

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 02/03/2014
--	---	--	---

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
--------------------	--	---------------	---	----------------------

W000000	<p>This visit was for a PCR (Post Certification Revisit) to the investigation of complaint #IN00135402 completed on 9/18/13.</p> <p>This visit was in conjunction with a pre-determined full recertification and state licensure survey. This visit included the investigation of complaints #IN00141135, #IN00141928 and #IN00142820.</p> <p>This visit was in conjunction with a PCR to the investigation of complaints #IN00137244 and #IN00138052 completed on 10/18/13.</p> <p>This visit was in conjunction with a PCR to the investigation of complaint #IN00138987 completed on 11/27/13.</p> <p>Complaint #IN00135402-Not Corrected.</p> <p>Dates of Survey: 1/15, 1/16, 1/17, 1/21, 1/22, 1/23, 1/24, 1/28 and 2/3/14</p> <p>Facility Number: 000614 Provider Number: 15G068 Aim Number: 100272120</p> <p>Surveyors: Paula Chika, QIDP-TC</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 the 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>	
---------	---	---------	--	--

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.

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 02/03/2014
--	---	--	---

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
W000149	<p>Keith Briner, QIDP (1/21/14 to 1/24/14) Susan Eakright, QIDP (1/21/14 to 1/24/14) Vickie Kolb, RN (1/21/14 to 1/24/14)</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 2/12/14 by Ruth Shackelford, QIDP.</p> <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 2 of 10 sampled clients (#6 and #8) and for 7 additional clients (#11, #12, #29, #42, #61, #64 and #66), the facility neglected to implement its written policy and procedures to prevent neglect of clients #8, #12, #61 and #66. The facility failed to prevent neglect in regard to client #61's elopement behavior, to assess client #66's health each time the client went outside in sub zero degree temperatures, and to prevent neglect in regard to repeated incidents of "shearing," excoriation and/or pressure ulcers in regard to client #8 and #12's skin integrity and care.</p>	W000149	<p>1. What corrective action will be done by the facility? Client 61 is safe and secure. She does wear the secure care bracelet on her ankle. Our secure care alarm is on at all times. Staff do not have the ability to "turn it on." What the employee did was turn the sound off. The alarm in the main building is active at all times. The sound is what can be shut off, not the alarm. However, if client 61 turns the bracelet around it is possible for her to exit without the alarm sounding. Because of that, we have added another bracelet which will prevent her from being able to turn it around completely and prevent her from exiting the building without supervision. During the stated dates and times that Client 61 exited the building, except for the</p>	03/05/2014

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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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>Findings include:</p> <p>1. During the 1/15/14 observation period between 11:55 AM and 12:45 PM, at the training center (TC), client #61 was at the TC for programming.</p> <p>During the 1/22/14 observation period between 6:50 AM and 8:45 AM, at the facility, client #61 walked out of the main door of the dining room. No alarms sounded when client #61 exited the building. Client #61 did not have a coat on as the temperatures were in the single digits and snow was on the ground. Staff #1 followed client #61 out the door of the main building and caught up with the client before she got to the landing of the administration building. Staff #1 physically prompted client #61 to turn around and return to the building. Once inside, staff #1 turned an alarm on which was located on the wall by the main door.</p> <p>Interview with staff #1 on 1/22/14 at 8:20 AM stated staff #1 turned a "Secure Care" alarm system on. Staff #1 indicated client #61 wore a bracelet around her ankle and if the client would go through the door an alarm would sound. Staff #1 indicated the alarm was placed on the door as client #61 had attempted to elope from the facility.</p>		<p>11/20/13 incident, she was actually observed going outside and was always assisted back in the building. Client 61's elopement on 12-5-13 was not reported because there is no documentation that the elopement actually occurred. Surveyor said she read it on a behavior card but we are unable to find the behavior card. We have interviewed all staff who worked that day in the training center and nobody recalls Client 61 eloping to a "wooded area." All staff have been re-educated regarding the requirement to report these events to the Administrator. Client 8 continues to have an area of shearing. He is now being toileted and re-positioned every 2 hrs as required. The history of skin issues began in May, 2013. He is on a specialty mattress to aid in healing. Client 12's area has healed. He remains on a specialty mattress and is toileted and re-positioned every 2 hrs. According to her physician, Client 66 expired as a result of "sudden cardiac death syndrome." When asked if he felt that the cold might have been a contributing factor the physician stated "absolutely not." When reminded that she had a diagnosis of asthma and asked if having asthma and being in the cold could have caused it he said "I have treated her since she came here (5-28-2009) and</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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 facility's reportable incident reports, investigations and/or internal Incident/Accident Reports (IARs) were reviewed on 1/16/14 at 1:51 PM. The facility's 11/20/13 reportable incident report indicated "Staff reported that [client #61] was down the street at the neighbor's house right beside the facility this morning when they came to work. [Client #61] did have a coat on, staff went to the house and assisted [client #61] back to the facility. [Client #61] was assessed by nursing and no injuries were noted. Will add a secure care bracelet that will chime when [client #61] goes outside the door. Will add a behavior program for elopement. Will continue to monitor.</p> <ol style="list-style-type: none"> Staff assisted [client #61] back inside the facility. Nursing assessed and no injuries were noted. [Client #61] did have a coat on. Will add a secure bracelet that will chime when [client #61] goes out the door. Will add a behavior program for elopement. Will continue to monitor." <p>The facility's 11/20/13 IAR indicated "Kitchen staff came in the building said there was a resident down the road (sic).</p>		<p>she has never had asthma. That diagnosis is a history of asthma. Her asthma was not acute. If she came in from the cold and did not show signs of having difficulty breathing (she did not) then the cold weather had nothing to do with her death. She was 61 years old and in poor health she died suddenly - that's all." She smoked approximately 2 hours prior to her death. The policy on smoking for clients during changes in weather has been updated. If the wind chill is below zero degrees, clients are to smoke on the front porch at least 8 feet from the entrance. Clients are always monitored when smoking. The incidents involving Client 29 was a bruise on her left buttock caused by becoming angry and slamming herself down in her merry walker. The BDDS regulations state that bruises of unknown origin are to be reported. Since the cause was known and the bruise was not of a reportable size, this injury was not reported. Client 42 was attempting to take coffee from the opposite side of a table he was sitting at. He "threw" himself at the coffee, hitting his groin area on the edge of the table. Since the cause was known and the bruise was not of a reportable size, this injury was not reported. Client 61's elopement was not reported because there is no documentation that the elopement actually occurred.</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>I (LPN #7) ran out saw her down the road (sic). She was passed (sic) the first house. A dog was barking at her. She was crying and she had a coat on."</p> <p>The facility's 11/24/13 follow-up report indicated "According to staff saw [client #61] between 6am-6:15am, and she was brought back inside the facility at approximately 6:30am. [Client #61] now wears a secure care bracelet which chimes when she goes out the door, to alert staff that she has left the building. [Client #61] also has a behavior intervention plan to address elopement. These interventions should prevent future elopement issues. [Client #61] did have her coat on at the time of elopement and she was not injured. Will continue to monitor..." The facility's 11/20/13 reportable incident report and/or 11/24/13 follow up report indicated the facility neglected to conduct a thorough investigation in regard to client #61's elopement. The facility's 11/20/13 reportable incident report and/or 11/24/13 follow up report neglected to indicate how client #61 got out of the building and/or where/what facility staff were doing at the time of the incident. The facility's 11/24/13 follow up report neglected to indicate the staffing pattern at the facility, at the time of the incident, and/or indicate if</p>		<p>Surveyor said she read it on a behavior card but we are unable to find the behavior card. We have interviewed all staff who worked that day in the training center and nobody recalls Client 61 eloping to a "wooded area." However, all staff were re-educated regarding the reporting requirements for any incident. Client 8 has a shearing. It was felt that since it was not considered a pressure area it was not reportable. Client 11's allegation of abuse was reported and investigated. Since it happened in the training center bathroom and there were no other clients present in the bathroom at that time, no other clients were interviewed. However, Client 11 herself admitted a day after reporting it that the incident had not actually been abuse but rather an employee touching her on the arm and asking her to finish washing her hands so that another client could access the restroom. Client 42 was the bruise from "throwing" himself across the table. We knew exactly how it occurred and therefore, according to guidelines we felt it was not reportable. Client 64 suffered a bite from another client. This was reported to the state and BDDS. Although the behavior intervention plan was reviewed, that review was not documented. 2. How will the</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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>client #61 had a history of getting out of the facility.</p> <p>Client #61's record was reviewed on 1/22/14 at 12:20 PM. Client #61's behavior cards indicated the following (not all inclusive):</p> <p>-1/17/14 "...Running out of TC (Training Center)."</p> <p>-12/6/13 "[Client #61] up @ (at) 4 AM went outside,...."</p> <p>-12/5/13 "[Client #61] Crying, NC (non compliant), ran out of TC and into wooded area behind the main facility." The behavior card did not indicate how client #61 was able to get to a wooded area and/or indicate any additional documentation of an investigation. The facility's reportable incident reports, IARs and/or investigations indicated facility staff did not immediately report the 12/5/13 elopement incident to the administrator for an allegation/investigation of possible neglect.</p> <p>-9/25/13 "outside without staff (1 time)." The facility's reportable incident reports and/or IARs did not indicate the 9/25/13 incident was reported to administrator.</p>		<p>facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</p> <p>Any client who might wander could be affected. Any client who might wander will have the secure care bracelet applied to alert staff if they attempt to exit. The secure care system is being installed at the training center as well to assure that staff will know if a client who might wander exits the building. Any client at risk for skin issues could be affected. All clients will be turned and re-positioned every 2 hrs. This will be for every client with skin integrity issues. Any client at risk for skin issues could be affected. All clients needing assistance will be turned and re-positioned every 2 hrs. This will be for every client with skin integrity issues. All clients could be affected. A procedure has been written regarding clients who smoke and inclement weather. Although we have typically modified our smoking area when the weather is bad, this has not been in writing. We will have any client who smokes go out the front door during inclement weather. They must be at least 8 feet away from the door according to state law and this will be honored. If the wind chill is below 0, clients will smoke on the front porch only. Any client with an injury could be affected. We will continue to comply with the</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>-9/20/13 "running out of building (4 times)."</p> <p>-9/16/13 "...AWOL (absence without leave/supervision) x 3."</p> <p>-9/4/13 "running outside down road (2 times)...."</p> <p>-8/31/13 Client #61 "ran outside and across street."</p> <p>-8/20/13 Client #61 was "outside alone x 1." The facility's above mentioned reportable incident reports did not indicate the elopement incident was reported to the administrator for an investigation. Another 8/20/13 behavior card from 1:30 PM to 9:00 PM indicated client #61 was "out of the building" 3 times.</p> <p>-8/12/13 "AWOL x 4."</p> <p>-8/8/13 "AWOL x (times) 2." Another 8/8/13 behavior card indicated client #61 was "AWOL x 4."</p> <p>-7/26/13 "[Client #61] up at 2nd (second) shift & (and) still up through all of 3rd (third) shift. yelling, screaming, going outside, running...." Another 7/26/13 behavior card indicated client #61...trying to run out the door to</p>		<p>reporting guidelines issued by BDDS and ISDH. Any client with an injury or allegation of abuse could be affected. All injuries will be thoroughly investigated. Clients and staff will both be interviewed during the investigation. 3. What measures will be put into place to ensure this practice does not recur? A secure care system is being installed at the Training Center so that any client who wanders will not be able to exit without the alarm sounding. Staff have been reeducated regarding documentation since it seems the incorrect term of AWOL was being used when the client was simply observed going out the door. All clients who require assistance will be turned every 2 hrs. The turn schedule will be checked daily by the charge nurse and tracked to assure compliance with turning schedules. All clients who require assistance will be turned every 2 hrs. The turn schedule will be checked daily by the charge nurse and tracked to assure compliance with turning schedules. Clients who smoke will be allowed to smoke on the front porch if weather is inclement. They will have to stay at least 8 feet from the door according to state law. However, the porch is covered and does offer some safety from snow, rain, etc. We will continue to comply with the reporting</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>go outside...."</p> <p>-7/25/13 "Running outside...." Another 7/25/13 behavior card indicated "Attempting to leave building x 5...AWOL x 4."</p> <p>-7/22/13 Client #61 "AWOL x 6...."</p> <p>-7/20/13 Client #61 "outside (3 times)."</p> <p>-7/10/13 "[Client #61] 7 AM resident in nurse's car x 1...."</p> <p>-7/9/13 Client #61 left the training center 3 times.</p> <p>-7/7/13 Client #61 left the building 2 times.</p> <p>-7/6/13 "AWOL x 1 in staff's car x 1."</p> <p>-7/4/13 "Client #61 "Getting into staff cars in parking lot - running out into the road." Another 7/4/13 behavior card indicated "AWOL x 3."</p> <p>Client #61's 2-13 summary of behavioral data from 1/13 to 12/13 indicated the facility tracked verbal aggression, self-injurious behavior, "Inappropriate Social Interaction" and non compliance. The facility's summary of behavioral data for the client neglected to indicate</p>		<p>guidelines issued by BDDS and ISDH. All injuries will be thoroughly investigated. Clients and staff will be interviewed during investigation.4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? During the monthly and quarterly QA meeting any client who wanders will be discussed by the QIDP's. This will be ongoing. The DON will monitor the turning schedule and assure that the turns are being completed and the schedule is being filled out correctly. A report will be given to the Medical Director during the quarterly QA meeting as well as at the monthly QA meeting with the IDT team. The DON will monitor the turning schedule and assure that the turns are being completed and the schedule is being filled out correctly. A report will be given to the Medical Director during the quarterly QA meeting as well as at the monthly QA meeting with the IDT team. A new procedure has been written regarding allowing clients who smoke outside during inclement weather. All staff will be in-serviced regarding this policy. The procedure will be discussed at the next HRC meeting with the committee's approval. The Administrator will assure that all suspicious injuries will be reported per guidelines. The results of this reporting will be</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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 client demonstrated AWOL behavior.</p> <p>Client #61's 2/5/13 Elopement Risk Assessment indicated client #61 demonstrated "...2. COGNITIVE PATTERNS Memory problem, Memory recall impaired, Decision-making skills impaired, indicators of delirium (1PT) (point) 1...6. MOBILITY STATUS Independent ambulates with or without assistive devices. (1PT) 1 7. TOTAL SCORE 2 Score of 4 or ore requires action. Describe action taken if 4 or more."</p> <p>Client #61's Progress Notes indicated the following (not all inclusive):</p> <p>-1/4/14 Client #61's IDT (interdisciplinary team) met in regard to the client's behavior on 1/4/14 where the client was aggressive toward staff, verbally aggressive, demonstrating inappropriate sexual behavior toward staff and eating a "small plastic disc."</p> <p>-11/25/13 "10:46 am: In response to nursing notes from 11/22/13 re: (regarding) [Client #61] went right outside the door, staff witnessed her going outside but secure care alarm did not sound until she came back inside the door. The placement of the secure care</p>		discussed at the monthly and quarterly QA committee meetings. This will be ongoing or until the committee determines there is no further need to continue. The Administrator will assure that all investigations will be thorough. The results will be discussed with the quarterly and monthly QA meetings. This will be ongoing		

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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>bracelet was adjusted on [client #61's] ankle. The secure care sensor will be adjusted. Nursing checks to ensure secure care ankle bracelets are working properly on the residents who utilize them. Bracelet is working properly at this time. Will continue to monitor."</p> <p>-11/20/13 "3:41pm: In response to nursing notes from 11/20/13 re: Staff report that [client #61] was down the street at the neighbor's house right beside the facility this morning when they came into work. [Client #61] did have a coat on, staff went to the house and assisted [client #61] back into the facility. [Client #61] was assessed by nursing and no injuries were noted. Will add a secure bracelet that will chime when [client #61] goes outside the door. Will add a behavior program for elopement. Will continue to monitor."</p> <p>Client #61's undated Behavior Intervention Plan (BIP) indicated client #61 demonstrated AWOL behavior defined as "Leaving the facility without staff supervision." The BIP indicated client #61 had "underdeveloped social skills" (no pedestrian safety skills). Client #61's BIP indicated a secure care bracelet was initiated on 11/20/13. The undated BIP neglected to indicate when the secure alarm was to be activated/on</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>to prevent client #61 from eloping from the main building. The undated BIP also neglected to indicate how the facility was to monitor/supervise client #61 while at the TC to prevent the client from eloping from the TC where the client spent the majority of her day. Client #61's BIP and/or 2/5/13 Individual Support Plan (ISP) indicated client #61's IDT (interdisciplinary team) did not meet to review the client's BIP for elopement/AWOL to ensure the protective measures in place met the needs of the client, and/or to ensure additional measures needed to be put in place to prevent reoccurrence. The facility neglected to address client #61's elopement behavior in a timely manner as the facility did not formally address client #61's AWOL behavior until 11/20/13 when the client demonstrated the behavior in 7/13.</p> <p>Client #61's 2/5/13 ISP indicated the facility neglected to address the client's identified need in regard to pedestrian safety. Client #61's ISP did not indicate how often/when client #61's secure care bracelet was to be monitored/checked to ensure the bracelet was in good working order and would sound/chime upon leaving the building.</p> <p>Confidential interview P indicated client</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>#61 would get out of building unsupervised. Confidential interview P stated "She (client #61) got out and ran in parking lot. One morning found her in a car. A lot of behaviors in the morning. No staff to control behavior." Confidential interview P indicated client #61 knew how to turn off the bracelet so it would not alarm/sound. Confidential interview P indicated the secure care bracelet only worked in the main building. Confidential interview P indicated client #61 had eloped/gone AWOL from the TC.</p> <p>Interview with QIDP #1 (Qualified Intellectual Developmental Professional) on 1/23/14 at 2:35 PM indicated client #61 only got outside one time without staff supervision. QIDP #1 stated client #61 "ran outside 2 times." QIDP #1 indicated facility staff was documenting the client went AWOL when staff was following the client when she left the building. QIDP #1 indicated the above mentioned behavioral cards indicated client #61 did not AWOL without staff's supervision. QIDP #1 indicated she was not aware of the 12/5/13 AWOL incident when client #61 got out to a wooded area behind the main facility. QIDP #1 indicated client #61 would have left the TC when the 12/5/13 incident occurred. QIDP #1 indicated a</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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	
	reportable incident report should have been completed in regard to the incident. QIDP #1 indicated the 12/5/13 incident was not brought up in the facility's daily management IDT meetings. QIDP #1 indicated client #61 did get inside staff's cars on 3 different occasions. QIDP #1 indicated facility staff was with the client when the client got into the staffs' cars. When asked if the facility completed internal incident reports in regard to the 7/10, 7/6 and 7/4/13 incidents, QIDP #1 stated "No." QIDP #1 indicated she was not aware client #61 got out of the building on 8/20/13 and 9/25/13. QIDP #1 indicated client #61 received the secure bracelet on 11/20/13 after client #61 got to the neighbor's house on 11/20/13. QIDP #1 indicated the client's IDT had not met to review client #61's continued elopement behaviors. QIDP #1 indicated the TC did not have an secure alarm system in place to prevent the client from leaving the building. QIDP #1 indicated facility staff were to monitor/supervise the client and would know when the client left the TC. QIDP #1 indicated client #61's ISP did not indicate how client #61 was to be monitored, and/or indicate who was to ensure client #61's bracelet was in good working order. QIDP #1 indicated the facility's nursing services were to monitor the client's bracelet				

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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>once a shift. QIDP #1 indicate she was not aware client #61 would turn the bracelet to a position so it would not alarm. QIDP #1 indicated an investigation was conducted in regard to the 11/20/13 incident where the client was found at the neighbor's house.</p> <p>Interview with administrative staff #1 on 1/24/14 at 11 AM indicated she was not aware of client #61 getting out into a wooded area. Administrative staff #1 indicated facility staff should have reported the incident (allegation of possible neglect) to her immediately. Administrative staff #1 indicated no investigation was conducted of the incident since administration was not aware the incident occurred. Administrative staff #1 indicated she was not aware of any other incidents where client #61 got out of the facility unsupervised except on 11/20/13. Administrative staff #1 indicated the facility did not have a secure alarm system at the TC.</p> <p>2. The facility's reportable incident reports, investigations and/or internal Incident/Accident Reports (IARs) from 11/1/13 to 1/14 were reviewed on 1/16/14 at 1:51 AM. The facility's 12/27/13 IAR indicated "Resident (client #8) noted to have sheering (sic) to</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>buttocks 3 cm (centimeters) x (by) 1.5 cm on (R) (right) side of buttocks. Light brown in color."</p> <p>The 12/27/13 IAR indicated an attached 1/2/14 Progress Note "1:27 PM: In response to nursing notes from 12/27/13 re: 3cm x 1.5cm sheering (sic) brown in color to right side of buttocks. Skin flow sheet initiated. [Client #8] placed on a 24 hour nursing log. Treatment ordered. [Client #8] only up for meals until area is healed. Will continue to monitor." The 12/27/13 IAR and/or 1/2/14 Progress Note did not indicate any additional documentation and/or investigation in regard to client #8's injury of unknown source. The facility's above mentioned IARs, reportable incident reports and/or investigations indicated the facility neglected to report the injury of unknown source to state officials and to conduct an investigation in regard to client #8's injury of unknown source.</p> <p>During the 1/15/14 observation period between 4:40 AM and 9:00 AM, at the main building, client #8 was in a custom made wheelchair. Client #8 stayed in bed except to get up for the breakfast meal.</p> <p>During the 1/15/14 observation period</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>between 10:50 AM and 11:55 AM, at the main building, client #8 was in his bedroom in his bed laying on his backside/buttock.</p> <p>During the 1/16/14 observation period between 9:10 AM and 10:13 AM, at the main building, client #8 was up for the breakfast meal. At 9:10 AM, client #8 indicated he had to use the bathroom. A Certified Nursing Aide (CNA) took client #8 back to his bedroom and left the client sitting in his wheelchair until 10:13 AM. After which, the unidentified CNA put the client in bed. Client #8 was laying on his backside/buttock in the hospital bed with a special mattress.</p> <p>Interview with client #8 on 1/16/14 at 9:40 AM indicated the client had an area on his bottom. Client #8 stated he would get out of his wheelchair "every 3 hours."</p> <p>Client #8's record was reviewed on 1/17/14 at 11:02 AM. Client #8's physician orders indicated the following (not all inclusive):</p> <p>-1/15/14 Client #8 had an order for a Bariatric Gel Cushion which was ordered 8/17/09 The 1/15/14 order indicated "...May</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>have bedrest, turn from side to side. May participate in activities as tolerated..." as ordered on 5/3/13. Client #8's 1/15/14 physician' order indicated client #8's diagnoses included, but were not limited to, Cerebral Palsy, Bells Palsy and Peripheral Vascular Disease.</p> <p>-12/27/13 "Bactroban (antibiotic ointment) TID (three times a day) to sheering (sic) on buttocks x (times) 14 days (1/10/14) ."</p> <p>-10/21/13 "Bactroban q (every) shift to excoriation buttocks x 14 days."</p> <p>-9/23/13 "Discontinue Bactroban to buttocks."</p> <p>-9/14/13 "Bactroban TID to open areas on (L) (left) buttocks x 14 days for sheering (sic)."</p> <p>-9/12/13 "Bactroban to open area to coccyx TID until healed."</p> <p>Client #8's Nurse Notes indicated the following (not all inclusive):</p> <p>-12/31/13 "Seen [name of doctor], 60 day review done and annual physical done, no new orders."</p> <p>-12/30/13 at 2:50 PM, "...Excoriation to</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 02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
---	---

(X4) 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>buttocks remains. No drainage noted. Tx (treatment) applied as ordered. Res (resident) has no complaints of pain...." Client #8's record indicated the facility neglected to monitor and/or document any additional information in regard to client #8's area on his buttock after the 12/30/13 2:50 PM note.</p> <p>-12/30/13 at 7:00 AM, "...Excoriated areas remain to buttocks, bactroban continues. Up for meals only, Turned & incont (incontinent) care given every 2 hrs (hours) & as needed."</p> <p>-12/30/13 at 1:05 AM, "...Resident resting in bed...as usual with no c/o (complaints of) pain or discomfort. Area to buttocks remains with no drainage noted. Resident up for meals only, turned and incont care completed every 2 hours and as needed. No s/s (signs/symptoms) of distress."</p> <p>-12/29/13 at 7:00 AM, "... Area remains to buttocks (with) no drainage. Up for meals only. Turned & incont care given every 2 hours & as needed."</p> <p>-12/29/13 at 3:20 AM, "...Resident resting in bed. Area to buttocks remains with no drainage noted. Resident turned every 2 hours along with Toileted when requested. No c/o pain or discomfort.</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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>No s/s of distress."</p> <p>-12/28/13 at 3:00 PM, "...Area remains to buttocks, no drainage noted. Up for meals only. Turned & incont care done every 2 hours & as needed."</p> <p>-12/28/13 at 7:00 AM, "Area to buttocks remain, no redness or drainage noted. Up for meals only. ATB (antibiotic) oint (ointment) applied as ordered. (cont) (continue) Turned every 2 hours, incont care given every 2 hours & as needed. no complaints voiced."</p> <p>-12/28/13 at 12:15 AM, "...Area to right buttocks remains. no change noted (sic). No S/S of pain or distress noted."</p> <p>-12/27/13 at 3:05 PM, "RA (raised) area to right buttock remains. No drainage noted. Res. has 0 (zero) complaints of pain."</p> <p>-12/27/13 at 8:00 AM, "T (temperature) 96. 1. Resident noted to have sheering (sic) to buttocks."</p> <p>-10/28/13 at 9:30 PM, "Skin flow sheet for 10-21-13 resolved areas to left and right buttock healed."</p> <p>-10/22/13 at 2:30 PM, "Area to buttocks remain unchanged. 0 c/o. TX</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 02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
---	---

(X) 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>(treatment) continues. T 96.0. Will resolve focus charting et (and) follow along skin flow sheet."</p> <p>-10/22/13 12:05 AM "Areas of excoriations remain to buttocks. No complaints of pain or discomfort noted."</p> <p>-10/21/13 at 3:00 PM, "T. 97.6 Resident has no complaint of pain, excoriation remains to buttock."</p> <p>-10/21/13 at 2:30 PM, "Open areas of excoriation noted to (L) buttocks 2 cm x 2 cm et (and) 4 cm x 1 cm et to (R) buttocks 1 cm x 1 cm. [Name of doctor] updated (with) new orders received for Bactroban. DON (Director of Nursing) assessed...Staff informed in huddle to encourage bedrest et to turn resident side to side."</p> <p>-9/21/13 at 8:00 AM, "Area noted on 9-14-13 healed at this time."</p> <p>-9/15/13 at 10:00 AM, Area remains to (L) buttocks (with) 0 change. 0 C/O pain. Will resolve focus charting et follow along skin flow."</p> <p>-9/15/13 at 11:50 PM, "T 97.8. Area to (L) buttocks remain. Tx applied as ordered. No S/S of infection noted. Res (resident) on side."</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 02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
---	---

(X) 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>-9/14/13 at 2:50 PM, "T. 97.6 Area to Left Buttocks remains. Res has no complaints of pain. No S/S of infection noted."</p> <p>-9/14/13 at 9:00 AM, "1.5 cm x 0.8 cm sheered (sic) area to (L) buttocks noted. Skin flow sheet initiated. [Name of doctor] updated et new orders received...."</p> <p>-9/11/13 at 1:00 PM, "Seen by [name of doctor], 60 day review done, no new orders."</p> <p>The facility's Nurses' Weekly Summary Notes indicated the following (not all inclusive):</p> <p>-12/21/13 "...No skin issues noted."</p> <p>-1/7/14 "...No skin issues noted."</p> <p>-12/7/13 "...No skin issues noted."</p> <p>Client #8's Assessments Of Other Skin Abnormalities indicated the following (not all inclusive):</p> <p>- 10/21/13 Client #8's doctor was notified in regard to excoriation noted on the client's L buttock which measured 2 cm x 2 cm and 4 cm x 1 cm and an</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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>area on the client's R buttocks which measured 1cm x 1 cm. The 10/21/13 assessment form indicated on 10/28/13 "Areas to left and right buttock healed."</p> <p>-9/14/13 Client #8 had "excoriation/gaulding (chaffing of the skin from rubbing) 0.8 cm x 1.5 cm open area noted to (L) buttock." The assessment indicated on 9/12/13 "Area healed."</p> <p>Client #8's Braden Scale for Predicting Pressure Sore Risk indicated assessments by the facility's nurses were completed on 3/21/13, 5/2/13 and 5/22/13 with a score of 15 at each assessment. The above mentioned Braden Scales indicated "...A score of 17 or below requires care plan development for interventions and treatment."</p> <p>Client #8's 5/3/13 Occupational (OT) Evaluation indicated "...Pt (patient) is referred (due to) recent onset, 5/2/13, of pressure ulcer of coccyx of 1.0 cm x 3.0 cm. Pt is obese (with) wt (weight) of 325 # (pounds). Pt currently is in tilt in space w/c (wheelchair) (with) elevating leg rests. footbox (with) lateral thigh supports, head rests, & vicair cushion. Pt. had a new cushion on 3/29/13. Pt & staff of facility have been working with [name of wheelchair company] to</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>provide w/c positioning products. This pt. was referred for OT recommendations re: (regarding) seating system & possible new cushion. Pt seen by this OTR (OT therapist) (with) midline upright posture (with) custom back & all w/c adaptive devices. Per nursing present (with) posterior pelvic tilting when fatigued. OT recommendations: (1) Continue (with) current seating system. (2) Tilt W/C into reclined position when pt. does not need to be upright for work or meals. (3). Continue twice daily bed rest per MD orders or more until resolved. (4). Staff to hoyer pt, into w/c from side to ensure proper positioning. (5). May trial gel cushion if no change or worsening of coccyx area."</p> <p>Client #8's January 2014 Treatment Record (TR) indicated client #8 was to be "Turn/reposition Q (every) 2 hours. I=Independent D=Dependent A=Assist." The January 2014 TR indicated facility staff documented client #8 was turned/repositioned "Nocs (nights) Days Eves (evenings)." Client #8's TX record indicated the client was "D" on staff. The January 2014 TR indicated facility staff neglected to document and/or reposition/turn client #8 on "Days" 1/4, 1/5, 1/6, 1/7, 1/9 and 1/13/14. The TR also indicated facility staff neglected to</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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>document reposition/turning of client #8 on 1/1, 1/2 and on 1/7/13 during the evening shift.</p> <p>Client #8's January 2014 BedRest/Bladder Record indicated client #8 was on bed rest in the "AM" and "PM." The record indicated client #8 was not placed on bed rest in the AM and/or PM on 1/16, 1/7, 1/9 and/or 1/13/14 as the areas indicated were blank on the record. The January 2014 Bedrest record also indicated the facility neglected to toilet the client every 2 hours on 1/6/14 from 6:00 AM to 2:00 PM and on 1/9/14 from 6:00 AM to 2:00 PM as the areas were blank on the form.</p> <p>Client #8's 8/5/13 Comprehensive Functional Assessment Summary indicated client #8 was a "Skin integrity Risk."</p> <p>Client #8's 9/5/13 Individualized Support Plan (ISP) active treatment schedule indicated client #8 was to be placed on bed rest from 10:00 AM to 11:00 AM and from 2:00 PM to 3:00 PM daily.</p> <p>Client #8's 9/5/13 Repositioning Assessment indicated client #8 utilized a wheelchair for mobility. The 9/5/13 assessment indicated "...THIS</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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>RESIDENT REQUIRES REPOSITIONING BECAUSE [Client #8] is non-ambulatory. He has skin integrity issues according to the Braden Scale...BEDREST FREQUENCY: _2x a day_HOW LONG: approximately 1 hr. (hour) 2x per day_...COMMENTS: [Client #8] can indicate to staff when he needs to go to the bathroom and these times will also be considered repositioning."</p> <p>Client #8's 9/5/13 ISP Nursing Care Plan indicated the following in regard to "Skin Integrity Risk:"</p> <p>"...Monitor skin breakdown, treat as needed Pressure reliving (sic) mattress/cushion Bedrest as ordered Encourage change of position every 2 hours Manage moisture due to incontinence -Tena (topical cream) as ordered/needed -Toileting as scheduled/needed Braden Scale completed Quarterly Dermatology consult as ordered/needed...."</p> <p>Client #8's record indicated client #8 had a 5/2/13 Episodic (temporary care plan until area healed) Care Pan Open Area for client #8's "open area to coccyx" which was no longer being utilized.</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>Client #8's 10/12 to 1/14 Progress Notes indicated the QIDP documented the following (not all inclusive) in regard to client #8's skin integrity issues:</p> <p>-10/23/12 "...[Client #8] has very thin skin which tears easily...."</p> <p>-1/2/14 "1:27pm: In response to nursing notes from 12/27/13 re: 3cm x 1.5cm sheering (sic) brown in color to right side of buttocks. Skin flow sheet initiated. [Client #2] placed on 24 hour nursing log. Treatment ordered. [Client #8] only up for meals until area is healed. Will continue to monitor."</p> <p>Client #8's 9/5/13 ISP, Progress Notes and/or record indicated the client's interdisciplinary team (IDT) and/or facility neglected to specifically meet and/or address client #8's continual skin integrity issues in regard to pressure ulcers, excoriation, gaulding and/or shearing to prevent reoccurrence. The facility neglected to ensure client #8 was repositioned/turned and toileted every 2 hours, and developed specific risk plans in regard to the client's skin integrity, repositioning and monitoring.</p> <p>Interview with staff #2 on 1/16/14 at 10:09 AM indicated client #8 had a</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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>pressure area. Staff #2 indicated client #8 would have to be taken back to his bedroom after meals to lay down. Staff #2 indicated client #8 would be toileted every 1 1/2 hours to 2 hours.</p> <p>Interview with administrative staff #1 on 1/16/14 at 10:24 AM indicated she did not report client #8's injury/shearing to state officials and/or conduct an investigation in regard to the cause/nature of the injury.</p> <p>Interview with LPN #5 on 1/16/14 at 10:35 AM indicated client #8 had an area on his buttock. LPN #5 indicated client #8 was still on bed rest as a nursing measure.</p> <p>Interview with Director of Nursing (DON) #1 on 1/16/14 at 11:49 AM stated client #8 did not have a pressure ulcer but a "skin shear." DON #1 stated client #8 received the injury from "scotting against something" or when turned to be changed.</p> <p>Confidential interview Q stated client #8 was "regular for pressure sores."</p> <p>Interview with LPN #3 and LPN #4 on 1/17/14 at 11:20 AM indicated client #8 did not have an area on his buttock at this time. LPN #3 and #4 indicated the</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>area had healed. When asked why client #8 was in bed, LPN #3 and #4 indicated client #8 was being kept in bed for bed rest to make sure the area was healed. LPN #3 and #4 stated client #8 did not have a physician's order for "continual bed rest."</p> <p>Confidential interview P indicated CNAs were responsible for repositioning clients. Confidential interview P indicated facility nursing staff would assist to reposition clients when needed. Confidential interview P indicated when the facility was short of staff, the facility did not have enough staff/CNAs to reposition and toilet clients every 2 hours. Confidential interview P stated "Showers are not getting done. Skin care not being done properly."</p> <p>Interview with DON #1 and the facility's consulting/corporate nurse on 1/22/14 at 1:11 PM indicated CNAs would lay the client down for bedrest 2 times a day. DON #1 indicated the CNAs would document the client's bedrest and repositioning on "ADL (adult daily living) flow sheets." DON #1 indicated the flow sheet did not specifically indicate to document the repositioning of client #8 every 2 hours as facility staff was only documenting once per shift.</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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>When asked if client #8 had been treated for a pressure area, DON #1 stated client #8 was treated for "shearing" which was an "abrasion/friction." The facility's consulting/corporate nurse stated "We look at it as a pressure area." DON #1 indicated client #8 would refuse to be repositioned/laid down as the client wanted to stay in his wheelchair. DON #1 indicated client #8's flow sheets did not indicate how client #8 was to be repositioned to ensure healing of the area. When asked how the facility was preventing pressure areas and/or shearing of the client's skin, DON #1 stated "I will have to check." DON #1 stated "There are no care plans at the facility." DON #1 stated the facility was using "Episodic Care Plans." DON #1 indicated the Episodic Care Plans were "Temporary" until an area was healed.</p> <p>Interview with QIDP #1 on 1/23/14 at 2:35 PM stated clients were to be repositioned "approximately every 2 hours." QIDP #1 indicated the CNAs were to document the repositioning of clients in the CNA book. QIDP #1 indicated she did not know how client #8 was to be repositioned. When asked what caused the area on client #8's buttock, QIDP #1 stated "Not sure, a nursing thing. Not being repositioned or positioned correctly in bed. It would be</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 02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
---	---

(X4) 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>in the nursing part of the ISP." QIDP #1 indicated client #8's IDT had not met to address the client's repeated skin integrity issues/care.</p> <p>The facility's policy and procedures were reviewed on 1/15/14 at 9 AM and on 1/22/14 at 1:53 PM. The facility's 4/08 policy entitled Prevention of Pressure Ulcers indicated "After conducting a risk assessment to identify risk factors, then focus the prevention program on minimizing their negative effects. When addressing pressure ulcers, prevention is the number one solution...Frequent positioning of the resident is recommended to prevent capillary occlusion which leads to tissue ischemia and pressure ulcers. Although repositioning will not reduce the intensity of pressure, it will reduce duration, which is more critical...." The facility's policy indicated clients should be repositioned "at least every 2 hours." The policy indicated "...positioning schedules should be designed with an individual resident needs and preferences in mind, which is important in maintaining resident compliance with interventions...." The 4/08 policy indicated "...Repositioning does not always entail a full turn from left side to right side or from back to left side. It may be helpful to intervene with small,</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 02/03/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
(X) 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>frequent position changes using pillows, bath blankets, wedges to reduce pressure...." The facility's policy indicated "friction usually, but not always, accompanies shear. Friction and gravity often result in shear. Friction is the force of rubbing two surfaces against one another. Friction without force (pressure) causes damage to the epidermis and upper dermal layers and is not commonly known as 'sheet burn.' Shear is the result of gravity pulling down on the resident's body and the resistance between the resident and the chair or bed. Shear damages the tissue layers that slide against each other and the underlying blood vessels. Therefore, when combined with gravity/force (pressure), friction causes shear and the outcome can be more devastating than pressure alone...Up to 40% of reported pressure ulcers may actually originate from shear. As a mechanical force perpendicular to an area, pressure alone usually damages the point of impact and the pressure gradient area. Shear, however, is a parallel mechanical force and therefore damages in a wider plan of tissue...." The facility's 4/08 policy indicated once a client was determined to have risk factors for skin breakdown, a care plan would need to be developed.</p> <p>3. During the 1/15/14 observation</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 02/03/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON			STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342		
(X) 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>period between 4:40 AM and 9:00 AM at the facility, and the 1/16/14 observation period between 9:10 AM and 11:30 AM, client #12 was in his room in his bed. Specifically during the 1/16/14 observation period, client #12 laid in his bed on his back. Client #</p> <p>3. Review of the facility reportable records on 1/21/14 at 2 PM indicated: __A BDDS (Bureau of Developmental Disabilities Services) report dated 1/7/14 indicated "On Jan 6, 2014 [client #66] ate dinner and went to her room where she went to bed. Her roommate states that she was already in the room writing in her journal when [client #66] came in. [Client #66] got in bed, covered up and fell asleep. Roommate stated she was snoring which was usual for her. At some point in time after she fell asleep, her snoring 'sounded funny' to the roommate. The roommate looked at her and said she seemed to be okay. A few minutes later the snoring stopped. That is when the roommate looked at her again and said her mouth was open and she looked 'blue.' At that time she called for a nurse. Staff responded immediately and started CPR because [client #66] was a full code. One of them called 911 and when the EMTs arrived they continued the CPR. There did not appear to be any pulse or respirations. We were</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 02/03/2014
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>notified by [name of hospital] that she was pronounced dead. Physician and guardian were notified."</p> <p>The investigative packet contained: ___ An undated note from QIDP #2 indicated "[Client #66] was at dinner that evening and a few times that day she went to smoke (a cigarette) as well. [Client #66] seemed fine to me that day but staff had to keep reminding her that it's cold due to her persistence on wanting to go over to the training center (she kept going outside)."</p> <p>___ A note dated 1/10/14 from facility housekeeping staff #17 indicated "I was cleaning up the dining room the night [client #66] past (sic) away. I seen (sic) her come in the front door by west desk and she look (sic) like she didn't feel well and she groped for the wall. I ask (sic) her if she was OK and she said yes and went on down the hall way. And the next thing I seen (sic) [client #66] coming from the door out side and was walking back down the hallway to her room. It was dark and probably around 7 or 7:30 PM."</p> <p>___ An undated note from administrative staff #1 indicated "Spoke to [name of staff] who works here in housekeeping and laundry. She states that she saw</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 02/03/2014	
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>[client #66] in the front door (it was one of the cold days) sometime between 7 PM and 7:30 PM. [Housekeeping staff #17] said [client #66] looked like she didn't feel well and grabbed the wall to steady herself. [Housekeeping staff #17] asked her if she was okay and she said yes. A few minutes later [Housekeeping staff #17] saw her enter from the door going directly to the dining room. [Client #66] then shivered and made a comment about it being cold outside (she had her coat on). She walked down the hall to her room. [Housekeeping staff #17] states that even though [client #66] looked like she didn't feel well she did not report it to the nurse thinking that since [client #66] said she was okay she might just looked bad due to the cold weather.... In conclusion, based on the investigation and the fact that [name of facility doctor] feels [client #66] had a Myocardial infarction, I feel [client #66's] death was in no way a result of anything other than a sudden heart attack."</p> <p>Review of the IN.GOV web page (http://www.in.gov) on 1/23/14 at 9 PM indicated on 1/5/14 "Governor Pence Declares State of Disaster Emergency in 29 Indiana Counties: ...affected by the severe weather that began on January 5 (2014). As a result of the severe</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 02/03/2014	
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>snowstorms, extreme cold and dangerous wind conditions that have impacted counties across Indiana, I (Gov. Pence) have declared a state of disaster emergency in the 29 counties that were most affected by the storm, and the State of Indiana stands ready to assist Hoosiers as needed." Hickory Creek, where client #66 resided, was located in Delaware County and included in one of the counties declared to be in a state of emergency due to severe weather conditions with below zero temperatures on 1/6/14.</p> <p>Client #66's record was reviewed on 1/24/14 at 12 PM.</p> <p>__ Client #66's record indicated a diagnosis of, but not limited to, Bronchial Asthma.</p> <p>__ Client #66's ISP (Individual Support Plan) dated 6/20/13 indicated "According to [client #66's] smoking assessment she has no physical limitations that require a staff to hold her cigarette, she does have difficulty understanding the smoking policy due to her cognitive abilities. She has no other health issues and/or concerns that affect her ability to hold her cigarette and is able to smoke (a cigarette) without burning herself or her clothing. [Client #66's] smoking plan includes that she always smokes with a staff member with</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 02/03/2014	
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>her, she wears a 'smoking apron' for protection and does not carry her own smoking materials, including cigarettes and lighters."</p> <p>__ Client #66's nursing notes indicated on 1/6/14 at 7:20 PM "Resident's roommate yelled for this nurse stating resident was not breathing this nurse responded to resident's room resident lying on bed cyanotic and no visible respirations resident placed on floor this nurse checked and found no pulses chest compressions began and outer clothing removed call placed to 911 CPR (Cardio Pulmonary Resuscitation) continued per this nurse and [name of another nurse] (sic)."</p> <p>__ Client #66's nursing notes indicated no health assessment and/or documentation on 1/6/14. With the severe weather of below zero temperatures, client #66's record did not indicate when client #66 went outside to smoke (a cigarette), how client #6 was dressed when she went outside, if a staff member was with her, how long she was outside to smoke a cigarette and if an assessment was conducted by a nurse each time client #66 returned inside from the below zero temperatures. Client #66's record failed to indicate the housekeeping staff had reported to nursing when client #66 did not look good when returning in from the below</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 02/03/2014
--	---	--	---

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>zero temperatures and after having smoked a cigarette.</p> <p>Interview with LPN #15 on 1/23/14 at 10 AM indicated client #66 was not assessed by a nurse each time client #66 returned inside after going outside in the cold temperatures to smoke a cigarette. LPN #15 stated whenever a staff "thinks someone doesn't look right" or "thinks someone's heath was an issue", that staff "should report to us (nursing) immediately."</p> <p>Interview with the DON on 1/23/14 at 3 PM indicated client #66 had a diagnosis of Asthma. The DON stated the facility doctor had told her that client #66 "probably had COPD (Chronic Obstructive Pulmonary Disease) too" but it was not an official diagnosis. When asked if client #66 should have been going out in the below zero temperatures to smoke a cigarette, the DON stated, "No, but it was her choice and someone was with her." The DON indicated the staff tried to discourage client #66 from going outside due to the inclement weather, but was unsuccessful.</p> <p>Interview with administrative (Adm) staff #1 on 1/24/14 at 1 PM stated client #66 had gone outside "several times" on</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 02/03/2014	
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>1/6/14 to smoke a cigarette. Adm staff #1 indicated client #66 wore a coat, a toboggan type hat and was assisted by staff each time she went out to smoke a cigarette. Adm staff #1 stated, "Because it was so cold, we let her go out the front door and smoke a cigarette in the front of the building instead of going to the designated smoking area in the back of the building." The DON indicated the housekeeping staff did not report to the nursing staff the concern of client #66's health after coming in from inclement weather of below zero temperatures and having smoked a cigarette.</p> <p>The facility's policy and procedures were reviewed on 1/16/14 at 4:03 PM and on 1/22/14 at 1:53 PM. The facility's 9/10 revised policy entitled Resident Mistreatment, Neglect, Abuse & (and) Misappropriation of Property indicated "Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion." The facility's 9/10 policy indicated neglect was defined as "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</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 02/03/2014	
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>of resident care and services to assure that care is provided as needed by residents. Neglect occurs when a facility fails to provide necessary care for residents , such as situations in which residents are being left to lie in urine or feces...." The facility's policy indicated "...Staff, whether direct care, ancillary departments, contract staff, or volunteers, will be monitored and supervised by their respective supervisors to ensure that the residents receive appropriate care and services to meet the their needs and to prevent the potential of neglect and/or abuse...." The 9/10 policy indicated "I. Identification: Injuries of unknown or unwitnessed etiology, including but not limited to, fractures, bruises, skin tears, joint dislocations, and abrasion of residents are thoroughly investigated as to possible occurrence and are reported to the appropriate local, state, and federal agencies within the required time frames...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...." The policy indicated "...M. Reporting/Response: The administrator</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 02/03/2014
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	
W000227	<p>is to report all allegations of abuse, neglect, misappropriation of resident property, and injuries of unknown etiology, or significant injuries to his/her respective Director of Operations...."</p> <p>This federal tag relates to complaint #IN135402.</p> <p>This deficiency was cited on 9/18/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(a)</p> <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.</p> <p>Based on observation, record review, and interview, for 3 of 10 sampled clients (#1, #2 and #7) and for 4 additional clients (clients #11, #21, #28, and #61), the facility failed to have specific objectives to address client #2 and #7's mealtime behavior restrictions, client #11's use of hand sanitizer on her face, client #21's masturbation in public, client #28's excessive masturbation, and client #61's stripping and PICA (eating non-edible items) behavior.</p>	W000227	<p>What corrective action will be done by the facility? Client #2 has been reassessed and is currently receiving pre-made meals from the kitchen since he is diabetic and requires a more restrictive, specialized diet. Client #2 has had his ISP updated to accurately reflect the reason for this type of dining service, and he has not indicated any distress or issues with receiving his meal in this way. Client #7 has had an updated dining assessment and is excused from family style</p>	03/05/2014	

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 02/03/2014	
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>Findings include:</p> <p>1. Client #2's record was reviewed on 1/22/14 at 2:00pm. Client #2's 6/4/13 ISP (Individual Support Plan) and 6/4/13 BSP (Behavior Support Plan) both indicated client #2 did not participate in family style dining and no objective was available for review. Client #2's 6/4/13 "Assessment of Style of Dining" indicated "excused from family style dining. Focus on basic self feeding skills and/or behavior interventions...Family Style dining may be temporarily suspended due to illness where cross contamination is a concern. Reassess annually at ISP or as the needs/abilities of the resident changes." No objective for dining skills was available for review.</p> <p>On 1/23/14 at 11:20am, an interview with QIDP #2 was conducted. QIDP #2 indicated client #2 did not have an identified behavior to exclude him from family style dining. QIDP #2 indicated client #2 did not have a dining objective/goal.</p> <p>2. Client #7's record was reviewed on 1/22/14 at 3:35pm. Client #7's 10/24/13 ISP (Individual Support Plan) and 10/2013 BSP (Behavior Support Plan)</p>		<p>dining in an effort to focus him on basic self feeding skills and related behavioral issues. His objective has been revised to teach him appropriate eating behaviors and his goals will continue and be updated as his eating techniques improve. The results of the assessment and any behavioral issues identified have been documented in Client #7's medical record. Resident #21's behavior program has been updated and now includes his tendency for public masturbation, kissing behavior with other residents, and invading other resident's personal space. His behavior plan has been updated and it includes the reminder to wash his hands. Resident #61 has had her behavior plan updated to include taking her clothing off and her tendency to put non-edible objects in her mouth. Resident #15 has had her behavior plan updated to include her excessive use of hand sanitizer. All hand sanitizers have been removed from easy access. Resident #28 has had his behavior plan updated to include his excessive masturbating behavior. Resident #1 has had his behavior plan updated to include the diagnosis of depression. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? Any resident who is diabetic or</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 02/03/2014	
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>both indicated client #7 did not participate in family style dining and no objective was available for review. Client #7's 10/2013 "Assessment of Style of Dining" indicated "excused from family style dining. Focus on basic self feeding skills and/or behavior interventions." No objective for dining skills was available for review.</p> <p>On 1/23/14 at 11:20am, an interview with QIDP #2 was conducted. QIDP #2 indicated client #7 did not have an identified behavior to exclude him from family style dining. QIDP #2 indicated client #7 did not have dining objective/goal.</p> <p>3. During observation and interviews on 1/21/14 from 3:15pm until 5:25pm, client #21 was not observed to be offered and/or encouraged to participate in an activity. At 3:15pm, client #21 placed his hands inside the waist line of his pants and movement was observed to indicate client #21 was manipulating his private area inside his pants. ATF #31 did not redirect client #21 and/or offer him an activity.</p> <p>On 1/23/14 at 11:10am, an interview with QIDP (Qualified Intellectual Disabilities Professional) #3 was conducted. QIDP #3 indicated client</p>		<p>otherwise is unable to eat family style, any resident who has behaviors such as masturbation, kissing other residents, taking clothing off, putting non-edible objects in the mouth, using hand sanitizer excessively, or who is diagnosed with depression have the potential to be affected by this practice. Any identified issue or concern in these areas by any member of the IDT will be addressed immediately to make sure that the resident(s) involved are safe and secure. Once the residents are taken care of, the Administrator or Department Manager will re-train the staff involved regarding the facility policy and practices that the staff is expected to follow. Disciplinary action will be instituted as indicated. What measures will be put into place to ensure this practice does not recur? All clients who have the ability to participate in family style dining will be assessed by the QIDPs to assure that they are included, or if not, that the ISP properly reflects why. The QIDPs will be responsible for assessing their own residents. The QIDPs will also assess their own residents for excessive use of hand sanitizer, tendency to masturbate in public or private, tendency to take their clothing off or put non-edible objects in their mouth, and whether or not depression is evident. As the assessments are done, the behavior plans will be</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 02/03/2014	
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>#21 should have washed his hands and been offered activity after he placed his hands inside his pants.</p> <p>On 1/23/14 at 11:20am, an interview with QIDP #2 was conducted. QIDP #2 indicated client #21 did not have an identified behavior of public masturbation identified in his BSP. QIDP #2 indicated staff should have used redirection for client #21's masturbation behavior.</p> <p>Client #21's record was reviewed on 1/23/14 at 11:20am. Client #21's 7/9/13 ISP (Individual Support Plan) and BSP (Behavior Support Plan) did not indicate client #21 had the behavior of public masturbation.</p> <p>4. During the 1/15/14 observation period between 4:40 AM and 9:00 AM, at the main building, client #61 came out of her bedroom naked from the waist up. Client #61 walked down the hallway exposed and went into a closed off bathroom. Client #61 then came out of the bathroom and walked down the hallway into the doorway of a male client before returning to her bedroom.</p> <p>The facility's reportable incident reports, internal Incident/Accident Reports (IARs) and/or investigations were</p>		<p>updated accordingly. The ISPs will also be updated as needed and reviewed on a quarterly basis. If the QIDPs find any issues or concerns as part of their assessment, they will follow up with the IDT members for further review and discussion. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?The QIDPs will bring the results of their assessments for these type residents, as well as other behaviors and resulting plans to the monthly QA meeting for further review and recommendation. This will continue on an ongoing basis.</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 02/03/2014	
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>reviewed on 1/16/14 at 11:51 AM. The facility's 1/11/14 reportable incident report indicated "Resident was running in facility and taking her clothes off repeatedly, and would not listen to redirection...." The reportable incident report client #61 continued to try and remove her clothes while in a public area. The 1/16/14 reportable incident report indicated "...[Client #61] began eating stuff off the floor; one item appeared to be a small plastic disc. Staff tried to redirect [client #61] but she hurried and swallowed the item...."</p> <p>Client #61's record was reviewed on 1/22/14 at 12:20 PM. Client #61's Behavior Cards indicated the following (not all inclusive)</p> <p>-12/5/13 Client #61 was eating paper and plastic cotton balls.</p> <p>-11/4/13 Client #61 was stripping in the classroom times 3 and eating paper and crayons.</p> <p>-9/16/13 Client #61 was eating paper and making self vomit.</p> <p>-8/8/13 Client #61 was eating grass. The behavior card indicated "...Trying to eat a plastic bag-eating crayons." A second 8/8/13 behavior card indicated</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 02/03/2014	
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>client #61 was eating paper as well.</p> <p>-8/3/13 Client #61 ate paper 6 different times.</p> <p>-7/25/13 Client #61 was "Running outside, eating grass and eating dirt."</p> <p>-7/22/13 Client #61 was "Eating non-edible items."</p> <p>-7/4/13 Client #61 "Eating grass, sticks, mulch and mud."</p> <p>-1/27/13 "Up @ (at) 11pm...won't keep clothes on...."</p> <p>Client #61's 2/5/13 Assessment for PICA (eating inedible objects) Behavior indicated client #61 had a history of putting non edible objects in her mouth. The assessment indicated client #61 needed a "Behavior Intervention Plan (BIP) for PICA." The assessment indicated "...1. Continue to monitor for signs of ingesting non-food items and document that and all other unwanted behaviors. 2. The (QIDP) will present any occurrence of PICA behavior to the Interdisciplinary Team and the Behavior Management Committee. 3.. Reassess at the next ISP or when conditions change." The 2/5/13 assessment indicated client #61 had a plan in place.</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 02/03/2014	
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>Client #61's undated Behavior Intervention Plans indicated client #61 demonstrated "Inappropriate personal activity in public" which was defined as "rubbing her vagina on outside of clothes, asking other to then smell her hand...." Client #61's undated behavior intervention did not address the client's stripping/removing her clothes in public. Client #61's record indicated client #61 did not have an objective/plan which addressed the client's identified behavior in regards to eating inedible objects.</p> <p>Interview with QIDP #1 on 1/23/14 at 2:35 PM. QIDP #1 indicated she thought client #61 had a plan for eating inedible items. QIDP #1 indicated she would print the plan off her computer. QIDP #1 did not provide a plan in regard to client #61's identified need for eating inedible objects. QIDP #1 indicated client #61 did not have a program which addressed her stripping/removal of clothes behavior. QIDP #1 indicated client #61 only removed her clothes in her bedroom and did not come out of her room.</p> <p>5. Observations were conducted at the facility on 1/23/14 between 10 AM and 11 AM. At 10:20 AM client #11 sat up</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 02/03/2014	
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 the side of her bed to allow LPN #15 to assess her face/skin. Client #11's facial skin across her forehead and cheeks was flaky and dry. Client #11 was touching and rubbing her face/neck area. When asked does your skin itch, client #11 did not respond.</p> <p>Client #11's record was reviewed on 1/23/14 at 1 PM. Client #11's record indicated "Due to dry skin condition, [client #11] will bathe two times a week..." Client #11's 12/2013 physician's orders indicated client #11 had an order for Ammonium lactate (a skin softener) to use as needed and to use Dove soap for bathing and showering. Client #11's 2013 BSP (Behavior Support Plan) and client #11's 7/30/13 ISP (Individualized Support Plan) did not address client #11's use of hand sanitizer.</p> <p>Interview with LPN #15 on 1/23/14 at 10:25 AM indicated client #11 liked to use hand sanitizer and would frequently put it on her face, neck and hands. LPN #15 stated client #15's skin "Looks better than it usually does." LPN #15 stated client #11's face and forehead were "ashy and dry." The LPN stated, "We have lotions we put on her skin." LPN #15 indicated there was no plan in place to address client #15's use of hand</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 02/03/2014	
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>sanitizer.</p> <p>Interview with QIDP #1 on 1/24/14 at 1 PM indicated client #11's ISP/BSP did not address client #11's identified behavior of excessive use of hand sanitizer.</p> <p>6. Observations were conducted at the facility on 1/22/14 between 7:30 AM and 10 AM. At 7:35 AM client #28 was standing nude in the bathroom. Client #28's groin and perineal area was dark in color and looked scarred. The skin was intact with no open areas noted. CNA (Certified Nursing Assistant) #16 was assisting client #28 while in the bathroom and stated, "I think that is from where he is gaulded all the time." CNA #16 indicated client #28 would lay in his bed most of the day and masturbate. When asked what staff do when he does this, CNA #16 stated, "We just try to give him some privacy."</p> <p>On 1/23/14 at 11:15 AM client #28 had just gone to the bathroom. LPN #15 assisted client #28 back to bed. Client #28, with the help of LPN #15, removed his pants down to his underwear and client #28 got into bed. LPN #15 pulled client #28's covers up and client #28 rolled over to his side. Within two minutes of getting into bed, client #28</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 02/03/2014	
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>began masturbating.</p> <p>Interview with LPN #15 on 1/23/14 at 11:20 AM stated client #28's groin and skin between his legs was healed but darker than the other skin because of "gaulding" caused from "frequent masturbation." LPN #15 stated, "I don't know if it's because he is bored or just needs something to do with his hands." LPN #15 indicated client #28 was blind and liked to spend most of his time in his bedroom masturbating. When asked what the staff are to do when he is masturbating, redirect him or offer other activities, LPN #15 stated, "I think he is just given private time."</p> <p>Client #28's record was reviewed on 1/24/14 at 1 PM. Client #28's 1/19/14 Assessment of Other Skin Abnormalities indicated "Gaulding to groin." Client #28's 12/2013 physician's orders indicated client #28 had an order for Lotrisone cream to the groin area as needed for gaulding. Client #28's 8/6/13 ISP did not address client #28's excessive masturbating.</p> <p>7. Client #1's record was reviewed on 1/18/14 at 1 PM. Client #1's 12/2013 quarterly physician's orders indicated client #1 took Citalopram (Celexa) 20 mg (milligrams) a day for depression.</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 02/03/2014
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>Client #1's revised BSP (Behavior Support Plan) dated 1/28/13 indicated client #1 had targeted behaviors of non compliance with medical treatments to include podiatry services, audiology services, dental services and lab draws. The BSP indicated client #1 was started on Celexa 20 mg a day for depression.</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) #3 on 1/24/14 at 11:30 AM indicated client #1's BSP did not address and/or include targeted behaviors of depression in regard to the use of Celexa.</p> <p>This federal tag relates to complaint #IN00135402.</p> <p>This deficiency was cited on 9/18/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>				