12/13 from 7:20 A.M. until 9:10 A.M.. At 8:10 A.M., Bus Driver #1 assisted client #16 while eating his breakfast. Client #16 dropped a portion of his oatmeal onto the table. Bus Driver #1 picked the oatmeal up with his bare hands and placed it back on client #16's plate. Client #16 again dropped oatmeal on the bare table. Bus Driver #1 again picked the oatmeal up with his bare hands and placed it on client #16's plate, and hand over hand scooped the oatmeal up and fed it to client #16.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 was conducted on 2/14/13 at 10:00 A.M.. When asked if staff should pick client's food up from the table with their bare hands and place it back onto the client's plate and feed the food to the client, LPN #1 stated "Staff should not pick up the client's food with their bare hands and place it back on their</p>						

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	plates and feed it to the client. The tray should be returned and another tray should be given." 3.1-13(b)(1) 3.1-13(b)(2) 7-3(a)			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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W000218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development.</p> <p>Based on observation, record review, and interview, the facility failed for 4 of 10 sampled clients (clients #3, #4, #6 and #8) with sensorimotor deficits to assess the clients' assess the clients' visual impairments and/or have sensorimotor assessments reviewed annually by the interdisciplinary team for accuracy.</p> <p>Findings include:</p> <p>1. Observations were conducted in the facility on 02/11/13 from 3:29 PM until 5:53 PM and from 6:30 AM until 9:40 AM. During the observation times client #3 was observed to be nonambulatory and used a wheelchair. Client #3 was observed at the dining room table on 02/11/13 at 4:34 PM. Client #3 was fed his supper by staff #23.</p> <p>Client #3's record was reviewed on 02/13/13 at 10:54 AM. Client #3's Occupational Therapy (OT) Evaluation was dated 04/09/11 and the Physical Therapy Evaluation was dated 08/27/10. The record did not indicate the client's interdisciplinary team reviewed the 2010 sensory assessments, annually, to ensure the assessments still met the client's</p>	W000218	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; 1. Client # 3's assessments have been reviewed as of this time. Client # 3's assessments will be reviewed annually. #2. Client # 6's assessments have been reviewed as of this time. Client # 6's assessments will be reviewed annually. #3. Client # 8 has had a visual assessment completed. #4. Client # 4 is now being informed of the exact food and placement of the food on the tray to assist in eating. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; #1. All clients could be affected. All clients will have their assessments reviewed annually to assure that we are doing everything to assure our care is accurate and updated. #2. All clients could be affected. All clients will have their assessments reviewed annually to assure that we are doing everything to assure our care is accurate and updated. #3. All clients could be affected. All clients will have their assessments reviewed annually to assure that we are doing everything to assure our care is</p>	03/27/2013			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>needs.</p> <p>On 02/14/13 at 11:00 AM an interview with Administrative Staff (Admin) #2 was conducted. The Admin #2 indicated due to client #3's medical condition his sensory assessments should be reviewed annually to determine if the assessments met the client's needs.</p> <p>2. Observations were conducted in the facility on 02/11/13 from 3:29 PM until 5:53 PM and from 6:30 AM until 9:40 AM. During the observation times client #6 was observed to be nonambulatory and used a wheelchair. Client #6 was observed at the dining room table on 02/11/13 at 4:34 PM. Client #6 was fed his supper by staff #24.</p> <p>Client #6's record was reviewed on 02/13/13 at 12:53 PM. Client #6's Occupational Therapy (OT) Evaluation was dated 04/07/11 and the Physical Therapy Evaluation was dated 05/11/10. The record did not indicate the client's interdisciplinary team reviewed the 2010 sensory assessments, annually, to ensure the assessments still met the client's needs.</p> <p>On 02/14/13 at 11:00 AM an interview with Administrative Staff (Admin) #2 was conducted. The Admin #2 indicated</p>		<p>accurate and updated. #4. All clients could be affected. A re-education will be completed focusing on the importance of letting the clients who have visual impairments know where things are located on their meal trays. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. #1. An audit tool has been developed to assist the team to assure that all assessments are completed annually on every client. #2. An audit tool has been developed to assist the team to assure that all assessments are completed annually on every client. #3. An audit tool has been developed to assist the team to assure that all assessments are completed annually on every client. #4. The daily rounds tool will be completed during meal times to assure that all staff serving meals are assisting clients with their individual needs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. #1. The results of the audit tool will be discussed during the monthly QA meetings by the QMRP. These audits will be ongoing. #2. The results of the audit tool will be discussed during the monthly QA meetings by the QMRP. These audits will be ongoing. #3. The results of</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>due to client #6's medical condition his sensory assessments should be reviewed annually to determine if the assessments met the client's needs.</p> <p>3. Observations were conducted in the facility on 02/11/13 from 3:29 PM until 5:53 PM and on 02/12/13 from 6:30 AM until 9:40 AM. During the observation times client #8 was observed to be blind and to require total assistance from staff. Client #8 was observed at the dining room table on 02/11/13 at 4:50 PM. Client #8's plate was set in front of her by staff #25 who then walked away. Client #8 used her fingers to touch the food on the plate and place it in her mouth.</p> <p>Client #8's record was reviewed on 02/12/13 at 2:00 PM. Client #8's record contained a diagnosis which indicated she was blind. The record did not contain a visual impairment assessment which indicated how training should occur to meet the client's visual impairment needs.</p> <p>On 02/14/13 at 11:00 AM an interview with Administrative Staff (Admin) #2 was conducted. The Admin #2 indicated due to client #8's medical condition she should have an assessment in regard to the client's visual impairment.</p> <p>4. On 2/11/13 from 1:30pm until 2:32pm,</p>		<p>the audit tool will be discussed during the monthly QA meetings by the QMRP. These audits will be ongoing #4. The results of the daily rounds tool will be discussed during the monthly QA meetings. The Administrator will be responsible. The rounds tool will be ongoing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>on 2/11/13 from 3:20pm until 5:40pm, on 2/12/13 from 5:45am until 9:13am, and on 2/13/13 from 1pm until 1:40pm, observations were conducted and during the observation times, client #4 used a roller walker to walk and staff assisted him by guiding the roller walker with one hand and one hand on client #4's gait belt. On 2/11/13 at 5pm, client #4's preset meal tray with food, drinks, and silverware was placed in front of him and he was prompted to eat by the facility staff. No identification of the food and no identification of the location of the food was observed. On 2/12/13 at 7:20am, client #4's preset meal tray was placed in front of him and he was prompted to eat by the facility staff. No identification of the food and no identification of the location of the food was observed.</p> <p>Client #4's record was reviewed on 2/13/13 at 11:35am. Client #4's 4/3/2011 CFA indicated client #4 was blind. Client #4's 2/11/2013 "Physician's Order" indicated client #4 was blind. Client #4's record did not indicate an assessment to assist client #4 with his programming needs due to client #4's visual impairment.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #3 (Qualified Mental Retardation Professional) was completed. QMRP #3</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>indicated client #4 was legally blind and could see shadows. QMRP #3 indicated client #4 should have had items identified by the staff to assist client #4 with his programming needs. QMRP #3 indicated no assessment of client #4's programming needs due to visual impairment had been completed.</p> <p>3.1-31(c)(4)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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W000225	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills.</p> <p>Based on record review and interview for 7 of 10 sampled clients (#1, #3, #4, #5, #6, #8 and #10), the facility failed to ensure the clients' vocational assessments included recommendations for future employment opportunities and/or individual preferences for future employment.</p> <p>Findings include:</p> <p>1. Client #4's record was reviewed on 2/13/13 at 11:35am. Client #4's 4/3/2011 CFA did not indicate his work history and did not indicate his current work interests. Client #4's CFA (Comprehensive Functional Assessment) indicated "Vocational Skills: He is able to sit at his work station for an extended period of time. He is able to put his supplies away with one verbal prompt." Client #4's CFA vocational indicated "His needs are being met at this facility. There is no outside service at this time. In the future, it is possible that a basic developmental group home may be an appropriate placement for [client #4] once some basic and prerequisite skills are acquired." Client #4's record did not indicate his work history and did not indicate his</p>	W000225	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. Client # 4's work history and work interest has been assessed. Client # 4 is happy and content living here. The goal is for all of our clients to move to a lesser restrictive environment. That goal will continue for Client #4. #2. Client # 5's work history and work interest has been assessed. Client # 5 is happy and content living here. The goal is for all of our clients to move to a lesser restrictive environment. That goal will continue for Client #5. #3 Client # 1's work history and work interest has been assessed. Client #1 is not interested in outside work. Client # 1 is happy and content living here. Client #10's work history and work interest has been assessed. The goal is for all of our clients to move to a lesser restrictive environment. That goal will continue for Client #1 and 10. #4. Client #3's work history and work interest has been assessed. Client #6's work history and work interest has been assessed. Client #8's work history and interest has been assessed. **How the facility will identify other residents having the potential to be affected by the same deficient</p>	03/27/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>current work interests.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #3 (Qualified Mental Retardation Professional) was completed. QMRP #3 indicated the facility did not have a paid workshop on grounds. QMRP #3 indicated she could not recall when client #4 had gone to work. QMRP #3 indicated client #4 had not gone to a sheltered workshop since 2011 because the facility's funding was cut. QMRP #3 indicated client #4's CFA and clinical record did not indicate his work history and did not indicate his current/future work interests.</p> <p>2. Client #5's record was reviewed on 2/13/13 at 10:40am. Client #5's 5/8/2012 CFA did not indicate his work history and did not indicate his current work interests. Client #5's CFA failed to indicate the client's work history, work interests and abilities had been assessed. Client #5's CFA indicated a check mark "Yes" to the following areas sits at workstation, stays on tasks for at least 5 minutes, identifies immediate supervisor, self initiates working on tasks, respects work supplies belonging to other people, puts supplies away, can identify when project is finished, and stays on task for at least thirty minutes.</p>		<p>practice and what corrective action will be taken; #1. All clients could be affected. All ISP's have been updated to reflect the work history and interest of each client. #2. All clients could be affected. All ISP's have been updated to reflect the work history and interest of each client. #3. All clients could be affected. All ISP's have been updated to reflect the work history and interest of each client. #4. All clients could be affected. All ISP's have been updated to reflect the work history and interest of each client. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; #1. The job history and work interest has been added to each clients individual service plan (ISP). All QMRP's were re-educated regarding this issue. Once this is added to the ISP it will be updated annual with no further issues. #2. The job history and work interest has been added to each clients individual service plan (ISP). All QMRP's were re-educated regarding this issue.. Once this is added to the ISP it will be updated annual with no further issues. #3. The job history and work interest has been added to each clients individual service plan (ISP). All QMRP's were re-educated regarding this issue. Once this is added to the</p>				

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	On 2/14/13 at 9:55am, an interview with QMRP #1 was completed. QMRP #1 indicated the facility did not have a paid workshop on grounds. QMRP #1 indicated she could not recall when client #5 had gone to work. QMRP #1 indicated client #5 had not gone to a sheltered workshop since 2011 because the facility's funding was cut. QMRP #1 indicated client #5's CFA and clinical record did not indicate his work history and/or his current/future work interests/needs.		ISP it will be updated annual with no further issues. #4. The job history and work interest has been added to each clients individual service plan (ISP). All QMRP's were re-educated regarding this issue. Once this is added to the ISP it will be updated annual with no further issues. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place, #1. The results of the audit will be discussed during the monthly QA committee meeting by the QMRP. This audit will be a one time situation and have every client's information regarding work history and interest completed. All new admissions will have the same ISP including this information so there will be no further issues. #2. The results of the audit will be discussed during the monthly QA committee meeting by the QMRP. This audit will be a one time situation and have every client's information regarding work history and interest completed. All new admissions will have the same ISP including this information so there will be no further issues. #3. The results of the audit will be discussed during the monthly QA committee meeting by the QMRP. This audit will be a one time situation and have every client's information regarding work history and interest completed. All new		

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>3. Client #1's record was reviewed on 2/13/13 at 2:43 PM. Client #1's vocational assessment dated 7/31/12 indicated, "Recommend formal vocational skills training. Provide opportunities for paid work." Client #1's 7/31/12 vocational assessment did not include recommendations for future employment opportunities and/or client #1's preferences for future employment.</p> <p>Client #10's record was reviewed on 2/13/13 at 9:34 AM. Client #10's ISP (Individual Support Plan) dated 8/23/12 indicated a vocational assessment had been completed. Client #10's 8/23/12 ISP did not include recommendations for future vocational opportunities.</p> <p>Interview with administrative staff #1, QMRP #1, #2, #3 and #4 on 2/14/13 at 10:00 AM indicated client #1 and #10's vocational assessments did not</p>		<p>admissions will have the same ISP including this information so there will be no further issues. #4. The results of the audit will be discussed during the monthly QA committee meeting by the QMRP. This audit will be a one time situation and have every client's information regarding work history and interest completed. All new admissions will have the same ISP including this information so there will be no further issues.</p>		

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>specifically address the clients' future work options, interests and/or work opportunities outside the facility. Administrative staff #1 indicated 4 to 5 clients attended an outside paid workshop. Administrative staff #1 stated "State cut our funding."</p> <p>4. Client #3's record was reviewed on 02/13/13 at 10:54 AM. Client #3's ISP dated 04/12/12 failed to provide a vocational assessment which addressed future work options, interests, or work opportunities outside the facility.</p> <p>Client #6's record was reviewed on 02/13/13 at 12:53 PM. Client #6's ISP dated 06/07/12 failed to provide a vocational assessment which addressed future work options, interests, or work opportunities outside the facility.</p> <p>Client #8's record was reviewed on 02/12/13 at 2:00 PM. Client #8's ISP dated 01/22/13 failed to provide a vocational assessment which addressed future work options, interests, or work opportunities outside the facility.</p> <p>Interview with QMRP #1, #2, #3 and #4 on 2/14/13 at 10:00 AM indicated client #3, #6 and #8's vocational assessments did not specifically address the clients' future work options, interests and/or work</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	opportunities outside the facility. Administrative staff #1 indicated 4 to 5 clients attended an outside paid workshop. Administrative staff #1 stated "State cut our funding."			

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on interview and record review, the clients' Individual Support Plans (ISPs) failed to address client #38's identified behavioral need and client #4's identified developmental training need.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 2/11/13 at 3:45 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-5/16/12 "Medication error report of 5/16/12 at 7:15 am. During medication administration [client #38] grabbed a cup off the med cart as the nurse had turned to assist another resident in need if immediate nursing care. The cup contained medications intended for another resident and [client #38] inadvertently consumed the medications: Miralax (stool softener) 17mg (milligrams), Klonopin 0.5mg (antipsychotic), Sertraline 50mg (behavior). [Name of doctor] was immediately notified and noted [client</p>	W000227	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. Please refer to W149 related to Client # 38. #2. Client # 4 wears briefs at all times due to his incontinence. He is on a toileting schedule and is taken every 1 - 3 hrs to the bathroom. When he was taken to the toilet unfortunately the door was not closed by staff. All staff have been re-educated regarding privacy issues. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;#1. Please refer to W149 related to Client # 38. #2. All residents have the potential to be affected. No other residents were affected. Re-education of the employees will be completed to assure they are aware of all privacy matters. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; #1. Please refer to W149 related to Client # 38. #2. Re-education</p>	03/27/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
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	<p>#38] may be more sedated and to hold his Mellaril (antipsychotic) and risperdal (sic) (antipsychotic) for the day. Correct medication given to other resident. Resident was closely clinically monitored by licensed nursing staff (sic). There were no ill effects from the medications, resident as per usual (sic). Resident has a behavior program to address stealing (usually food or drink) in addition to behavioral medications...."</p> <p>-5/20/12 "Medication error report of 5/20/12 at 7:10 am. During medication administration [client #38] took a cup off the med cart as the nurse turned to assist another resident in need of nursing care. The cup contained medications intended for another resident and [client #38] inavertantly (sic) consumed the medications: Miralax 17mg, Klonopin 0.5 mg, Sertraline 50mg. [Name of doctor] was immediately notified and instructed to monitor. Resident was closely monitored by licensed nursing staff. Correct medication given to other resident. They (sic) were no ill effects from the medications, resident as per usual (sic). Resident has a behavior program to address stealing (usually food or drink) in addition to behavioral medications...."</p> <p>Client #38's record was reviewed on</p>		<p>of the employees will be completed to assure they are aware of all privacy matters. Daily rounds will be completed with the attention specially to privacy issues. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. #1. Please refer to W149 related to Client # 38. #2. Daily rounds will be discussed during the daily IDT meetings as well as the results will be discussed during monthly QA committee meetings by the Administrator. These rounds will be ongoing.</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>2/13/13 at 5:07 PM. Client #38's 4/29/11 Behavior Intervention Plan (BIP) indicated client #38's diagnoses included, but were not limited to, Severe Mental Retardation and Impulse Control Disorder. Client #38's BIP indicated the client demonstrated the behavior of "Stealing (Usually Food or Drink) which was defined as "Taking others people's pop or food and eating it. May go into a restricted area such as office to steal pop/food." Client #38's 4/29/11 BIP indicated the facility did not specifically address client #38's taking/grabbing medications as indicated by the facility's 5/16/12 and 5/20/12 reportable incident reports.</p> <p>Interview with LPN #1, Administrative staff #1 and Qualified Mental Retardation Professional (QMRP) #1 on 2/14/13 at 10:00 AM indicated client #38 would take others food, drink and medications. LPN #1 indicated LPN #3 was involved in both of the medication incidents with client #38. When asked how client #38 was able to grab medication off a medication cart, LPN #1 stated "He's quick." QMRP #1 and LPN #1 indicated staff would try to redirect client #38 away from the medication cart. LPN #1 and QMRP #1 indicated the client had a behavior program for stealing. QMRP #1 indicated client #38's 4/29/11 BIP did not</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>specifically address client #38's behavior of grabbing/taking others medications.</p> <p>2. On 2/11/13 from 1:30pm until 2:32pm, on 2/11/13 from 3:20pm until 5:40pm, on 2/12/13 from 5:45am until 9:13am, and on 2/13/13 from 1pm until 1:40pm, observations were conducted and during the observation times, client #4 wore an incontinence brief. On 2/12/13 at 6:50am, client #4 was observed alone sitting on the toilet with an incontinence brief around his ankles and the door to the bathroom was open to view.</p> <p>Client #4's record was reviewed on 2/13/13 at 11:35am. Client #4's 4/3/2011 CFA indicated "Toilet Training/Privacy: [Client #4] is incontinent of bowel and bladder since he regressed last year and was changed to a wheel chair. He does not indicate the need to toilet and cannot identify the men's restroom in a public place...has a goal to close door going into room to be changed...will have a goal to identify men's restroom...." Client #4's 4/3/12 CFA indicated an 4/3/12 "Assessment for Use of Depends (incontinence briefs). [Client #4] can no longer walk or see to his toileting needs. Wearing depends preserves his dignity and helps him to avoid skin breakdown." Client #4's 4/3/12 IPP (Individual Program Plan) did not identify the use of</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>incontinence briefs.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #3 (Qualified Mental Retardation Professional) was completed. QMRP #3 indicated client #4 was assisted to the bathroom every one to three hours by the facility staff. QMRP #3 indicated client #4 was to have worn an incontinence brief at night and underwear during the day. QMRP #3 indicated client #4 did not have a formal toileting objective/goal. QMRP #3 indicated client #4 wore an incontinence brief at night because of his incontinence and client #4 did not get up during the night to go to the bathroom.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 2 of 10 sampled clients (#1 and #4), the facility failed ensure client #1's ISP (Individual Support Plan)/BSP (Behavior Support Plan) included how staff were to monitor client #1 while outside to prevent elopement. The facility failed to ensure client #4's ISP/BSP included guidelines for the use of client #4's walker.</p> <p>Findings include:</p> <p>1. CNA (Certified Nurse Aide) #1 was interviewed on 2/11/13 at 4:40 PM. CNA #1 indicated client #1's behaviors included elopement. CNA #1 stated, "[Client #1] likes to walk off sometimes. [Client #1] will walk out into the street and go into the parking lot. We usually have to use a cookie to coax him back."</p> <p>Observations were conducted at the facility on 2/12/13 from 6:30 AM through 9:30 AM. Client #1 was observed throughout the observation period. At 7:36 AM client #1 walked from the main resident building to the training center building via a sidewalk outside and returned to the main resident building</p>	W000240	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. Client # 1 has had his BIP and ISP updated to include monitoring for wandering behavior. It now includes being in visual sight of an employee anytime he exits the building to assure he does not wander from the grounds. #2. Client # 4 has had the IPP updated and it now includes the use of a rolling walker. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; #1. All clients who wander could be affected. An re-education will be conducted to train staff regarding wandering specific behavior and the responsibility to monitor them to assure they are safe and do not leave the grounds unattended. #2. All clients could be affected. The QMRP's will be responsible to update each clients IPP to assure the goals go along with the physician's orders. If any extra help is required, the IPP will reflect that. The daily IDT meeting goes over all physician order changes. **What measures will be put into place or what systemic changes the facility</p>	03/27/2013			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>from the training center building without staff supervision. At 8:05 AM client #1 walked from the main resident building to the training center building via a sidewalk outside and returned to the main resident building from the training center building without staff supervision. At 8:30 AM client #1 walked from the main resident building to the training center building via a sidewalk outside and returned to the main resident building from the training center building without staff supervision. At 9:05 AM client #1 walked from the main resident building to the training center building via a sidewalk outside and returned to the main resident building from the training center building without staff supervision.</p> <p>Client #1's record was reviewed on 2/13/13 at 2:43 PM. Client #1's vocational assessment dated 7/31/12 indicated, "Going outside of boundaries has been a problem this year..." Client #1's Behavior Intervention Plan (BIP), 4/10/12 indicated client #1 had elopement as an identified target behavior. Client #1's BIP dated 4/10/12 indicated, "Targets are... leaving the property (includes in parking lot). Leaving the facility area without staff supervision, standing in the street behind the parking lot. It is usually a little easier if the intervention starts before he has gotten very far." Client #1's BIP and ISP</p>		<p>will make to ensure that the deficient practice does not recur; #1. An re-education will be conducted to train staff regarding wandering specific behavior and the responsibility to monitor them to assure they are safe and do not leave the grounds unattended. A list of any and all clients who have been assessed as a wandering risk will be placed in a log located for all staff to access to assure they are aware of any wandering clients. Any changes will be made by the QMRP's. #2. An re-education will be conducted addressing how to assure that all IPP's are followed and are accurate. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. #1. A synopsis of any and all clients who wander and exactly how we are monitoring them will be presented to the QA committee meetings to assure compliance. #2. Any physical changes requiring a change in a clients IPP will be discusseed during the daily IDT meeting as well as the QA meetings. The QMRP's will be responsible to do this. It will be ongoing.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>did not indicate how staff were to monitor client #1 while outside to prevent elopement.</p> <p>Interview with QMRP #1 (Qualified Mental Retardation Professional) on 2/14/13 at 1:00 PM indicated client #1 had walked away from the facility into the parking lot. QMRP #1 stated, "... wants somebody to chase him." When asked how often client #1 eloped from the facility, QMRP #1 stated, "Now and then, probably two or three times a month." When asked how staff are to monitor client #1 while outside, QMRP #1 stated, "Everybody kind of watches him if he steps past boundaries. He's on a sticker program, and has elopement specific in his plan when outside." When asked if staff were to keep client #1 in line of sight, accompany client #1 while outside or provide other supervision for client #1 while outside, QMRP #1 indicated client #1's ISP/BSP did not include specific information regarding how staff were to monitor client #1 while outside to prevent elopement.</p> <p>2. On 2/11/13 from 1:30pm until 2:32pm, on 2/11/13 from 3:20pm until 5:40pm, on 2/12/13 from 5:45am until 9:13am, and on 2/13/13 from 1pm until 1:40pm, observations were conducted and during the observation times, client #4 used a</p>						

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	<p>roller walker to walk and staff assisted him by guiding the roller walker with one hand and one hand on client #4's gait belt.</p> <p>Client #4's record was reviewed on 2/13/13 at 11:35am. Client #4's 4/3/2011 CFA indicated client #4 used a wheelchair for mobility. Client #4's CFA did not include the use of a roller walker. Client #4's 4/3/12 Individual Program Plan (IPP) did not include the use of a roller walker and did not include guidelines for its use. Client #4's IPP indicated the use of a wheelchair for mobility when out of bed. Client #4's 2/11/2013 "Physician's Order" indicated client #4 had a roller walker to use.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #3 (Qualified Mental Retardation Professional) was completed. QMRP #3 indicated client #4 was legally blind and could see shadows. QMRP #3 indicated client #4 used a roller walker to ambulate throughout the facility. QMRP #3 indicated client #4's walker was not included in his IPP and no guidelines for its use were available for review.</p> <p>3.1-35(b)(1)</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview, the facility failed to implement written objectives during times of opportunity for 7 of 10 sampled clients (clients #2, #3, #4, #6, #7, #8 and #9) and 1 additional client (client #16).</p> <p>Findings include:</p> <p>1. An observation was conducted at the facility on 2/11/13 from 1:55 P.M. until 6:10 P.M.. From 1:55 P.M. until 5:45 P.M., clients #2, #7, #9 and #16 sat in the classroom with no meaningful active treatment. From 1:55 P.M. until 3:30 P.M., client #16 had no shirt, socks or shoes on. Staff did not prompt client #16 to put a shirt, socks or shoes on. Direct Support Professionals (DSP) #1 and #2 walked around the room and checked on the clients occasionally, but did not offer meaningful active treatment.</p> <p>An observation was conducted at the facility on 2/12/13 from 7:20 A.M. until</p>	W000249	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. Clients # 2, 7, 9, & 16 have active treatment plans to be involved with daily activities. Client # 16 continues to remove his clothing at times but the employees are now implementing the BIP. Client # 2 is now encouraged to go to active treatment programs. All employees have been re-educated regarding the importance of following the behavior plans as written. #2. Client # 3 is now having his ISP implemented daily. #3. Client # 6 is now having his ISP implemented daily. #4. Client #8 is now having her ISP implemented daily. #5. Client # 4's ISP has been updated and re-assessed for the need for bedrest. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; #1. All residents have the potential to be affected. All employees have</p>	03/27/2013			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>9:10 A.M.. From 7:20 A.M. until 8:20 A.M., client #2 laid fully clothed in his bed with no meaningful active treatment or staff interaction. At 7:20 A.M., client #7 was walked over to her classroom. From 8:25 until 9:10 A.M., client #7 stood looking out a window with no staff interaction and no meaningful active treatment.</p> <p>An observation was conducted at the facility on 2/12/13 from 12:27 P.M. until 1:30 P.M.. During the entire observation period clients #2, #7, #9 and #16 sat in the classroom with no meaningful active treatment. Direct Support Professionals (DSP) #10 and #11 walked around the room and checked on the clients occasionally, but did not offer meaningful active treatment.</p> <p>A review of client #2's record was conducted at the facility's administrative office on 2/13/13 at 12:55 P.M.. The record indicated an Individual Support Plan (ISP) dated 7/12/12 which indicated: "Will work while sitting at his work station for no more than 5 minutes. He is able to do the work, although sometimes he is often non-compliant. He can follow one-step command and focus eyes on a project...Will identify nickel, dime and quarter...Will indicate what he wants to do between two activities...Will ID 3</p>		<p>been re-educated regarding the importance of following the behavior plans as written. #2. All residents have the potential to be affected. All employees have been re-educated regarding the importance of following the behavior plans as written. #3. All residents have the potential to be affected. All employees have been re-educated regarding the importance of following the behavior plans as written. #4. All residents have the potential to be affected. All employees have been re-educated regarding the importance of following the behavior plans as written. #5. All clients have the potential to be affected. All employees have been re-educated regarding the importance of following the behavior plans as written. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; #1. All employees have been re-educated regarding the importance of following the behavior plans as written. Rounds are completed daily and the results of these rounds will be discussed daily during the IDT meetings. #2. All employees have been re-educated regarding the importance of following the behavior plans as written. Rounds are completed daily and the results of these rounds will be discussed daily during the IDT meetings. #3. All employees</p>				

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	<p>common survival signs...Will attend to vocational tasks for increasing lengths of time."</p> <p>A review of client #7's record was conducted at the facility's administrative office on 2/13/13 at 9:30 A.M.. The record indicated an ISP dated 8/7/12 which indicated: "Will sign eat, drink, toilet, sleep, happy, wash hands and brush teeth...Will match coins...Will separate coins from other objects...Will wear eyeglasses during meals."</p> <p>A review of client #9's record was conducted at the facility's administrative office on 2/13/13 at 11:45 A.M.. The record indicated an ISP dated 10/30/12 which indicated: "Will identify money from objects that are not money...Will identify coins...Will participate in money making activities such as breaking down boxes, making memo pads, and crafts to sell given physical assistance...When trainer hands [client #9] 10 cards, he will place the card one at a time into the container."</p> <p>A review of client #16's record was conducted at the facility's administrative office on 2/13/13 at 1:55 P.M.. The record indicated an ISP dated 6/14/12 which indicated: "Will identify money from objects that are not money...Will</p>		<p>have been re-educated regarding the importance of following the behavior plans as written.</p> <p>Rounds are completed daily and the results of these rounds will be discussed daily during the IDT meetings. #4. All employees have been re-educated regarding the importance of following the behavior plans as written.</p> <p>Rounds are completed daily and the results of these rounds will be discussed daily during the IDT meetings. #5. All employees have been re-educated regarding the importance of following the behavior plans as written.</p> <p>Rounds are completed daily and the results of these rounds will be discussed daily during the IDT meetings. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. #1. The results of the daily rounds will be discussed during the QA committee meetings. These rounds will be ongoing. #2. The results of the daily rounds will be discussed during the QA committee meetings. These rounds will be ongoing. #3. The results of the daily rounds will be discussed during the QA committee meetings. These rounds will be ongoing. #4. The results of the daily rounds will be discussed during the QA committee meetings. These rounds will be ongoing. #5. The results of the</p>		

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>identify coins...Behavior Intervention Plan: Taking clothes off in public: Immediately intervene to protect [client #16]'s dignity...Assist him to redress...Taking off shoes: Staff will assist [client #16] to put his shoes on at the beginning of the interval...Will stay with [client #16] and assist him to put them back on immediately when he takes them..[Client #16] must wear shoes to walk at all times."</p> <p>An interview with Qualified Mental Retardation Professional (QMRP) #4 was conducted on 2/14/13 at 10:00 A.M.. The QMRP stated client objectives should be implemented "during times of opportunity." The QMRP further indicated clients #2, #7, #9 and #16 should have been provided with meaningful active treatment activities during the observation periods.</p> <p>2. Observations were conducted in the facility on 02/11/13 from 2:00 PM until 5:53 PM and on 02/12/13 from 1:35 PM until 4:30 PM. During the observation times client #3 was absent from the group room and in his bed on the following dates and times: 02/11/13 from 2:00 PM until 4:22 PM and on 02/12/13 from 1:35 PM until 3:30 PM. On 02/11/13 client #3 went from his</p>		daily rounds will be discussed during the QA committee meetings. These rounds will be ongoing.				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>bedroom to the group room at 4:22 PM and into the dining room at 4:34 PM. On 02/12/13 client #3 went from his bedroom at 3:30 PM to the group room and sat in the group room without interaction during the observation until it ended at 4:30 PM. On 02/11/13 at 4:50 PM and on 02/12/13 at 9:15 AM client #3 was observed to be fed his meal by staff #23 and #26. During neither observation did client #3 touch the napkin to wipe his mouth.</p> <p>Client #3's records were reviewed on 02/13/13 at 10:54 AM. Client #3's 02/15/10 active treatment schedule indicated the following for the specified time frames: "6-6:45 AM - Get up, Dressing Skills/Grooming Skills/TS 6:45-7:00 AM - Vocational Skills 7:00-7:15 AM - Current Events (Leisure Skills)-e.g. news stories, newspaper, Discussion of articles in magazines, conversation-involving time of day (morning/afternoon/evening), light/dark outside, sun/stars/etc. Calendar-day, month, year, etc., other leisure activities. 7:15-7:30 AM: Money Management Skills 7:30-7:45 AM: Communication of Basic needs Skills 8:00-8:30 AM: Handwashing, breakfast (train formal goal) 8:30-9:15 AM: Social Skills (attending</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>and Social Skills related to group participation and involvement such as taking turns, sharing, social amenities, social greetings, etc.)</p> <p>9:15 AM-9:45 AM: Object ID</p> <p>10:00 AM-11:30 AM: Bed Rest</p> <p>11:30 AM-11:45 AM: Money Management</p> <p>11:45 AM-12:15 PM: Hand washing, Lunch (train formal goal)</p> <p>12:15-12:45 PM: Current Events, Colors, Shapes, Weather</p> <p>12:45 PM-1 PM: Object ID</p> <p>1-2 PM: Communication of Basic Needs Skills</p> <p>2-3 PM: Bed Rest</p> <p>3-3:30 PM: Gross Motor and Mobility (exercise and/or mobility goals) Range of Motion</p> <p>3:30-4 PM: Social Skills (Attending and Social Skills related to group participation and involvement such as taking turns, sharing, social amenities, social greeting, etc.)</p> <p>4-4:15 PM: Hydration Training</p> <p>4:15-4:30 PM: Object Identification Skills</p> <p>4:30-4:45 PM: Vocation Skills</p> <p>4:45-5 PM: Money Management</p> <p>5-5:15 PM: Gross Motor Activity and Mobility</p> <p>5:15-5:45 PM: Object ID</p> <p>5:45-6:15 PM: Hand washing, Dinner (train formal goal)</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>6:15-6:45 PM: Vocational Time 6:45-7 PM: Music (Music games, action singing, radio, audio tapes, etc.) 7-7:15 PM: Snacks, Hydration 7:15-7:30 PM: Grooming Skills, Personal Hygiene Skills, Dressing Skills, Dental Hygiene Skills, Toileting Skills. 7:30-8 PM: Clean up Classroom, Bed." Facility staff did not follow and/or implement client #3's active treatment schedule as written.</p> <p>Client #3's ISP was dated 04/12/12 and contained but was not limited to the following goals: move hands toward toothbrush; touch napkin prepare to wipe mouth; accept shower box; move hand toward comb; accept the vocational item from staff; accept a penny from staff; put right arm through arm hole; move hand towards privacy curtain and scoop medication out of the cup.</p> <p>On 02/14/13 at 11:30 AM an interview was conducted with the QMRP #1. The QMRP #1 indicated client #3's goals should have been implemented and could not have been implemented if the Active Treatment Schedule was not followed. She further indicated staff were to follow the Active Treatment Schedule as written and goals should be implemented at all formal and informal opportunities.</p>						

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	<p>3. Observations were conducted in the facility on 02/11/13 from 2:00 PM until 5:53 PM and on 02/12/13 from 1:35 PM until 4:30 PM. During the observation times client #6 was absent from the group room and in his bed on the following dates and times: 02/11/13 from 2:00 PM until 4:42 PM and on 02/12/13 from 1:35 PM until 4:30 PM.</p> <p>On 02/11/13 client #6 went from his bedroom to the group room at 4:42 PM, sat by the window in his wheelchair without interaction and was wheeled into the dining room at 5:35 PM. On 02/12/13 client #6 remained in his room for the duration of the observation and was still in his bed when the observation ended at 4:30 PM. On 02/11/13 at 5:43 PM client #6 was observed to feed himself without any staff at the table or any verbal prompting to not spill his food. On 02/12/13 at 8:45 AM client #6 was observed to be fed his meal by staff #26.</p> <p>Client #6's records were reviewed on 02/13/13 at 12:53 PM. Client #6's 2010 active treatment schedule indicated the following for the specified time frames: "6:00-7:30 AM - Get up, Dressing Skills/Grooming Skills/TS 7:30-8:00 AM - Resident's Breakfast - Handwashing, Eating Skills, Personal Hygiene skills to clean up after breakfast</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>Arts and Crafts for those residents who are in the classroom</p> <p>8:00-8:30 AM: Music, Leisure skills. (range of motion, cd, songs, clapping, rhythm) You must be actively involved with the residents during this time in these activities</p> <p>8:30-8:45 AM: Money Management Skills</p> <p>8:45-9:00 AM: Current Events (Leisure Skills)-e.g. news stories, newspaper, Discussion of articles in magazines, conversation-involving time of day (morning/afternoon/evening), light/dark outside, sun/stars/etc. Calendar-day, month, year, etc., other leisure activities.</p> <p>9:00-9:45 AM: Vocational</p> <p>9:45-10:15 AM: Gross Motor and Mobility (exercise and/or mobility goals)</p> <p>Music (Music games, action, singing, radio, audio tapes, etc. You must be actively involved with the residents during this time in these activities</p> <p>10:45-11:15 AM: Arts and Crafts</p> <p>11:15-11:45 AM: Resident's Lunch - Handwashing, Eating Skills, Personal Hygiene skills to clean up after lunch, Arts and Crafts for residents who are in the classroom</p> <p>11:45-12:00 PM: Exercise, ROM (Range of Motion); Music (Music games, action, singing, radio, audio tapes, etc.)</p> <p>12:00-12:30 PM: Arts and Crafts</p> <p>12:30-12:45 PM: Object Identification</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>12:45-1:00 PM: Communication Skills</p> <p>1:00-1:15 PM: Money Management Skills</p> <p>1:15-1:30 PM: Social Skills (attending and Social Skills related to group participation and involvement such as taking turns, sharing, social amenities, social greetings, etc.)</p> <p>1:30-2:00 PM: Vocational Skills</p> <p>2:00-3:00 PM: Time out of classroom (Hydration Training - Go to Beverage Station in Dining Room) Current events, social skills, colors, weather, conversation, games, parachute, etc.</p> <p>3:00-3:30 PM: Object Identification Skills</p> <p>3:30-4:00 PM: Vocation Skills</p> <p>4:00-4:15 PM: Hydration Skills</p> <p>4:15-4:30 PM: Money Management Skills</p> <p>4:30-4:45 PM: Social Skills (Attending and Social Skills related to group participation and involvement such as taking turns, sharing, social amenities, social greeting, etc.)</p> <p>4:45-5:00 PM: Communication of Basic Needs</p> <p>5:00-5:15 PM: Money Management</p> <p>5:15-5:45 PM: Resident's Dinner - Handwashing, Eating Skills, Personal Hygiene skills to clean up after dinner, Vocational Skills for those residents who are in the classroom</p> <p>5:45-6:00 PM: Object Identification</p>				

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	<p>Skills</p> <p>6:00-6:30 PM: Gross Motor Activity, Mobility, and Leisure skills; Music (Music games, action singing, radio, audio tapes, etc.) You must be actively involved with the residents during this time in these activities.</p> <p>6:30-7:00 PM: Arts/Craft Activity</p> <p>7:00-7:15 PM: Music, Leisure skills (Music games, action, singing, radio, audio tapes, etc) (Attending and Social Skills related to group participation and involvement) You must be actively involved with the residents during this time in these activities</p> <p>7:15-7:30 PM: Current Events (Leisure Skills) e.g. news stories, newspaper, discussion of articles in magazines, conversation involving time of day (morning, afternoon, evening), light/dark/outside, sun/stars, etc. Calendar -day, month, year, etc., other leisure activities</p> <p>7:30-7:45 PM: Clean up classroom with resident's participation</p> <p>7:30-8:00 PM: Snacks, Hydration</p> <p>8:00-9:00 PM: Grooming Skills, Personal Hygiene Skills, Dressing Skills, Dental Hygiene Skills, Toileting Skills"</p> <p>Facility staff did not follow and/or implement client #6's active treatment schedule as written.</p> <p>Client #6's ISP was dated 04/12/12 and</p>						

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	<p>contained but was not limited to the following goals: touch a vocational item; eat without spilling, touch the washcloth to his arm; move his hand towards the waistband of his pants; choice between 2 objects - pick the deodorant; accept a coin from staff; move hands towards his shirt in preparation to put on; touch the toothbrush in prep of brushing and with nurse assistance pick up spoon.</p> <p>On 02/14/13 at 11:30 AM an interview was conducted with the QMRP #1. The QMRP #1 indicated client #6's goals should have been implemented and could not have been implemented if the Active Treatment Schedule was not followed. She further indicated staff were to follow the Active Treatment Schedule as written and goals should be implemented at all formal and informal opportunities.</p> <p>4. Observations were conducted in the facility on 02/11/13 from 2:00 PM until 5:53 PM and on 02/12/13 from 1:35 PM until 4:30 PM. During the observation times client #8 was absent from the group room and in her bed on the following dates and times: 02/11/13 from 2:00 PM until 4:53 PM and on 02/12/13 from 1:35 PM until 3:30 PM. On 02/11/13 client #8 went from her bedroom to the dining room. During</p>						

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	<p>dining client #8 was observed to feed herself with her fingers. During neither observation did client #8 wipe her mouth with a napkin, nor was she prompted.</p> <p>Client #8's records were reviewed on 02/13/13 at 2:00 PM. Client #8's 02/15/10 active treatment schedule indicated the following for the specified time frames:</p> <p>"6-6:30 AM - Get up, Dressing Skills/Grooming Skills/TS 6:30-7:00 AM - Hand washing, breakfast, (train formal goal) 7:00-7:15 AM - Current Events (Leisure Skills)-e.g. news stories, newspaper, Discussion of articles in magazines, conversation-involving time of day (morning/afternoon/evening), light/dark outside, sun/stars/etc. Calendar-day, month, year, etc., other leisure activities. 7:15-7:30 AM: Money Management Skills 7:30-7:45 AM: Communication of Basic needs Skills 7:45-8:15 AM: Playing organ in living room or bed room, sit in her rocking chair 8:45-9:15 AM: Social Skills (attending and Social Skills related to group participation and involvement such as taking turns, sharing, social amenities, social greetings, etc.) 9:15 AM-9:45 AM: Object ID 10:00 AM-10:30 AM: Bed Rest (per</p>						

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	<p>behavior program)</p> <p>10:30 AM-11:00 AM: Hand washing, Lunch (train formal goal)</p> <p>11:15 AM-12:15 PM: Bed Rest</p> <p>12:15-12:45 PM: Object ID</p> <p>12:45 PM-1 PM: Current Events, Colors, Shapes, Weather</p> <p>1-2 PM: Communication of Basic Needs Skills</p> <p>2-3 PM: Playing organ in living room or bed room, sit in rocking chair.</p> <p>3-3:30 PM: Gross Motor and Mobility (exercise and/or mobility goals) Range of Motion</p> <p>3:30-4 PM: Social Skills (Attending and Social Skills related to group participation and involvement such as taking turns, sharing, social amenities, social greeting, etc.)</p> <p>4-4:30 PM: Bed Rest (per behavior program)</p> <p>4:30-5:00 PM: Hand washing, Dinner (train formal goal)</p> <p>5-5:15 PM: Gross Motor Activity and Mobility</p> <p>5:15-5:45 PM: Object ID</p> <p>5:45-6:15 PM: Playing organ in living room or bedroom, sit in rocking chair.</p> <p>6:15-6:45 PM: Vocational Time</p> <p>6:45-7 PM: Music (Music games, action singing, radio, audio tapes, etc.)</p> <p>7-7:15 PM: Snacks, Hydration</p> <p>7:15-7:30 PM: Grooming Skills, Personal Hygiene Skills, Dressing Skills,</p>						

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	<p>Dental Hygiene Skills, Toileting Skills. 7:30-8 PM: Clean up Classroom, Bed." Facility staff did not follow and/or implement client #8's active treatment schedule as written.</p> <p>Client #8's ISP was dated 01/22/13 and contained but was not limited to the following goals: wipe mouth with napkin, touch lathered washcloth, touch doorknob to close; touch hairbrush to hair, place swab in her mouth, pull sock on right foot, touch 25 cents to identify; touch washcloth before folding; communicate name of object - deodorant and wash hands after using the toilet.</p> <p>On 02/14/13 at 11:30 AM an interview was conducted with the QMRP #1. The QMRP #1 indicated client #8's goals should have been implemented and could not have been implemented if the Active Treatment Schedule was not followed. She further indicated staff were to follow the Active Treatment Schedule as written and goals should be implemented at all formal and informal opportunities.</p> <p>5. On 2/11/13 from 1:30pm until 4:45pm, on 2/12/13 from 5:45am until 6:50am, and on 2/12/13 from 1:05pm until 2:05pm, observations were conducted and during the observation times client #4 was in his bed inside his bedroom.</p>						

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	<p>Client #4's record was reviewed on 2/13/13 at 11:35am. Client #4's 4/3/2011 IPP (Individual Program Plan) indicated "Special Provisions, Time out of Room: [Client #4] is in Program A for class. He likes to go on outings and go outdoors. He may also spend time in his room when he wishes provided that it doesn't interfere with active treatment. He has two bed rest times per day." Client #4's 10/11/2010 active treatment schedule indicated "6am-7:30am, Get up, dressing skills, grooming skills. 7:30am-8am, Residents breakfast, eating skills, personal hygiene skills, arts/crafts if he is in the classroom. 8am-8:30am, Music, leisure skills. 8:30am-8:45am, Money management skills. 8:45am-9am, Current Events, calendar. 9am-9:45am, vocational. 9:45am-10:15am, Hydration training. 10:15am-10:45am, Gross Motor and Mobility, Music. 10:45am-11:15am, Arts and Crafts. 11:15am-11:45am, Residents lunch, personal hygiene skills to clean up after lunch. Arts and Crafts for residents who are in the classroom. 11:45am-12noon, exercise, ROM (Range of motion), Music. 12noon-12:30pm, Arts and Crafts. 12:30pm-12:45pm, Object Identification. 12:45pm-1pm, Communication skills. 1pm-1:15pm, Money Management skills, 1:15pm-1:30pm, Social skills.</p>				

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	<p>1:30pm-2pm, Vocational skills, 2pm-2:30pm, Time out of classroom hydration training. 2:30pm-3pm, time out of classroom hydration training. 3pm-3:30pm, Object Identification skills. 3:30pm-4pm, Vocational skills. 4pm-4:15pm, Hydration training. 4:15pm-4:30pm, Money Management. 4:30pm-4:45pm, Social Skills. 4:45pm-5pm, Communication of basic needs. 5pm-5:45pm, Residents dinner, personal hygiene, vocational skills for those residents who are in the classroom...." The staff did not implement client #4's active treatment schedule/goals as outlined.</p> <p>On 2/14/13 at 9:55am, an interview with LPN #1 was conducted. LPN #1 indicated client #4 had no identified medical need for bedrest.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #3 (Qualified Mental Retardation Professional) was completed. QMRP #3 indicated client #4's active treatment schedule did not include bed rest times. QMRP #3 indicated client #4's active treatment schedule/training should be implemented as written.</p> <p>3.1-23(a) 3.1-32(a) 3.1-37(a)</p>						

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W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on record review and interview, the facility failed for 10 of 10 sampled clients (clients #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10) and for 1 additional client (#16), the facility failed to update and individualize the active treatment schedules (ATS).</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 02/13/13 at 10:54 AM. Client #3's ATS was dated 02/15/10.</p> <p>Client #10's record was reviewed on 2/13/13 at 9:34 AM. Client #10's active treatment schedule was dated 2/7/08.</p> <p>Client #6's record was reviewed on 02/13/13 at 12:53 PM. Client #6's ATS was dated 2010.</p> <p>Client #8's record was reviewed on 02/12/13 at 2:00 PM. Client #8's ATS was dated 02/15/10.</p> <p>Client #1's record was reviewed on 2/13/13 at 2:43 PM. Client #1's active</p>	W000250	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. Clients #3, 10, 6, 8, & 1 have all had their Active Treatment Schedules updated. #2. Client # 4 has had his Active Treatment Schedule updated. #3. Client # 5 has had his Active Treatment Schedule updated. #4. Clients #2, 7, 9 & 16 are receiving active treatment according to their schedule. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; #1. All clients have the potential to be affected. All clients have had their active treatment schedules updated to assure they are in compliance with their ISP. #2. All clients have the potential to be affected. All clients have had their active treatment schedules updated to assure they are in compliance with their ISP. #3. All clients have the potential to be affected. All clients have had their Active Treatment Schedules updated to assure they are in compliance with the ISP. #4. All clients have the potential to be affected. All employees have been re-educated on the</p>	03/27/2013			

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	<p>treatment schedule was dated 2/7/08.</p> <p>On 02/14/13 at 11:30 AM an interview was conducted with the QMRP #1. The QMRP #1 indicated the Active Treatment Schedules were to be updated yearly along with the ISP. She indicated ATSS of 2010 were outdated.</p>		<p>importance of following every clients ISP and the Active treatment schedules. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; #1. An audit tool has been developed to assist the QMRP's in assuring that the Active Treatment Schedules are updated along with the annual ISP's. #2. An audit tool has been developed to assist the QMRP's in assuring that the Active Treatment Schedules are updated along with the annual ISP's. Daily rounds are completed by the QMRP's to monitor and assure that the Active Treatment Schedules are being followed correctly. All employees have been re-educated on the importance of following the active treatment plans for each client. #3. An audit tool has been developed to assist the QMRP's in assuring that the Active Treatment Schedules are updated along with the annual ISP's. #4. An audit tool has been developed to assist the QMRP's in assuring that the Active Treatment Schedules are updated along with the annual ISP's. Daily rounds are completed by the QMRP's to monitor and assure that the Active Treatment Schedules are being followed correctly. All employees have been re-educated on the importance of</p>		

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	2. Client #4's record was reviewed on 2/13/13 at 11:35am. Client #4's 4/3/2011 IPP (Individual Program Plan) indicated "Special Provisions, Time out of Room: [Client #4] is in Program A for class. He likes to go on outings and go outdoors. He may also spend time in his room when he wishes provided that it doesn't interfere with active treatment. He has two bed rest times per day." Client #4's 10/11/2010 active treatment schedule indicated "6am-7:30am, Get up, dressing		following the active treatment plans for each client. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. #1. The results of the audit tool will be discussed during the QA committee meetings to assure compliance. #2. The results of the daily rounds will be discussed during the QA committee meetings by the QMRP. The rounds will be ongoing. #3. The results of the audit tool will be discussed during the QA committee meetings by the QMRP. This audit will continue until there are no further issues with outdated Active Treatment Schedules. #4. The results of the daily rounds will be discussed during the QA committee meetings by the QMRP. The rounds will be ongoing.		

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	<p>skills, grooming skills. 7:30am-8am, Residents breakfast, eating skills, personal hygiene skills, arts/crafts if he is in the classroom. 8am-8:30am, Music, leisure skills. 8:30am-8:45am, Money management skills. 8:45am-9am, Current Events, calendar. 9am-9:45am, vocational. 9:45am-10:15am, Hydration training. 10:15am-10:45am, Gross Motor and Mobility, Music. 10:45am-11:15am, Arts and Crafts. 11:15am-11:45am, Residents lunch, personal hygiene skills to clean up after lunch. Arts and Crafts for residents who are in the classroom. 11:45am-12noon, exercise, ROM (Range of motion), Music. 12noon-12:30pm, Arts and Crafts. 12:30pm-12:45pm, Object Identification. 12:45pm-1pm, Communication skills. 1pm-1:15pm, Money Management skills, 1:15pm-1:30pm, Social skills. 1:30pm-2pm, Vocational skills, 2pm-2:30pm, Time out of classroom hydration training. 2:30pm-3pm, time out of classroom hydration training. 3pm-3:30pm, Object Identification skills. 3:30pm-4pm, Vocational skills. 4pm-4:15pm, Hydration training. 4:15pm-4:30pm, Money Management. 4:30pm-4:45pm, Social Skills. 4:45pm-5pm, Communication of basic needs. 5pm-5:45pm, Residents dinner, personal hygiene, vocational skills for those residents who are in the</p>				

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	<p>classroom...." Client #4's active treatment schedule was not individualized for client #4.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #3 (Qualified Mental Retardation Professional) was completed. QMRP #3 indicated client #4's active treatment schedule did not include bed rest times. QMRP #3 indicated client #4's active treatment schedule had not been updated since 10/2010.</p> <p>3. Client #5's record was reviewed on 2/13/13 at 10:40am. Client #5's 11/15/2010 active treatment schedule indicated: "6am-7:30am, Get up, dressing skills, grooming skills. 7:30am-8am, Residents breakfast, eating skills, personal hygiene skills, arts/crafts if he is in the classroom. 8am-8:15am, Current Events. 8:15am-8:30am, Money management skills. 8:30am-8:45am, Communication of basic needs. 8:45am-9am, Social Skills. 9am-10am, Music. 10am-10:15am, Hydration training. 10:15am-10:30am, Gross Motor and Mobility training. 10:30am-10:45am, Vocational skills. 10:45am-11:15am, Residents lunch, personal hygiene skills to clean up after lunch. 11:15am-11:30am, Social skills. 11:30am-12noon, Vocational skills. 12noon-12:15pm, Object identification.</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(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>12:15pm-12:30pm, Money Management Skills. 12:15pm-12:45pm, Current events/colors/shapes/weather. 12:45pm-1pm, Communication of basic need skills. 1pm-2pm, Music. 2pm-2:15pm, Gross motor and mobility/ROM. 2:15pm-2:30pm, Hydration training. 2:30pm-2:45pm, Object identification skills. 2:45pm-3pm, Social Skills. 3pm-4pm, Time out of class/Hydration training. 4pm-4:30pm, Vocational training. 4:30pm-4:45pm, Money Management. 4:45pm-5:15pm, Handwashing/dinner/personal hygiene. 5:15pm-5:30pm, object ID (identification). 5:30pm-6pm, Vocation training." Client #5's active treatment schedule was not individualized for client #5.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #1 was completed. QMRP #1 indicated client #5's active treatment schedule had not been updated since 11/2010.</p> <p>4. An observation was conducted at the facility on 2/11/13 from 1:55 P.M. until 6:10 P.M.. From 1:55 P.M. until 5:45 P.M., clients #2, #7, #9 and #16 sat in the classroom with no meaningful active treatment. From 1:55 P.M. until 3:30 P.M., client #16 had no shirt, socks or shoes on. Staff did not prompt client #16</p>						

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	<p>to put a shirt, socks or shoes on. Direct Support Professionals (DSP) #1 and #2 walked around the room and checked on the clients occasionally, but did not offer meaningful active treatment.</p> <p>An observation was conducted at the facility on 2/12/13 from 7:20 A.M. until 9:10 A.M.. From 7:20 A.M. until 8:20 A.M., client #2 laid fully clothed in his bed with no meaningful active treatment or staff interaction. During this time period, housekeeping staff made clients #2, #7, #9 and #16's beds and retrieved each client's dirty laundry basket. At 7:20 A.M., client #7 was walked over to her classroom. From 8:25 until 9:10 A.M., client #7 stood looking out a window with no staff interaction and no meaningful active treatment.</p> <p>An observation was conducted at the facility on 2/12/13 from 12:27 P.M. until 1:30 P.M.. During the entire observation period clients #2, #7, #9 and #16 sat in the classroom with no meaningful active treatment. Direct Support Professionals (DSP) #10 and #11 walked around the room and checked on the clients occasionally, but did not offer meaningful active treatment.</p> <p>A review of client #2's record was conducted at the facility's administrative</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>office on 2/13/13 at 12:55 P.M.. The record indicated a most current Active Treatment Schedule (ATS) dated 2/7/08 which indicated:</p> <p>"6:00-7:00: Get Up...Dressing/Grooming/Toileting...Make Bed...Put dirty clothes in barrel...Can go to living room to watch tv or dining room for coffee (wash hands before having coffee.)</p> <p>7:15 A.M.: Cross to Training Center...Wash hands...Set table for breakfast</p> <p>8:00 A.M.: Breakfast...Clean up area...Wash Hands...Brush Teeth</p> <p>9:00 A.M.: Safety and miscellaneous goals</p> <p>9:30 A.M.: Object Identification</p> <p>10:00 A.M.: Hydration...Money Management</p> <p>10:30 A.M.: Communication</p> <p>11:00 A.M.: Vocational</p> <p>11:45 A.M.: Wash Hands...Set table for lunch...Lunch...Clean up area...Wash Hands...Brush teeth...Everyone is to be up</p>			

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	<p>1/2 hour after meals</p> <p>1:00 P.M.: Leisure/Radio/TV/Books (offer a wide choice of activities)</p> <p>2:00 P.M.: Hydration</p> <p>2:15 P.M.: Arts and Crafts</p> <p>2:45 P.M.: Music/Exercise (ROM)</p> <p>3:15 P.M.: Safety and miscellaneous goals</p> <p>3:45 P.M.: Vocational</p> <p>4:15 P.M.: Hydration</p> <p>5:00 P.M.: Money management</p> <p>5:30 P.M.: Communication/Object Identification</p> <p>5:45 P.M.: Wash Hands...Set table for lunch</p> <p>6:00 P.M.: Lunch...Clean up area...Wash hands...Brush teeth...Everyone is to be up 1/2 hour after meals</p> <p>6:45 P.M.: Resident participation: Clean up room...put away supplies...wash tables and chairs...dust</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>7:00 P.M." Watch TV 1 hour...Provide alternate activities for those who do not want to watch TV</p> <p>7:30 P.M.: Snacks and hydration (continue TV)</p> <p>8:30 P.M.: Cross to main building...Go to bed."</p> <p>A review of client #7's record was conducted at the facility's administrative office on 2/13/13 at 9:30 A.M.. The record indicated failed to indicate an ATS.</p> <p>A review of client #9's record was conducted at the facility's administrative office on 2/13/13 at 11:45 A.M.. The record indicated a most current ATS dated 2/7/08 which indicated:</p> <p>"6:00-7:30 am: Get Up, Dressing Skills/Grooming Skills/TS</p> <p>7:30-8:00 am: Current Events</p> <p>8:00-8:30 am: Resident's Breakfast</p> <p>8:30-8:45 am: Money Management Skills</p> <p>8:45-9:00 am: Communication of Basic Needs Skills</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>9:00-9:45 am: Vocational Skills</p> <p>9:45-10:00 am: Object Identification Skills</p> <p>10:00-10:15 am: Hydration Training</p> <p>10:15-10:45 am: Gross Motor and Mobility</p> <p>10:45-11:30 am: Arts and Crafts</p> <p>11:30-12:00 pm: Exercise, ROM (Range of Motion); Music</p> <p>12:00-12:30 pm: Resident's lunch</p> <p>12:30-12:45 pm: Object Identification</p> <p>12:45-1:00 pm: Communication Skills</p> <p>1:00-1:15 pm: Money Management Skills</p> <p>1:15-1:30 pm: Social Skills</p> <p>1:30 PM-2:00 pm: Arts and Crafts</p> <p>2:00 PM-3:00 pm: Time out of classroom (Hydration Training)</p> <p>3:00-3:30 pm: Object Identification</p> <p>3:30-4:00 pm: Vocational Skills</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	4:00-4:15 pm: Hydration Skills			
	4:15-4:30 pm: Money management			
	4:30-4:45 pm: Social Skills			
	4:45-5:00 pm: Communication of Basic Needs			
	5:00-5:15 pm: Money Management			
	5:15-5:30 pm: Object identification Skills			
	5:30-6:00 pm: Gross Motor Activity and Mobility; Music			
	6:00-6:30 pm: Resident's Dinner			
	6:30-7:00 pm: Arts/Craft Activity			
	7:00-7:15 pm: Music			
	7:15-7:30 pm: Current events (Leisure Skills)			
	7:30-7:45 pm: Clean up classroom with resident's participation			
	7:30 (sic)-8:00 pm: Snacks...Hydration			
	8:00-9:00 pm: Grooming skills, Personal Hygiene Skills, Dressing Skills, Dental			

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	<p>Hygiene Skills, Toileting Skills."</p> <p>A review of client #16's record was conducted at the facility's administrative office on 2/13/13 at 1:55 P.M.. The record indicated a most current ATS dated 2/7/08 which indicated:</p> <p>"6:00-7:30 am: Get Up, Dressing Skills/Grooming Skills/TS</p> <p>7:30-8:00 am: Current Events</p> <p>8:00-8:30 am: Resident's Breakfast</p> <p>8:30-8:45 am: Money Management Skills</p> <p>8:45-9:00 am: Communication of Basic Needs Skills</p> <p>9:00-9:45 am: Vocational Skills</p> <p>9:45-10:00 am: Object Identification Skills</p> <p>10:00-10:15 am: Hydration Training</p> <p>10:15-10:45 am: Gross Motor and Mobility</p> <p>10:45-11:30 am: Arts and Crafts</p> <p>11:30-12:00 pm: Exercise, ROM (Range of Motion); Music</p>			

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	12:00-12:30 pm: Resident's lunch				
	12:30-12:45 pm: Object Identification				
	12:45-1:00 pm: Communication Skills				
	1:00-1:15 pm: Money Management Skills				
	1:15-1:30 pm: Social Skills				
	1:30 PM-2:00 pm: Arts and Crafts				
	2:00 PM-3:00 pm: Time out of classroom (Hydration Training)				
	3:00-3:30 pm: Object Identification				
	3:30-4:00 pm: Vocational Skills				
	4:00-4:15 pm: Hydration Skills				
	4:15-4:30 pm: Money management				
	4:30-4:45 pm: Social Skills				
	4:45-5:00 pm: Communication of Basic Needs				
	5:00-5:15 pm: Money Management				
	5:15-5:30 pm: Object identification Skills				

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	<p>5:30-6:00 pm: Gross Motor Activity and Mobility; Music</p> <p>6:00-6:30 pm: Resident's Dinner</p> <p>6:30-7:00 pm: Arts/Craft Activity</p> <p>7:00-7:15 pm: Music</p> <p>7:15-7:30 pm: Current events (Leisure Skills)</p> <p>7:30-7:45 pm: Clean up classroom with resident's participation</p> <p>7:30 (sic)-8:00 pm: Snacks...Hydration</p> <p>8:00-9:00 pm: Grooming skills, Personal Hygiene Skills, Dressing Skills, Dental Hygiene Skills, Toileting Skills."</p>			

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 1 of 10 sampled clients (#8), and 2 additional clients (client #23 and client #59), by not ensuring clients received nursing services according to their medical needs, by not obtaining a yearly mammogram for client #8, for documenting a change of status for client #23 and for not ensuring client #59's Bacitracin Ointment (antibiotic) contained a pharmacy label and was locked in the medicine cart.</p> <p>Findings include:</p> <p>1. Client #8's records were reviewed on 02/12/13 at 2:00 PM. Client #8's record indicated she had a mammogram completed on 01/20/12 and there was no evidence of breast cancer. The mammogram indicated she should have a yearly mammogram. The record did not contain a mammogram after 01/20/12.</p> <p>The LPN (Licensed Practical Nurse) #1 was interviewed on 02/14/13 at 11:45 AM. The LPN indicated client #8 had not yet had a mammogram in 2013.</p>	W000331	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice: #1. A mammogram for client #8 was completed on 2/22/13. The results were negative. #2. Client # 23 had a change of status assessment completed. The entry was not timely. Her lethargy was an unusual occurrence. Normally she is alert and able to eat properly. #3. Client #59 suffered no ill effects because the tube of bacitracin was accidentally left in the room.</p> <p>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; #1. All female clients have the potential to be affected. An effort will always be made to complete all annual tests within 12 months, based on physician availability. #2. All clients have the potential to be affected. A nursing re-education has been completed to address exactly how and when to do a change of status assessment #3. All clients have the potential to be affected. A nursing re-education has been completed to address safety in medication administration and the importance of not leaving items in the residents room. ** What</p>	03/27/2013			

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	2. Observations were conducted at the facility on 2/11/13 from 3:22 PM through 5:30 PM. At 4:15 PM client #23 was seated in her walker in TC (Training		measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; #1. An audit tool will be utilized by nursing to monitor all annual exams necessary to assure that every client requiring an annual mammogram will receive one. #2. The DON is aware of all changes in status of the clients. She will check the chart of the client after any change of status to assure all changes are being properly recorded. #3. Rounds are completed daily with these type of safety issues addressed. The results of the rounds are discussed during the daily IDT meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place; #1. The results of the audit tool will be discussed during QA meetings to assure compliance. The DON will be responsible. #2. The DON will report during the IDT meeting on a daily basis and the results of her checks will be discussed during the QA committee meetings. #3. The results of the daily rounds will be discussed during the QA committee meetings.		

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	<p>Center) room number one. Client #23 was awake, alert and participated in activities with her peers. At 4:30 PM client #23 was seated in her walker at the dining area. Client #23 was awake, alert and sitting up in her chair. At 4:33 PM client #23 laid her head down on the lap tray of her walker. CNA (Certified Nurse Aide) #1 prompted client #23 to sit up and eat her meal which had been placed on the lap tray of her walker. Client #23 did not respond to CNA #1's verbal prompt to sit up. Client #23 remained bent over with her head down on her arm across the lap tray on her walker. CNA #1 tapped client #23 on the shoulder and verbally prompted her to sit up and eat. Client #23 did not respond to CNA #1's physical or verbal prompts to wake. Client #23 did not sit up. CNA #1 continued physically and verbally prompting client #23 to wake, sit up and eat her meal. At 4:48 PM LPN (Licensed Practical Nurse) #3 verbally prompted client #23 to wake. Client #23 did not respond to LPN #3's verbal prompts to wake. At 4:55 PM client #23 was transferred by CNA #1 from her walker to a wheelchair and taken to her bedroom to lay down.</p> <p>Interview with CNA #1 on 2/11/13 at 4:45 PM indicated client #23 would not sit up for her meal. CNA #1 stated, "[Client #23] gets tired sometimes after</p>				

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	<p>her medications. We will take her to her bed and let her lay down and try to give her tray to her after while."</p> <p>Interview with LPN #3 on 2/11/13 at 5:00 PM indicated client #23 was taken to her bed to lay down.</p> <p>Interview with LPN #1 on 2/14/13 at 1:50 PM indicated client #23 was assessed by LPN #1 on 2/11/13. When asked if LPN #1 had documented her assessment of client #23 on 2/11/13, LPN #1 stated, "If [client #23] had a change of status then [LPN #3] should have performed a change of status assessment." When asked if LPN #1 had performed a change of status assessment, LPN #1 stated, "[LPN #3] should have. I would have."</p> <p>Client #23's record was reviewed on 2/14/13 at 8:30 AM. Client #23's record did not indicate documentation of client #23's change of status on 2/11/13. Client #23's record did not indicate documentation LPN #3 had completed a change of status assessment or initiated follow up care/observation of client #23.</p> <p>3. On 2/11/13 at 1:30pm, clients #4 and #59 were each in bed in the main building inside bedroom #2. On client #59's bedside dresser was a 1 ounce tube of unlabeled Bacitracin Ointment laying</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>within arms reach of client #59. On 2/11/2013 at 3:45pm, clients #4 and #59 remained in bed and the unlabeled tube of Bacitracin Ointment remained in the same location at the bedside of client #59. On 2/11/13 at 5:40pm, inside bedroom #2 in the main building the unlabeled tube of Bacitracin Ointment laid on client #59's bedside dresser.</p> <p>On 2/12/13 at 6:50am, client #59 was in bed and an unlabeled tube of Bacitracin Ointment laid on his bedside dresser within arms reach. Client #4 was independently up in the bathroom.</p> <p>On 2/14/13 at 10:10am, an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 indicated the Bacitracin Ointment was for client #59. LPN #1 indicated the nurse was responsible to apply the ointment treatment for client #59 and the Bacitracin Ointment should have been kept secured and locked inside the medication cart. LPN #1 indicated client #59's Bacitracin Ointment should have been kept inside the baggie which had the directions for the use of the Bacitracin Ointment. LPN #1 indicated the unlabeled and unsecured Bacitracin Ointment medication should not have been at client #59's bedside. LPN #1 indicated the facility's nursing staff did not follow the facility policy and</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>procedure for medication administration.</p> <p>On 2/14/13 at 1:30pm, a review of the facility's policy and procedure 6/2004 "Medications - Storage & Labeling" indicated "Each drug shall be kept and stored in a labeled dispensing container...During a medication pass, medications will be under the direct observation of the person administering medications or locked in the medication storage area/cart...Medication kept at bedside for resident's self administration shall be stored in some type of secured container, such as a locked box, locked drawer, etc...."</p> <p>3.1-17(a)</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview, for 1 of 10 sampled clients (client #7) and 1 additional client (client #20), the facility failed to furnish recommended adaptive equipment and failed to teach and encourage the use of prescribed eyeglasses.</p> <p>Findings include:</p> <p>A day observation was conducted at the facility on 2/11/13 from 1:55 P.M. until 6:10 P.M.. During the entire observation period client #7 did not and was not prompted to wear her prescribed eyeglasses. At 5:45 P.M., client #7 ate her dinner and did not wear her eyeglasses. Client #20 was observed sitting in his wheelchair. The left foot rest was missing. Facility staff crossed client #20's left leg atop his right leg so both legs could rest on the right foot rest. Client #20 slid himself out of his wheelchair onto the ground. There was no seat cushion in client #20's wheelchair.</p>	W000436	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; Client # 7 is currently being reminded to wear her eyeglasses. Client #20 has two foot rests on his wheelchair as well as a cushion in his seat. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All clients have the potential to be affected. All employees have been re-educated regarding assuring that all eyeglasses are worn as appropriate and that we have the proper adaptive equipment on all wheelchairs. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The use of necessary equipment for our clients will be monitored during the daily rounds that are conducted. All employees have been re-educated regarding assuring that all eyeglasses are worn as appropriate and that we have the proper adaptive</p>	03/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>Observations of the facility's TC (Training Center) building were conducted on 2/12/13 from 12:15 PM through 1:08 PM. At 12:20 PM client #20 was seated in his wheelchair. Client #20's wheelchair did not have a left foot rest. Client #20 began sliding down in his seat while using his feet to push himself away from the wheelchair. CNA (Certified Nurse Aide) #19 redirected client #20 to sit upright in his wheelchair. CNA #19 physically positioned client #20's right leg on the foot rest then crossed client #20's left leg over his right leg to position both his right and left legs onto the right foot rest. Client #20 was then pushed in his wheelchair with both left and right feet positioned on the right foot rest of his wheelchair from the TC to the main residential building.</p> <p>An observation was conducted at the facility on 2/12/13 from 7:20 A.M. until 9:10 A.M. and from 12:27 P.M. until 1:30 P.M.. From 7:20 A.M. until 9:10 A.M., client #7 did not wear eyeglasses. At 1:00 P.M., client #7 was observed wearing eyeglasses. When staff #21 was asked if client #7 wore eyeglasses, staff #21 indicated client #7 did wear her eyeglasses and was compliant with wearing them when prompted to do so. During both observation periods client #20's left foot rest was missing. Facility</p>		<p>equipment on all wheelchairs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. The results of the daily rounds will be presented to the QA committee during the monthly meetings by the Administrator. These rounds will be ongoing.</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>staff crossed his left leg atop his right leg so both legs could rest on the right foot rest. At 1:00 P.M., client #20 slid himself out of his wheelchair onto the ground. There was no seat cushion on his wheelchair. Staff #15 and #16 then put him back into his wheelchair and pushed him outside to his living quarters. When Qualified Mental Retardation Professional (QMRP) #4 was asked if client #20 should have a left foot rest, she stated "Yes I will have to have staff go over to get it."</p> <p>A review of client #7's record was conducted on 2/13/13 at 9:30 A.M.. Review of the record indicated an Individual Support Plan (ISP) dated 8/7/12 which indicated: "Adaptive Devices: Eyeglasses to improve vision...Will wear eyeglasses during meals...will put eyeglasses in case when not wearing...Will obtain own eyeglasses to wear."</p> <p>A review of client #20's record was conducted on 2/13/13 at 2:30 P.M.. Review of the record indicated a Physician's Order dated 12/31/12 which indicated: "Use footrests during transport outside of building...Seat cushion with contour base to prevent sliding."</p> <p>An interview with Licensed Practical</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>Nurse (LPN) #1 and QMRP #4 was conducted on 2/14/13 at 10:00 A.M..</p> <p>LPN #1 stated "Yes both footrests should be on [client #20]'s wheelchair and he should have a cushion on his chair."</p> <p>QMRP #4 stated "Yes [client #7] should wear her eyeglasses at all meal times if it's in her ISP."</p> <p>3.1-39(a)</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, the facility failed to maintain/ensure proper hygiene practices to prevent cross contamination for 2 of 10 sampled clients (#4 and #5) and for 1 additional client (#16) in regard to encouraging clients to wash their hands, and not placing contaminated food back onto a client's plate at meal time.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the facility on 2/12/13 from 7:20 A.M. until 9:10 A.M.. At 8:10 A.M., Bus Driver #1 assisted client #16 while eating his breakfast. Client #16 dropped a portion of his oatmeal onto the table. Bus Driver #1 picked the oatmeal up with his bare hands and placed it back on client #16's plate. Client #16 again dropped oatmeal on the bare table. Bus Driver #1 again picked the oatmeal up with his bare hands and placed it on client #16's plate, and hand over hand scooped the oatmeal up and fed it to client #16.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 was conducted on</p>	W000455	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. There were no adverse effects to client #16. #2. Clients #5 & #4 suffered no adverse effects from the lack of handwashing. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; #1. All clients could be affected. The bus driver has been trained regarding proper procedures when he is in the dining room. A re-education will be conducted with all employees regarding the dining room and proper handling of food. #2. All clients could be affected. All employees have been re-educated regarding encouraging and reminding the clients to wash their hands. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; #1. All employees have been re-educated regarding the dining room and proper handling of food. #2. All employees have been re-educated regarding encouraging and reminding the clients to wash their hands.</p>	03/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
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	<p>2/14/13 at 10:00 A.M.. When asked if staff should pick client's food up from the table with their bare hands and place it back onto the client's plate and feed the food to the client, LPN #1 stated "Staff should not pick up the client's food with their bare hands and place it back on their plates and feed it to the client. The tray should be returned and another tray should be given."</p> <p>2. On 2/11/13 at 3:40pm, client #5 independently left Program Room D (PRD), and entered the men's bathroom outside PRD. At 3:45pm, client #5 exited the bathroom stall, exited the open men's bathroom door, and did not wash his hands. At 4:05pm, client #5 was handed a pre filled glass of tea, client #5 drank the tea, and no handwashing was taught or encouraged. At 4:45pm, client #5 went to the dining room with facility staff, sat down at the table in the dining room, and no handwashing was taught or encouraged. At 4:50pm, client #5 consumed his meal of cheeseburger and fries, licked his fingers between bites, and no handwashing was taught or encouraged. At 5pm, client #5 came to the dining room and no handwashing was</p>		<p>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. #1. During administrative rounds, the dining rooms will be observed for proper food handling by all employees. The results of the daily rounds will be discussed during the QA meeting by the Administrator #2. This component will be added to the Administrative rounds tool to assure that someone is looking at it daily. The results will be discussed during QA committee meetings by the Administrator.</p>		

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(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>taught or encouraged.</p> <p>On 2/12/13 at 7:13am, client #4 came into the dining room with facility employee (FE) #37. Client #4 placed his fingers into his dishes to identify hot/cold items and licked his fingers without redirection. At 7:15am, FE #37 indicated she did not assist client #4 to wash his hands. At 7:45am, client #5 came into the dining room and was served breakfast. No handwashing was taught or encouraged. Facility Employee #38 indicated she did not assist client #5 to wash his hands before the meal.</p> <p>3.1-37(a)</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, interview and record review for 6 of 10 sampled clients (clients #2, #3, #4, #6, #7 and #9) and 3 additional clients (#20, #31 and client #66), the facility failed to assure the staff provided food in accordance with each client's prescribed diet order.</p> <p>Findings include:</p> <p>1. An observation was conducted at the facility on 2/11/13 from 1:55 P.M. until 6:10 P.M.. At 5:45 P.M., clients #2, #7 and #9 ate their dinner. Client #2's dinner consisted of a whole hamburger bun with a whole slice of cheese, with ground dry meat atop the bun, mashed potatoes and coleslaw. Client #2's hamburger bun was not soaked in liquid, her ground meat was not in broth and she did not get double portions of dessert. Client #7's dinner consisted of a whole hamburger bun with a whole slice of cheese, with ground dry meat atop the bun, mashed potatoes and coleslaw. Client #7's dinner was not of a mechanical soft texture and he did not get double portions. Client #9's dinner consisted of a whole hamburger bun with a whole slice of cheese, with ground dry</p>	W000460	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. Client #2, 7, & 9 suffered no ill effects from not having the bun soaked. #2. Client #4 did not suffer any ill effects from eating the cornflakes or the coleslaw. Speech Therapy is in the process of evaluating Client #4 for safety in eating cold cereal to see if his diet can be upgraded. #3. Client # 66 is no longer on ATB and his pneumonia has cleared up. Client 31 tries to "mother" other clients. Client # 66 is now in a different area during the coffee time in the morning so that this will not recur. #4. No client suffered ill effects from not having the coleslaw to the correct consistency. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; #1. All clients on mechanical soft diet could be affected. The dietary employee who served the incorrect diet has been re-educated. #2. All clients on a pureed diet who eat in the family style setting has the potential to be affected. All clients with pureed diet will receive properly</p>	03/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>meat atop the bun, mashed potatoes and coleslaw. Client #9's dinner was not of a mechanical soft texture. Client #20's dinner consisted of a whole unsoaked hamburger bun with a whole slice of cheese, with ground dry meat atop the bun, mashed potatoes and coleslaw. Client #20's dinner was not of a mechanical soft texture, his hamburger bun was not soaked and his ground meat was not in broth. During the observation no dietary cards were observed.</p> <p>A review of client #2's record was conducted on 2/13/13 at 12:55 P.M.. Review of client #2's Nutritional Assessment dated 6/15/12 indicated: "Mechanical soft diet, double portions."</p> <p>A review of client #7's record was conducted on 2/13/13 at 9:30 A.M.. Review of client #7's Nutritional Assessment dated 8/10/12 indicated: "Mechanical Soft diet, regular thin liquids, ground meat with broth added, cut bread, cookies and crackers cut into pieces and soak, double dessert at lunch and supper."</p> <p>A review of client #9's record was conducted on 2/13/13 at 2/13/13 at 11:45 A.M.. Review of client #9's Nutritional Assessment dated 9/21/12 indicated: "Mechanical soft diet."</p>		<p>pureed coleslaw. The dietary employees have been re-educated concerning how to properly puree coleslaw. All employees were re-educated regarding safety with meals specifically related to diets of different consistencies. #3. All clients on a thickened liquid diet could be affected. Client #31 has a specific behavior program to train her that she should not give others drinks of liquids. Employees are aware and monitor this closely. #4. All clients on pureed diet have the potential to be affected. Dietary employees were re-educated on how to puree coleslaw. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; #1. All employees have been re-educated on the importance of diets. An audit tool has been developed to assist the Dietary Manager in assuring that all mechanical soft diets are served correctly. #2. The dietary employees have been re-educated concerning how to properly puree coleslaw. All employees were re-educated regarding safety with meals specifically related to diets of different consistencies. An audit will be conducted during meal times to assure safety. #3. There will be a daily interval sheet designed to address Client 31's behavior to assure this does not</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>A review of client #20's record was conducted on 2/13/13 at 9:30 A.M.. Review of client #20's Physician's Orders dated 12/31/12 indicated: "Mechanical Soft diet, ground meat with broth, soaked breads, cakes, cookies, crackers."</p> <p>An interview with LPN #1 was conducted on 2/14/13 at 10:00 A.M.. When asked who prepares each client's meals, LPN #1 stated "Dietary staff." When asked how are prescribed diet orders/textures relayed to the staff who prepare the meals, LPN #1 stated "They work along with nursing and the dietician. They receive a copy of the order via nursing. There is a card system that reflects each client's diet order. The staff are trained and updated in the huddle (meeting) and dietary cards. The dietary cards come out with the meal trays at all meal times. The staff supervisor should check the card and diet; if it is not correct it is returned." LPN #1 indicated whole hamburger buns are not part of a mechanical soft texture and further indicated staff should have provided each client with their prescribed diets.</p> <p>2. On 2/11/13 at 5pm, client #4's preset</p>		<p>recur. #4. An audit will be completed by the Dietary manager whenever coleslaw is served to assure that it is of the proper consistency. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. #1. The audits will be discussed during the QA committee meetings. These audits will be completed 1 X daily alternating meals for one month. If no further issues occur the audit will be completed 1 X weekly for 3 months. If no further problems, the QA committee will determine the need to continue. #2. The results of the mealtime audit will be brought before the QA committee monthly. This audit will be completed 5X's weekly for one month. If no further problems then it will be conducted 1 X weekly for 3 months. After that the QA committee will decide if it needs to continue. #3. The results of the interval sheet will be discussed during the QA committee meetings. It will continue daily until the QA committee decides it is no longer necessary. #4. The results of the audit for coleslaw will be discussed during the QA committee meeting with recommendations to continue or to stop.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2013	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(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>meal tray with pureed food, drinks, and silverware was placed in front of him and he was prompted to eat by the facility staff. Client #4's pureed Cole Slaw was not smooth and orange slivers of food could be identified as carrots in the pureed mixture.</p> <p>On 2/12/13 at 7:13am, client #4's preset pureed meal tray was placed in front of client #4. Client #4 consumed his pureed hot cereal from a bowl. Client #4 located with his hands a plastic container of Cornflakes on the table and poured the cornflakes into his empty cereal bowl. From 7:20am until 7:30am, client #4 filled an empty bowl from his meal tray with Cornflakes three separate times, opened his sippy cup of milk, poured milk onto the cornflakes, and unidentified facility staff people took the bowls away from him each time as they passed client #4's table. Facility staff went to dietary department door and requested an additional serving of hot cereal. At 7:20am, Facility Employee (FE) #39 indicated the dietary department does not serve pureed Cornflakes and client #4 could not have regular Cornflakes. At 7:30am, client #4 received an additional pre filled bowl of hot cereal and client #4 consumed it. From 7:30am until 7:40am, client #4 located the plastic container of Cornflakes again and poured himself two</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>additional servings of regular Cornflakes without milk and without redirection. Client #4 had consumed three bowl of regular cornflakes at the dining room table.</p> <p>Client #4's record was reviewed on 2/13/13 at 11:35am. Client #4's 4/3/2011 CFA (Comprehensive Functional Assessment) indicated client #4 was to receive a pureed diet due to swallowing problems and client #4 was a choking risk. Client #4's 2/11/13 "Physician's Order" indicated client #4 was on a pureed diet. Client #4's 1/7/13 "Nursing Quarterly" indicated client #4 was on a Pureed diet. Client #4's 1/24/13 "Nutritional Assessment" indicated client #4 was on a Pureed diet.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #3 (Qualified Mental Retardation Professional) was completed. QMRP #3 indicated client #4 should receive a pureed diet.</p> <p>On 2/14/13 at 10:10am, an interview with LPN #1 was conducted. LPN #1 indicated client #4 was on a pureed diet. LPN #1 indicated client #4 should not have eaten regular Cornflakes. LPN #1 indicated a pureed diet was to be a smooth consistency. LPN #1 indicated slivers of carrots identified in the pureed</p>			
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(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>Coleslaw mixture indicated it was not smooth and should have been pureed.</p> <p>3. On 2/12/13 at 5:45am, QMRP #1 was observed inside the dining room at the main building. At 5:45am, client #31 took a sip from her glass of thin consistency water. Client #31 walked to client #66 in front of QMRP #1, and client #31 gave client #66 a drink from her glass of thin liquid water. At 5:45am, client #31 held the glass of thin water up to client #66's mouth until her water glass was empty. Client #31 filled her water glass with thin consistency hot black coffee. From 5:45am until 6am, client #31 fed client #66 the thin consistency hot coffee from her glass and no redirection was observed. At 6am, client #66 made a sour face and left the dining room.</p> <p>On 2/13/13 at 9:30am, client #66's record was reviewed. Client #66's 12/24/12 "Physician's Order" indicated "Diet, Pureed, Nectar thick liquids." Client #66's diagnoses included, but were not limited, to Esophageal Ulcer and Dysphasia. Client #66's 6/1/2012 "Nutritional Assessment" indicated client #66 was to have nectar thickened liquids. Client #66's 1/29/13 "Physician Order" indicated client #66 was started on an antibiotic with a diagnosis of "Aspiration Pneumonia, Drinks offered slowly 2-4 oz</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>(ounces) every 15 minutes during mealtimes." Client #66's 1/29/13 "Radiology Report" indicated a diagnosis of aspiration pneumonia.</p> <p>On 2/14/13 at 10:10am, an interview with LPN #1 was conducted. LPN #1 indicated client #66 was a choking and swallowing risk. LPN #1 indicated client #66 required sippy cups to calibrate the size of drink he takes and client #66's drinks should have been thickened to nectar consistency. LPN #1 indicated client #66 was being treated for aspiration pneumonia at this time. LPN #1 indicated client #31 should not have fed client #66 her unthickened drinks.</p> <p>4. Observations were conducted in the facility on 02/11/13 from 2:00 PM until 5:53 PM.</p> <p>On 02/11/13 client #3 went into the dining room at 4:34 PM. At 4:45 PM client #3's meal was placed in front of him and he was fed by staff #23. At 5:35 PM client #6 was wheeled into the dining room. At 5:40 PM client #6's meal was placed in front of him and he fed himself. Clients #3 and client #6's food looked the same and the food had been altered in texture. One of the food items was white in color and contained orange specks. Staff #23 indicated the food substance was slaw and the orange specks were</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(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>probably carrots. Staff #23 indicated clients #3 and #6 were to have pureed food.</p> <p>Client #3's record was reviewed on 02/13/13 at 10:54 AM. Client #3's Nutritional Assessment and Progress Notes dated 01/09/13 indicated client #3 was to be on a pureed diet.</p> <p>Client #6's record was reviewed on 02/13/13 at 12:53 PM. Client #6's Nutritional Assessment and Progress Notes dated 11/02/12 indicated client #6 was to be on a pureed diet.</p> <p>A review of the agency's 2002 "Dysphagia Diets" guidelines was conducted on 02/13/13 at 12:27 PM. The guideline indicated for pureed foods the, "Foods are totally pureed. No coarse textures or lumps of any sort are allowed...'pudding like'...Vegetables Allowed...smooth, pureed vegetables...Vegetables Not Allowed...cabbage...or other fibrous vegetables...".</p> <p>The LPN (Licensed Practical Nurse) #1 was interviewed on 02/14/13 at 11:45 AM. The LPN indicated clients #3 and #6 were to have pureed diets. She indicated there should not have been any orange specks in the food. She indicated</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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	<p>a pureed diet was to be of a smooth, pudding like/baby food like consistency. She further indicated clients with pureed diets should not have been eating the slaw.</p> <p>3.1-21(a)</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(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			
W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview for 10 of 10 sampled clients (clients #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) and for 1 additional client (#16), the facility failed to ensure clients assisted to prepare their food as independently as possible.</p> <p>Findings include:</p> <p>1. On 2/11/13 at 5pm, client #4's preset meal tray with pureed food, drinks, and silverware was placed in front of him and he was prompted to eat by the facility staff. On 2/12/13 at 7:20am, client #4's preset meal tray was placed in front of him and he was prompted to eat by the facility staff. Client #4 did not have the opportunity to set his table service, cook his own food, or serve his own meal.</p> <p>On 2/12/13 at 7:13am, client #4 came into the dining room with facility employee (FE) #37. Client #4 was served his pre set and pre filled meal tray. Client #4 placed his fingers into his dishes to identify hot/cold items and licked his fingers without redirection.</p>	W000488	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; #1. Correction - Client # 4 is unable to set his own table and his ISP does not indicate that as well. Therefore, we feel the citation refers to Client #5 and will respond for that client. Client # 5 is being trained to set his own table and bus his own meal tray. #2. Client # 5 is being trained to set his own table and bus his own meal tray. #3. Client #3 suffered no ill effects from being fed. Staff # 23 was re-educated regarding the importance of following a client's ISP. #4. Client #6 suffered no ill effects from being fed. Staff # 26 was re-educated regarding the importance of following a client's ISP. #5. Client # 8 is now being assisted. She is blind. Employees were re-educated on the importance of identifying the food set before her. Employee # 25 was re-educated. #6. Client # 2, 7, 9 and & 16 are fine. They are encouraged to follow their ISP by employees. #7. Client # 1 and 10 are fine. They are allowed and encouraged to perform the duties on their ISP. **How the facility will identify other residents having the potential to be affected by the</p>	03/27/2013			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>Client #4's record was reviewed on 2/13/13 at 11:35am. Client #4's 4/3/2011 CFA (Comprehensive Functional Assessment) indicated client #4 could set his own table and serve himself food and drink. Client #4's 4/3/12 IPP (Individual Program Plan) indicated an objective/goal to help bus his meal tray after he consumed his meal. Client #4's CFA indicated client #5 was able to set the table, carry items, assist with serving, and pouring drinks.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #3 (Qualified Mental Retardation Professional) was completed. QMRP #3 indicated client #4 had the skill to set his own table and the dietary department pre set client #4's meal tray. QMRP #3 indicated client #4 was not involved with setting the table, cooking, or serving his meal.</p> <p>2. On 2/11/13 at 4:05pm, client #5 was handed a pre filled glass of tea. Client #5 drank the tea, and was not prompted to pour his own drink. At 5pm, client #5 consumed his pre filled and set meal of cheeseburger and fries, licked his fingers between bites, and client #5 was not prompted to set his own table, cook, or serve his own food.</p> <p>On 2/12/13 at 7:45am, client #5 came into</p>		<p>same deficient practice and what corrective action will be taken; #1. Other applicable clients will be assessed to determine if they are a candidate to set their own meal tray and bus their own tables. #2. Other applicable clients will be assessed to determine if they are a candidate to set their own meal tray and bus their own tables. #3. Other applicable clients will be assessed to determine if they are a candidate to set their own meal tray and bus their own tables. #4. Other applicable clients will be assessed to determine if they are a candidate to set their own meal tray and bus their own tables. #5. Clients with visual deficits could be affected. All employees were re-educated regarding proper assist for all clients and following the ISP. #6. All clients could be affected. All employees have been re-educated to follow the ISP's for each client. #7. all clients could be affected. All employees have been re-educated to follow the ISP's for each client. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; #1. An assessment tool has been developed to assist QMRP's in the decision regarding each applicable client's abilities. All staff will be re-educated regarding the necessity to allow clients this independence. #2. An</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(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>the dining room, was served a pre set and pre filled meal tray for breakfast. Client #5 was not prompted or encouraged to cook, set the table, or serve his own food.</p> <p>Client #5's record was reviewed on 2/13/13 at 10:40am. Client #5's 5/8/2012 CFA indicated client #5 was able to set the table, carry items, assist with serving, and pour drinks with assistance.</p> <p>On 2/14/13 at 9:55am, an interview with QMRP #1 was completed. QMRP #1 indicated client #5 had the skill to set his own table, carry items, assist with serving and pour drinks with assistance. QMRP #1 indicated the dietary department cooks the meals, dips up the serving for each client, and pre pours the drinks.</p>		<p>assessment tool has been developed to assist QMRP's in the decision regarding each applicable client's abilities. All staff will be re-educated regarding the necessity to allow clients this independence. #3. An assessment tool has been developed to assist QMRP's in the decision regarding each applicable client's abilities. All staff will be re-educated regarding the necessity to allow clients this independence. #4. An assessment tool has been developed to assist QMRP's in the decision regarding each applicable client's abilities. All staff will be re-educated regarding the necessity to allow clients this independence. #5. All staff will be re-educated regarding the necessity to assist clients if necessary. Daily rounds will be conducted to assure clients are assisted as needed. #6. All staff will be re-educated regarding the necessity to assist clients if necessary. Daily rounds will be conducted to assure clients are assisted as needed. #7. All staff will be re-educated regarding the necessity to assist clients if necessary. Daily rounds will be conducted to assure clients are assisted as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. #1. The results of the assessment tool will be</p>		

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(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>3. Observations were conducted in the facility on 02/11/13 from 2:00 PM until 5:53 PM.</p> <p>On 02/11/13 client #3 went into the dining room at 4:34 PM. On 02/11/13 at 4:50 PM client #3 was observed to be fed his meal by staff #23 after she obtained it from the food cart and set it in front of him. Client #3 made no attempt to get any of his food, drink or feed himself. Staff #23 did not seek client #3's assistance to prepare his food, serve it to his plates, or feed himself.</p> <p>Client #3's record was reviewed on 02/13/13 at 10:54 AM. Client #3's ISP dated 04/12/12 indicated client #3 had physical limitations and required assistance to feed himself.</p>		<p>brought before the QA committee. #2. The results of the assessment tool will be brought before the QA committee. #3. The results of the assessment tool will be brought before the QA committee. #4. The results of the assessment tool will be brought before the QA committee #5. The results of the daily rounds will be discussed with the QA committee. #6. The results of the daily rounds will be discussed with the QA committee #7. The results of the daily rounds will be discussed with the QA committee</p>		

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(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>On 02/14/13 at 11:30 AM an interview was conducted with the QMRP #1. The QMRP #1 indicated client #3 should have been assisted to be as independent as he could and staff #23 should have used hand over hand assistance.</p> <p>4. On 02/11/13 at 5:43 PM client #6 was observed to feed himself without any staff at the table or any verbal prompting to not spill his food. On 02/12/13 at 8:45 AM client #6 was observed to be fed his meal by staff #26 after she obtained it from the food cart and set it in front of him. Client #6 made no attempt to get any of his food, drink or feed himself. Staff #26 did not seek client #6's assistance to prepare his food, serve it to his plates, or feed himself.</p> <p>Client #6's record was reviewed on 02/13/13 at 12:53 PM. Client #6's ISP dated 06/07/12 indicated client #6 had physical limitations and required assistance to feed himself.</p> <p>On 02/14/13 at 11:30 AM an interview was conducted with the QMRP #1. The QMRP #1 indicated client #6 should have been assisted to be as independent as he could and staff #26 should have used constant prompting and guidance throughout the meal.</p>						

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(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>5. Client #8 was observed at the dining room table on 02/11/13 at 4:50 PM. Client #8's plate was set in front of her by staff #25 who then walked away. Client #8 made no attempt to get any of her food, drink or eat with silverware. Client #8 used her fingers to touch the food on the plate and place it in her mouth. Staff #25 did not seek client #8's assistance to prepare her food, serve herself and/or to eat with silverware.</p> <p>Client #8's record was reviewed on 02/12/13 at 2:00 PM. Client #8's ISP dated 01/22/13 indicated client #8 had the ability to use a spoon and fork.</p> <p>On 02/14/13 at 11:30 AM an interview was conducted with the QMRP #1. The QMRP #1 indicated client #8 should have been assisted to be as independent as she could and staff #25 should have used prompted her to use a fork and spoon.</p> <p>6. An observation was conducted at the facility on 2/11/13 from 1:55 P.M. until 6:10 P.M.. From 1:55 P.M. until 5:45 P.M., clients #2, #7, #9 and #16 sat in the classroom with no meaningful active treatment. At 5:20 P.M., Direct Support Professionals (DSP) #18 and #19, walked over the dinner cart containing clients #2, #7, #9 and #16's meal. DPS #17 set plates, bowls, cups and cloth napkins with</p>						

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	<p>silverware on the two dining tables. At 5:45 P.M., clients #2, #7, #9 and #16 were prompted to sit at the already set dining tables. Clients #2, #7, #9 and #16 were available but did not assist in setting the dining table and did not assist in wrapping the silverware.</p> <p>A review of client #7's record was conducted at the facility's administrative office on 2/13/13 at 9:30 A.M.. The record indicated a most current ISP dated 8/7/12 which indicated: "Vocational Assessment: Past work experience...Fold towels and wash clothes. [Client #7] seems to like this task but has a limited attention span...Wrap silverware: [Client #7] can match knives, forks and spoons but has difficulty placing one of each on a napkin."</p> <p>7. Observations were conducted at the facility on 2/11/13 from 3:22 PM through 5:30 PM. At 4:30 PM client #1 was prompted by CNA (Certified Nurse Aide) #1 to sit down at the table in the dining area of the TC (Training Center). CNA #1 removed a plate of food from a rolling food cart and placed the plate on the dining area table in front of client #1. The plate already had portions of cole slaw, potatoes wedges and a hamburger with bun on the plate. Client #1 was not offered the opportunity to serve himself</p>						

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	<p>coleslaw, potatoes wedges or hamburger.</p> <p>Observations were conducted at the facility on 2/12/13 from 6:30 AM through 9:30 AM. At 7:00 AM client #1 entered the main facility dining area. CNA #2 removed a plate with a serving of sausage patty, pudding cup, jelly doughnut and fried eggs from a rolling food cart. CNA #2 handed client #1 the plate with the food already on the plate. Client #1 was not encouraged to or given the opportunity to serve himself a sausage patty, pudding cup, doughnut or eggs. At 7:56 AM client #10 entered the main facility dining area and sat down at his seat. CNA #2 removed a plate with a serving of sausage patty, pudding cup, jelly doughnut and fried eggs from a rolling food cart. CNA #2 handed client #10 the plate with the food already on the plate. Client #10 was not encouraged to or given the opportunity to serve himself a sausage patty, pudding cup, doughnut or eggs.</p> <p>Client #1's record was reviewed on 2/13/13 at 2:43 PM. Client #1's ISP (Individual Support Plan) dated 7/31/12 indicated client #1 did not require staff to serve his food to him. Client #1's FSA (Functional Skills Assessment) dated 7/31/12 did not indicate client #1 needed staff assistance to serve him his food.</p>						

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	<p>Client #10's record was reviewed on 2/13/13 at 9:34 AM. Client #10's ISP dated 8/23/12 indicated client #10 did not require staff to serve his food to him.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 2/14/13 at 12:15 PM indicated clients #1 and #10 should be informally encouraged to serve themselves servings of food and/or retrieve their own plates from the meal cart.</p>			

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W009999	<p>STATE FINDINGS:</p> <p>The following Comprehensive Care Facility rules were not met:</p> <p>410 IAC 16.2-3-1-14 PERSONNEL</p> <p>Sec. 14(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personal policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review for 1 of 3 personnel records reviewed, the facility failed to obtain reference checks for CNA #1 (certified nurses aide).</p> <p>Findings include:</p> <p>CNA #1's employee file was reviewed on 2/12/13 at 1:45 PM. CNA #1's employee filed contained no documentation of reference checks.</p>	W009999	<p>**What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; The employee who had no documentation of reference checks was hired on April 22, 1988. I'm sure that upon hire in 1988 there were reference checks completed, however, they were no found. She now has reference checks in her file.</p> <p>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; No residents are involved. All employee files have been audited to assure proper reference checks are included. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Reference checks are completed prior to hire. This will continue. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. The QA committee will be informed if there are any other issues found during the audit of the employee files.</p>	03/27/2013	

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	<p>Interview with AS #6 (Administrative Staff) on 2/12/13 at 2:40 PM indicated there should be two references for all employees.</p> <p>3.1-14(a)</p>				