

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 03/20/2014
--	---	--	---

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 PCR completed on 2/3/14 to the investigation of complaint #IN00135402 completed on 9/18/13.</p> <p>This visit was in conjunction with a PCR to the pre-determined full recertification and state licensure survey. This visit included the investigation of complaints #IN00141135, #IN00141928 and #IN00142820 completed on 2/3/14.</p> <p>This visit was in conjunction with the investigation of complaints #IN00144209 and #IN00144540.</p> <p>This visit was in conjunction with a PCR to the PCR completed on 2/3/14 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 PCR completed on 2/3/14 to the investigation of complaint #IN00138987 completed on 11/27/13.</p> <p>Complaint #IN00135402-Not corrected.</p> <p>Dates of Survey: 3/11, 3/12, 3/13, 3/17 and 3/20/14</p>	W000000	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Gaston desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 4/19/14.</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 03/20/2014
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>Facility Number: 000614 Provider Number: 15G068 Aim Number: 100272120</p> <p>Surveyors: Paula Chika, QIDP-TC Keith Briner, QIDP (1/21/14 to 1/24/14) Amber Bloss, 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 3/28/14 by Ruth Shackelford, QIDP.</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 03/20/2014	
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			
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 10 sampled clients (#1) and for 2 additional clients (#21, #29), the facility neglected to implement its written policy and procedures to prevent neglect of clients #1, #21 and #29. The facility failed to prevent neglect in regard to a fracture/falls involving client #21, client #1's health condition/status which had potential to result in respiratory failure, and to address the client's skin integrity issues. The facility failed to implement its policy and procedures to prevent neglect of client #29 in regard to the client's skin integrity/continual skin breakdown issues.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 3/11/14 at 2:36 PM and on 3/13/14 at 1:30 PM. The facility's reportable incident reports, IARS and/or investigations indicated the following (not all inclusive):</p> <p>-2/7/14 "Res (resident) (client #21) sitting</p>	W000149	<p><u>1. What corrective action will be done by the facility?</u> Resident #21 remains in a reclining geri-chair with a pelvic stabilizing belt. A wedge is used behind his back for meals. He has a care/risk plan with interventions relating to his current level of mobility, as well as interventions for prevention of future injuries. A mechanical lift with assistance of 2 staff is being used for all transfers. The staff has been trained on bathing the resident while keeping the cast dry. The nurse who did not assess Resident #21 after his seizure and did not document the seizure has received disciplinary action. The nurses will be re-trained on assessment after injuries and documentation of unusual events, such as seizures. In addition, staff has been re-trained on the expectation of complete documentation on all documents, including the 15 minute checks. The Administrator has developed and is using a different format for investigations that includes different sections to be taken under consideration when doing an investigation in an attempt to improve the depth and content of any investigation that is done, including those of allegations of neglect abuse, and/or injuries of unknown</p>	04/19/2014			

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 03/20/2014
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>in W/C (wheelchair) in LR (living room) had 30 seconds (sic) seizure and fell forward on floor, seatbelt unbuckled, res assessed, no apparent injury at this time. ROM (range of motion) as usual, neuro (neurological) & (fall) flow sheet initiated."</p> <p>An attached 2/7/14 Progress Note indicated "...4.) Trained with him to please keep his seatbelt on to prevent sliding out of his wheelchair...."</p> <p>-2/28/14 "[Client #21] was noted to have bruising on his (R) foot of 14cm (centimeters) x (by) 7cm blush (sic) at the heel and ankle and (15cm x 9cm) reddish yellow on skin and inner side. Moderate swelling in foot & (and) lower leg. [Name of doctor] was notified and requested nursing to monitor the area and gave nursing an order to send [client #21] out to [name of orthopedic group]. As of 4:00 PM [client #21] is still at [name of orthopedic group] waiting on his results. An investigation has been initiated to question staff and other residents to determine the likely cause...."</p> <p>The facility's 3/6/14 follow-up report indicated client #21 was found to have a fracture to his right tibia and was sent to the hospital for admission for a "surgical repair" on 2/28/14. The follow-up report</p>		<p>source. The content of the new investigation tool contains such things as: synopsis of the event, including specific details of the event itself and those who were involved in it or witnessed it; employees, residents, and other people interviewed; any identification of abuse or neglect and any necessary follow up done at that time; medical records reviewed; personnel records reviewed; chart/care plan review; employee time cards reviewed; other pertinent documents reviewed; physical evidence reviewed; summary of event based on results of interviews, document reviews, and physical evidence; conclusion based on evidence that supports the conclusion of the investigation. Changes in residents' conditions, including physician telephone orders are brought by the DON to the morning interdisciplinary management meeting which occurs at least 5 times a week for review by the IDT (interdisciplinary team) and development of recommendations and interventions to meet the residents' condition changes. The QIDPs attend this meeting and will update their records and care/risk plans to address the residents' change in status as had been done with Resident #21. Resident #1 continues to refuse to use her Bi-Pap. The respiratory</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 03/20/2014	
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>indicated client #21 returned to the facility on 3/6/14. The follow-up report indicated "...He is non-weight bearing on his right leg and he returned with orders for physical and occupational therapy. We began an investigation in regard to the cause of the fracture on 2/28/14. As a result of the investigation, the facility is able to determine the most likely cause of the fracture was due to a seizure. During the seizure, he was sitting in a wheelchair, leaned forward with his buttocks off the seat of the wheelchair and he had placed his feet under the foot rests. He is a very large man and extremely strong. He has frequent seizures. This particular seizure was violent, grand mal seizure. During this seizure he threw his body forward. He was secured in chair and did not hit the ground...."</p> <p>The facility's attached witness statements indicated the following (not all inclusive):</p> <p>On 3/4/14, "I (staff #37) seen (sic) a resident [client #21] have a seizure. After seizure I [staff #37] help (sic) walk [client #21] to his room. While walking to his room [client #21] was leaning forward and trying to sit down. I and another staff got [client #21] to his room and [client #21] laid down to rest.</p>		<p>services vendor has been contacted once and brought a different mask for the resident to use. She continues to refuse the use of this new mask, so the vendor has been contacted again to see if there is any other alternative that might be acceptable to the resident. These efforts are documented in the resident's clinical record. Resident #1 is on 15 minute checks during naps and at night, so that staff can assess her respiratory status as she sleeps. Her lung sounds, oxygen saturation levels, and temperature are being assessed every shift and documented in the clinical record. The physician will be notified if the assessment results in a concern related to her current status. Her ISP has been updated to address the resident's refusal to wear the Bi-Pap mask, and a care/risk plan has been developed for her dysphagia and to show the interventions and monitoring that staff is doing when the resident is sleeping and napping. A care plan has been developed regarding the resident's dry skin issues and related treatment. Her dry skin issues have improved at this time. The CNAs and nurses have been instructed on the use of a draw/turn sheet to turn Resident #29 from side to side without adding undo pressure or stress to his gluteal area. Nursing staff has been in-service 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 03/20/2014	
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 #21] smiled and I covered him up." The 3/4/14 witness statement indicated the facility neglected to have the staff person describe the seizure, neglected to ask when the seizure occurred and/or neglected to indicate if the nurse was contacted/involved/assessed client #21 for injuries.</p> <p>Client #54's undated witness statement indicated "I (client #54) saw him have a seizure and a nurse was with him."</p> <p>Undated witness statement by staff #38 indicated "...worked Tuesday and Thursday nights. Nothing unusual either night. [Client #21] stood up for them Tuesday night but did not stand Thursday night. On Thursday night he sat up in bed 2 or 3 times 'like he always does.' She thinks he might have had a seizure but was not sure. At one point he yelled out (which she states is normal right before a seizure) and she went to check on him before her 3:30 rounds. His right leg was hanging over the bed and his left leg was on the bed. She said he sometimes urinates on himself when he has a seizure and he did not do so at that time and that's why she's not sure if he had a seizure or not. She did state he was 'wobbly' while in bed but otherwise there was nothing different about him."</p>		<p>providing privacy during showers for all residents, including #29, as well as identifying and using the correct size shower chair for each resident. Thenurses have been re-in-serviced on the need for complete documentation of medications and treatments as ordered by the physician. The facility is now documenting the specific times that a resident, such as #29, is turned and repositioned, the position the resident was placed in at the time of the repositioning, and what, if any, supports are used to make sure that the resident was comfortable and in good body alignment when repositioned. The facility staff has been in-serviced on the need to document toileting efforts as they occur for each resident. Resident #29's care plan has been updated to include interventions such as the use of a draw/turn sheet when repositioning Resident #29, positioning devices used in bed and in wheelchair to prevent skin issues, adaptive equipment needed for positioning during showers and appropriate positioning during showers to prevent injury to skin and circulation. Please see W154 related to investigation of allegations of abuse, neglect, and injuries of unknown source for residents #2, #21, #31, #45, #54, and #56.</p> <p><u>2. How will the facility identify other residents having the</u></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 03/20/2014	
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>Staff #39's 2/28/14 witness statement indicated staff #39 "Saw him sitting Indian Style in his bed @ (at) 1 AM Wed (Wednesday) (2/27/14) morning...." Staff #39's undated witness statement indicated on 2/27/14, client #21 got up and ate dinner in his wheelchair in the dining room.</p> <p>LPN #11's 2/28/14 witness statement indicated LPN #40 "Did a skin assessment on 2-24-24, gave medications to him on Thurs (Thursday) 2-27-14- he was in bed both time (sic) (AM & mid-day med pass)...." LPN #11's 2/28/14 witness statement indicated "...he (sic) remained in bed all day shift on Thurs 2-27-14 that I am aware of."</p> <p>Staff #42's 2/28/14 witness statement indicated client #21 "walked fine" on 2/26/14 (Wednesday) when assisting the client from the bathroom.</p> <p>Staff #43's 2/28/14 witness statement indicated "...He rolls out of the bed. He seizes. He gets up without assistance and stumbles."</p> <p>Staff #44's 2/28/14 witness statement indicated on 2/26/14, she (staff #44) and staff #42 "...walked behind [client #21] to his bedroom. He kept trying to throw</p>		<p><u>potential to be affected by the same practice and what corrective action will be taken?</u> All residents who have seizures, havedysphagia or respiratory issues, have skin issues and are dependent upon staffor turning and repositioning, including during showers have the potential tobe affected. If the Administrator, DON, or any member of the IDT managementteam observes or finds a concern in any of these areas, he/she will address thesituation immediately to ensure the resident's safety and notify the DON andAdministrator if they are not already involved. Once the resident is taken careof, the Administrator will begin an immediate investigation regarding thepotential abuse or neglect that may have occurred and will report the issue tothe state agencies as required. The DON will begin re-training all staffinvolved and will address the situation with progressive disciplinary action upto and including termination of employment as deemed necessary by the resultsof the investigation.</p> <p><u>3.What measures will be put into place to ensure this practice does not recur?</u> The DON will review the focus charting, 24hour report, and physician telephone orders at least 5 days a week during eachtour of duty. She will bring that information to the morning IDT managementmeeting for review</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 03/20/2014
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>himself to the ground."</p> <p>Staff #45's 2/28/14 witness statement indicated client #21 walked to the dining room for his lunch on 2/27/14 and back to his bedroom afterwards. Staff #45's witness statement indicated client #21 had a seizure at lunch on Wednesday. The witness statement indicated client #21 "...Stayed in the table chair. Possibly hit leg on metal post under table."</p> <p>Staff #46's 2/28/14 witness statement indicated "...He (client #21) will get mad & (and) drop to the floor he will also do this after he has a seizure (sic). He gets up without any assistance & has an unsteady gait so he will sometimes stumble. Yesterday, 2-27-14, sometime between 11 am-11:30 am I was with [LPN #41] helping to try to get him up. I was originally in there by myself. He had socks on & his pull up & pants were down to his knees so I didn't see his legs. I pulled his pull up & pants up and sat him up in bed. He was wobbly & wouldn't sit up by himself so I laid him back down & went to get [LPN #41] to help me. He would not bear any weight. We lifted him into his chair. When he was in the chair he threw himself back & yelled. We caught him & put him back to bed. We covered him & turned the alarm on." The 2/28/14 witness statement</p>		<p>and discussion with the IDT. Any interventions that are formulated will be added to the care/risk plan and ISP at that time. The DON will note those changes on the CNA assignment sheets and the 24 hour report so that oncoming shifts will be made aware of the changes. The DON or designee will monitor by means of the "Staff Treatment of Residents – W149, W154, W240 & W252" audit format at least 5 days a week. The DON will bring the results of the audits to the next scheduled morning IDT management meeting for review and further discussion. Any issues will be addressed as indicated in question #2. The DON or designee will also document their response and immediate action taken on the audit form itself for those things found as not being in compliance at the time of the audit.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put in place?</u> The DON will bring the results of her audit to the monthly QA committee meeting for review and recommendations for further process improvement. Any recommendations will be followed through by the DON or designee, with results brought back to the next month's QA committee for consideration. 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 03/20/2014
--	---	--	---

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>indicated the facility did not ask if client #21 would yell when he was placed in his chair, and/or ask if client #21 was assessed for any pain/injury.</p> <p>Staff #47's 2/28/14 witness statement indicated client #21 was at the training center on 2/25/14. The witness statement indicated client #21 was "walking normally" on Tuesday.</p> <p>LPN #7's 2/28/14 witness statement indicated client #21 "Will seizure and flip his W/C (wheelchair)."</p> <p>Staff #49's 2/28/14 witness statement indicated client #21 would not get out of bed on 2/27/14. Staff #49's witness statement indicated he thought client #21 was last walked on 2/26/14.</p> <p>Staff #50's 2/28/14 witness statement indicated client #21 did not want to stand up on Thursday 2/27/14. Staff #50's witness statement indicated "Thursday he did not want to leave bed...Wed (Wednesday) morning drop down to the floor but got up and went to his room and he was fine."</p> <p>Staff #51's 2/28/14 witness statement indicated on "2/24/14 went down to see if he wanted to go to store. He refused."</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 03/20/2014
--	---	--	---

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>Staff #52's 2/28/14 witness statement indicated "He walked on Wed. after lunch to his room...I spoke with him and assisted him with getting his items for lunch...."</p> <p>Staff #53's 2/28/14 witness statement indicated client #21 "...threw himself (sat) on the floor when she (staff #53) was with him." The facility neglected to ask and/or indicate what day client #21 threw himself to the floor, and/or indicate if the client was injured.</p> <p>Staff #53's 2/28/14 witness statement indicated client #21 sat down on the floor at the dinner meal. The 2/28/14 witness statement indicated staff #55 and LPN #10 came over to help client #21 get up.</p> <p>The Housekeeping supervisor's 2/28/14 witness statement indicated client #21 was sitting on the floor on Monday (2/24/14). The witness statement indicated client #21 was "fine."</p> <p>LPN #5's 3/3/14 witness statement indicated on 2/27/14 (Thursday) a CNA (Certified Nurse Aide) asked for assistance as client #21 was not wanting to get out of bed. The witness statement indicated "...He was half way out et (and) half standing. We attempted to put him in his wheelchair when he screamed in</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 03/20/2014	
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>anger and refused. I at that time helped pull his pants (gray sweats) up over his feet as we assisted him to bed. I noted no 0 (zero) injury at that time to his feet/legs." LPN #5's witness statement neglected to indicate client #21 had a seizure on any day.</p> <p>The facility's 2/28/14 reportable incident report and/or 3/6/14 follow up report indicated the facility neglected to conduct a thorough investigation as no additional information was documented in regard to a seizure which resulted in the client's fracture. The facility neglected to re-interview staff to obtain clarification in regard to the client's ambulating with staff, not ambulating for 2 days and behaviors demonstrated. The facility neglected to include a formal conclusion with facts and/or include recommendations/corrective actions to ensure client #21's protection. The facility's 2/28/14 reportable incident report did not indicate the facility conducted/open additional investigations in regard to allegations of neglect by nursing staff in regard to the client's health, and injury of unknown source.</p> <p>-3/10/14 Client #21 was "Up in LR (living room)in g-chair. Staff stated was squirming in chair and slid out to floor. Assisted w (with) hoyer lift and taken 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 03/20/2014
--	---	--	---

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>bed. Assessment done w no new injuries noted. No redness or discoloration noted. No s/s (signs and symptoms) pain. [Name of doctor] updated- will assess when comes to facility today." The 3/10/14 IAR neglected to indicate how client #21 slid out of his chair with a fractured right leg, and/or neglected to indicate the facility initiated an investigation in regard to neglect and/or reported the 3/10/14 fall/incident to state officials.</p> <p>Client #21's record was reviewed on 3/13/14 at 2:02 PM. Client #21's 3/6/14 Discharge To Skilled Care indicated client #21 was diagnosed with a Tibia (large shin bone) and Fibula (smaller bone in leg) fracture on the client's right leg. The discharge sheet indicated client #21 had a history of falls and required "Max (maximum) assist" with transfers and "Total Dependence" with mobility. The discharge sheet indicated client #21 was not to bear weight on his right leg.</p> <p>Client #21's Final Report indicated client #21 presented with a "Spiral Fracture (twisting force fracture) of his Tibia." The discharge sheet indicated "...Was called on the morning of this patient's admission by nursing home personnel. They noted that his leg was discolored and edematous. He was taken to a local</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 03/20/2014	
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>orthopedics office for he was diagnosed as having a spiral fracture. He is admitted for definitive therapy. He was not observed to have any injury. This patient has frequent and severe seizures. It is not known whether he had a seizure or simply fell. He was put to bed last night apparently in good condition and when attempted to arouse this morning, had a swollen t (nothing else typed/part of sentence missing)."</p> <p>Client #21's 2/28/14 Report of Consultation indicated an Xray showed client #21 had a fractured Tibia and Fibula of the Left (sic) leg and required surgical treatment. The consult note indicated a splint and dressing was applied to the client's leg as client #21 was being admitted to the hospital. The 2/28/14 note indicated client #21 injured the leg "...possibly after seizure last night. Pain with weight bearing."</p> <p>Client #21's indicated the following physicians' orders (not all inclusive):</p> <p>-3/10/14 "OT (occupational therapy) recommendations per discussion (with nursing: 1) Pt (patient) to wedge cushion behind back in geri chair when up for meals. 2) D/C (discontinue) wedge cushion at all other times except meals."</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 03/20/2014	
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>-3/8/14 "P.T. (physical therapy) evaluation completed with D/C of further P.T. services at this point. P.T. to re-evaluate whenever (rt) (right) L.E (lower extremity) wt (weight)- bearing becomes FWB (full weight bearing). Pt to remain Hoyer Lift for transfers and G-chair for mobility."</p> <p>-3/7/14 "OT eval (evaluation) complete (with) d/c of OT services. Will reassess when FWB on (R) LE. PT. to remain in geri chair (with) wedge pillow & pelvic stabilizing belt."</p> <p>-3/6/14 "Lowbed, Bolster Mattress (specialty mattress to reduce gaps between mattress and side rails), 15 minute checks"</p> <p>-3/4/14 "May use low bed with alarm, floor mat, W/C for transport." The 3/4/14 signed order indicated "...Resident may wear comfort bet (sic) during waking hours as tolerated to/from dining room and bathrooms as able with comfort belt staff assist x (times) 2...." Client #21's 3/4/14 order also indicated "May use standard safety belt with buckle for pelvic stabilizer while in wheelchair during transfers between buildings, may use foot rests." Client #21's 3/4/14 physician's order indicated client #21's diagnosis included, but was not limited to "Seizure</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 03/20/2014	
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>Disorder."</p> <p>Client #21's Nursing Notes indicated the following (not all inclusive):</p> <p>-1/29/14 Client #21's doctor ordered a PT evaluation due to falls.</p> <p>-2/2/14 at 9:30 AM, "...res (resident) sitting up in LR in W/C, had seizure & fell on floor. did (sic) not hit head, seizure lasted 45 sec (seconds), res assisted up, no apparent injury."</p> <p>-2/3/14 at 8:00 AM, "Resting in bed, refusing to get up for breakfast...no distress noted."</p> <p>-2/5/14 at 8:00 AM, "...alert, up in W/C. ROM as usual, amb (ambulates) (with) steady gait, no problems noted."</p> <p>-2/7/14 at 10:30 AM, Res sitting in W/C in LR. had (sic) 30 second seizure and fell forward on the floor, seatbelt was on. res (sic) assessed, no apparent injury at this time. ROM as usual. neuro (sic) and fall flow sheet initiated."</p> <p>-2/8/14 at 4:00 PM "...No injury noted from fall...."</p> <p>-2/15/14 at 3:16 PM, Client #21's doctor and nurse practitioner were at facility 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 03/20/2014	
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>assessed the client.</p> <p>-2/27/14 "OT assessment done, no new orders."</p> <p>-2/28/14 at 8:00 AM, "Staff reported res noted to have bruising 14 cm x 7 cm bluish around heel and ankle and 15 cm x 9 cm reddish yellow on lower leg inner side, moderate swelling in foot & lower leg."</p> <p>-2/28/14 at 8:15 AM, Client #21's doctor was paged.</p> <p>-2/28/14 at 8:30 AM, "[Name of doctor] returned call, orders rec'd (received)."</p> <p>-2/28/14 at 2:00 PM, "Rec'd call from staff, res being admitted to [name of hospital] for surgery in AM D/T (due to Tib/fib fracture...."</p> <p>-3/1/14 at 3:10 PM, Facility nurse spoke with a nurse at the hospital. The note indicated client #21 had "...surgery D/T spiral FX (fracture) et compartmentalization (separation into sections). RN spoke (with) res. mother and she stated, 'he has a rod in his leg!...."</p> <p>-3/3/14 LE (late entry) at 2:00 PM, "for 2/26/14 12 n (noon) Resident noted to have seizure et slid down in wheelchair.</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 03/20/2014
--	---	--	---

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>VNS (Vagal Nerve Stimulator) magnet used with success. Head drop, body held rigid, et jerking of arms et legs noted. Footrests on W/C et resident legs under footrests. Resident uncooperative (with) sitting back or assisting (up) in W/C and walked to his room (with) the assistance of two staff. Resident alert et ambulating as usual." The 3/3/14 late entry for client #21's seizure on 2/26/14 was signed by LPN #5. The 3/3/14 late entry indicated the facility nurse neglected to assess the client's legs after the seizure and/or neglected to document the client's seizure in the client's Nurse note at the time the seizure occurred.</p> <p>-3/6/14 at 11:30 AM, Client #21 returned from the hospital. The note indicated client #21 had an "...Ace wrap in place to rt leg from mid thigh to toes...New orders rec'd for non-wt bearing on rt leg lovenox and Norco (pain medication). To use hoyer lift for transfers. To use G-chair to DR (dining room) for lunch meal..."</p> <p>-3/6/14 at 1:00 PM, "Resident had seizure...(up) in dining getting ready to eat. Body supported for injury prevention. Wedge above head in geri chair...Legs did not move off of geri chair. Head drop, eyes rolled backward, body held rigid, cyanotic, slept after seizure, face red et jerking of arms noted.</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 03/20/2014	
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>VNS used et resident coughed (after) use...." The 3/6/14 nurse's note indicated client #21's seizure lasted for 45 seconds. The note also indicated a "full body assessment" was completed and client #21 was not found to have any new injuries.</p> <p>-3/7/14 at 7:10 AM, The RN rewrapped client #21's fractured right leg. The note indicated "...Noticed the back side of (R) knee looked bruised (purple like) most likely from injury surgery...."</p> <p>-3/7/14 at 2 PM, "...OT eval completed (with) D/C of OT services. Will reassess when FWB on (R) LE. Pt to remain in geri chair (with) wedge pillow & pelvic stabilizing belt."</p> <p>-3/7/14 at 3:00 PM, "PRN (as needed) Vicodin (pain) given for S/S of pain. Facial grimacing noted. Resident up in class...."</p> <p>-3/7/14 at 4:48 PM, "resident (sic) had 13 second seizure resident attempting to get up out of Geri chair leg held steady and comfort provided resident able to be calmed and provided care by staff (sic)."</p> <p>-3/8/14 at 7:00 PM, "PT eval completed, discontinue further PT services until non-wt bearing is lifted."</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 03/20/2014
--	---	--	---

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>-3/10/14 at 12:02 AM, "resident (sic) up in bed trying climb out of bed (sic) resident attempting to climb out of bed attempting to rip of (sic) bandage to half cast resident yelling refusing VS (vital signs) resident redirected and lay back down at this time (sic)."</p> <p>-3/10/14 at 12:50 AM, "resident (sic) sitting up in bed yelling attempting to get out of bed pulling and shaking leg (R) refusing assessment PRN pain medication given and resident redirected will reattempt assessing when resident is resting (sic)."</p> <p>-3/10/14 at 1:50 AM, "resident (sic) resting in bed (with) eyes closed PRN pain medication appears to be effective...." The note indicated the nurse was able to assess the client at that time.</p> <p>-3/10/14 at 10:45 AM, "...Had 30 second seizure activity with no injuries noted, witnessed by [LPN #5] & VNS magnet was used (with) success. Up in G-chair (geri chair) to rt (right) leg up on pillow, ace wrap remains in place...."</p> <p>-3/10/14 at 1:30 PM, "Resident up in g-chair in living room and slid out of chair to the floor. Assist up with hoyer lift and taken to bed. Assessment done</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 03/20/2014
--	---	--	---

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>with no new injuries noted. No redness/discoloration. No S/S pain/discomfort noted....No seizure activity noted. Staff report resident was trying to remove wedge from behind him & was squirming around in g-chair prior to sliding out...[name of doctor] to be here today at 3 P (3:00 PM) and will assess then." The 3/10/14 nursing note did not indicate client #21 was eating at the time he slid out of the Geri chair to the floor due to the wedge pillow.</p> <p>-3/10/14 at 3:40 PM, "pt (sic) seen by MD D/T sliding out of Geri chair. 0 (zero) N.O. (new orders) at this time. MD reviewed PT/OT POC. (papers on chart) 0 N.O."</p> <p>-3/11/14 at 7:15 AM, Client #21 was asked if he was in pain, the note indicated client #21 nodded his head "yes." The note indicated client #21 was given a PRN pain medication.</p> <p>-3/11/14 at 4:10 PM, "resident (sic) given PRN pain medication grimacing and very restless...."</p> <p>-3/13/14 at 7:30 AM, "15 minute checks continue...Vicodin given for S/S pain (grimacing). Cast intact (with) ace wrap (with) toes pink in color,...."</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 03/20/2014
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 #21's Seizure Episode Record indicated the facility documented seizures on the following:</p> <p>-3/3/14 for 2/27/14 at 12 noon, the following had check marks next to them: blank stare, head drop, body held rigid, slept after seizure, other "VNS used" and jerking of arms and legs. The entry indicated the seizure occurred on 2/27/14 versus 2/26/14 which allegedly resulted in client #21's fracture. The facility neglected to document client #21's seizure on the day and time the seizure occurred.</p> <p>-3/6/14 VNS swiped/used for 45 second seizure.</p> <p>-3/10/14 VNS swiped/used for 30 second seizure. Client #21's seizure records indicated the facility neglected to document client #21's 3/7/14 seizure of 13 seconds on the seizure record.</p> <p>Client #21's 6/20/13 Individualized Support Plan (ISP) indicated the following Supports and Purposes:</p> <p>-Helmet "To prevent injury during seizure activity...."</p> <p>-Magnet "To use for VNS...."</p> <p>-"High/low bed without headboard...To prevent injury during seizure activity...."</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 03/20/2014
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>- "Mat on floor by bed...To prevent injury during seizure activity...."</p> <p>- "Bed alarm...To alert staff when [client #21] may have fallen out of bed...."</p> <p>- "Shower chair with gaitbelt & 2 staff ...To prevent injury during seizure activity...."</p> <p>- "Comfort belt...Assistance during seizure...."</p> <p>- "Weighted chair with back against the wall...To support against seizure activity...."</p> <p>- "Ambulate with comfort belt and staff assistance holding belt...."</p> <p>- "Wheelchair for longer distances...safely transport...."</p> <p>- "Self-release pelvic stabilizer...Pelvic positioning to prevent sliding forward...."</p> <p>- "Padding to table...To prevent injury during seizure activity...."</p> <p>Client #21's record and/or ISP neglected to indicate client #21 would throw himself and/or place himself on the floor. Client #21's ISP and/or record review indicated client #21's interdisciplinary team (IDT) neglected to meet and/or review client #21's falls (without and/or without seizures) to ensure the client was monitored/protected to prevent injuries and/or potential injuries.</p> <p>Client #21's 3/6/14 Interdisciplinary Care Plan (ICP) indicated client #21 had a risk</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 03/20/2014	
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>plan for his fractured tibia. The ICP/risk plan indicated 15 minute checks were to be completed by nursing. The 3/6/14 ICP also indicated client #21 was to utilize a G-chair with a pelvic stabilizer belt. The 3/6/14 ICP indicated "...1) 3-10-14 Wedge cushion when I am eating or drinking in my g/c (G-chair)...." Client #21's ICP did not indicate a wedge cushion should be utilized at other times. Client #21's 3/6/14 ICP indicated "...15) Keep my cast dry...." The ICP did not specifically indicate how facility staff were to keep client #21's cast dry when bathing, and/or how facility staff were to assist the client to bathe/shower.</p> <p>Client #21's 3/6/14 ICP for "I am @ (at) risk for sz (seizure disorder)" indicated "...3) Encourage me to wear my helmet. 4) Use my magnet (I have a VNS implant). 5) Ambulate me (with) a 2 person & gait belt. 6) Sit me in sand chair or high back arm chair. 7) Low bed (with) alarm, floor mat, bolster mattress. 8) pelvic (sic) stabilizer while in W/C (wheelchair) during transfers between buildings. May use foot rests. 9) Note time Sz started & protect me from injury. Note time Sz ends...12) Assess me for any injuries (after) Sz...14) Complete my Sz record & document in my chart. Client #21's 3/6/14 ICP, developed after client #21's fracture, neglected to indicate</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 03/20/2014	
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 #21 was to be non-weight bearing and to utilize a G-chair with a pelvic stabilizer only as his primary means of mobility.</p> <p>Client #21's 15 Minute Observation Checklist indicated 15 minute checks were started on 3/6/14 at 1:30 PM. Client #21's 3/6/14 15 minute checks indicated on 3/6/14 at 5:15 PM client #21 "Tried to shift around in chair." Client #21's 3/6/14 15 minute check sheet also indicated client #21 had a seizure at 4:00 PM. The facility provided 15 minute checks for the following days: 3/6/14, 3/9/14, 3/10/14, 3/11/14 and 3/12/14. The facility did not provide any additional documentation of 15 minute checks for 3/7/14 and 3/8/14.</p> <p>Interview with the Director of Nursing (DON), administrative staff #1 and Qualified Intellectual Disabilities Professional (QIDP) #2 on 3/13/14 at 5:25 PM indicated client #21 had a fractured Tibia. Administrative staff #1 indicated the DON was conducting the investigation in regard to client #21's injury of unknown source/fracture. The DON indicated the facility would complete a follow-up report on 3/14/14. The DON indicated the facility's investigation did not include a summary/conclusion of what happened and/or include any</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 03/20/2014
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>recommendations/corrective actions.</p> <p>When asked what happened, the DON stated "Not able to say 100%. Had fallen on 2/26/14." The DON stated client #21 fell out of his wheelchair during a seizure and the client's feet were "tangled underneath footrests." The DON indicated client #21 was put back in his wheelchair and then walked back to his bedroom. The DON indicated some staff indicated client #21 was walking fine and some said the client would not walk/bear weight. The DON indicated client #21 was put back to bed. The DON stated client #21 did not get up for supper "all day Thursday and Friday." The DON indicated she was asked to look at the client's leg and it was swollen and bruised. The DON stated it looked like the injury was "42 to 72 hours old." The DON indicated client #21 was sent out to an orthopedic doctor and the client was found to have a fracture which required surgery. The DON indicated staff had indicated client #21 consumed 100% of his lunch and supper on Thursday which indicated the client would have gone to the dining room. The DON indicated she went to review the nurse notes and found there was no documentation in client #21's record regarding a seizure on 2/26/14. The DON indicated LPN #5 did not document the seizure and the LPN was instructed to make a late entry. 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 03/20/2014	
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		
	DON stated LPN #5 indicated "She (LPN #5) was not educated on what to do with a seizure." The DON indicated LPN #5 knew where the policy book/policy for seizures was located. The DON indicated LPN #5 received disciplinary action in regard to the incident. The DON indicated nursing staff was retrained on the facility's seizure policy and what to do when a client had a seizure on 3/5/14. When asked if the facility conducted an investigation in regard to neglect, the DON indicated the facility did not conduct an investigation for neglect once the facility was aware a nursing staff did not document the seizure and/or document the client was monitored/assessed for injury. The DON indicated client #21's seizures were to be documented on the client's seizure record in the client's chart. QIDP #2 and the DON stated client #2 "normally used a wheelchair for mobility." The DON indicated client #21 was to utilize a Geri-Chair with a pelvic stabilizer when the client was in the Geri-chair. The DON stated client #21 "slid out of his chair" on 3/10/14. The DON indicated client #21 was to use the wedge pillow at meals only. QIDP #2 indicated client #21's IDT had not met to review the client's fracture and/or 3/10/14 fall since the fracture to determine how client #21 should be monitored/supervised to						

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 03/20/2014	
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>prevent further injuries/falls. QIDP #2 and the DON indicated client #21 was on 15 minute checks. QIDP #2 and the DON indicated client #21 was on 15 minute checks on 3/10/14 when client #21 slid out of his wheelchair to the floor on 3/10/14. QIDP #2 and the DON indicated client #21 continued to be on 15 minute checks. The DON indicated client #21's care plan for seizures, fall risk and fractured leg were done on 3/6/14. When asked how facility staff were to keep client #21's cast dry, the DON stated "No shower. He is getting complete bed baths." The DON indicated client #21's care plan did not specifically indicate how facility staff were to keep client #21's cast dry, and/or indicate how facility staff was to bathe/shower the client. When asked why client #21's 3/6/14 care plan indicated client #21 was a 2 person assist with a gait belt when ambulating, the DON stated "It was an error and I will change it right away." The DON stated client #21 was to be "non-weight bearing."</p> <p>2. The facility's reportable incident reports, Incident/Accident Reports (IARs) and/or investigations were reviewed on 3/11/14 at 2:26 PM. The facility's 2/4/14 reportable incident report indicated "ON (sic) 2-4-14, the resident (client #1) presented with an elevated temperature of</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 03/20/2014	
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>100 degrees. A cough was noted along with nasal congestion. Respirations were short and shallow. Oxygen saturation was 80% on room air. Wheezing was auscultated in the right upper lobe. The physician was notified and the facility received an order to transport to ER (emergency room). The hospital notified the facility later today, (sic) the resident had been admitted with a diagnosis of pneumonia...The resident had been monitored closely by the licensed staff since 1-29-14, when the resident started having a non productive cough and nasal drainage. The MD was notified and he issued no new orders. The resident was placed on focused charting by the nurses, which includes a full set of vital signs, lung assessment, etc., every shift. The resident was receiving prn Tylenol for pain/elevated temp (temperature) and prn Tessalon Perles for cough, per order. On 1-31-14, the resident had a low grade temp of 99.3 degrees. The resident remained afebrile until 2-4-14, when she was sent to the hospital...."</p> <p>The facility's 2/18/14 follow-up report indicated "The resident was admitted to the hospital on 02-04-14 with a diagnosis of pneumonia. The resident returned to the facility on 2-16-14. While at the hospital, the resident's admitting diagnosis was pneumonia 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 03/20/2014
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>hypoxemia (low oxygen levels), respiratory failure, sleep apnea...The resident returned with orders for a bi-pap to be worn at night and when she naps. The resident refuses to wear. Staff continue to encourage the resident to wear the bi-pap. The resident also returned with a 'No code' status. The guardian does not CPR (cardiopulmonary resuscitation) or incubation. The resident was released back to the facility with new medication orders of Theophylline and Diamox (Obstructive Sleep Apnea). The resident also returned on a mechanically altered diet. The resident had been on a regular diet prior to hospitalization. Speech therapy will be evaluating the resident to ensure a safe diet is provided...Since return, the resident has been up and ambulating throughout the facility ad lib. O₂ (oxygen) saturations have been between 93-96% every shift. Appetite has been between 75-100% of all meals. Lung sounds are clear. Resident has denied any pain or discomfort. Will continue to monitor and address any health concerns as they arise...."</p> <p>During the 3/13/14 observation period between 2:09 AM and 4:15 AM, at the facility, client #1 was laying on her back sleep and with her mouth open making loud sounds with intermittent silence.</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 03/20/2014	
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 #1 did not have her Bi-pap on. The Bipap machine was laying on the client's dresser next to her bed.</p> <p>Interview with staff #56 on 3/13/14 at 2:55 AM indicated client #1 was to wear her Bi-pap at night. Staff #56 indicated client #1 refused to wear the Bi-pap mask. Staff #56 indicated client #1 stated she was afraid she would die as her mother had an oxygen mask on and died.</p> <p>Client #1's record was reviewed on 3/13/14 at 11:32 AM. Client #1's 2/4/14 Admission Note/H&P (History and Physical) indicated "...patient is admitted with cough and tachypnea and hypoxia...." The H&P indicated client #1 "...had developed a cold several days ago. She does not seem to be having any distress with on the day of her admission when she awakened she was noted to be very cachectic (bad condition) (sic)...."</p> <p>Client #1's 2/16/14 Discharge Summary indicated client #1 was discharged from the hospital on 2/16/14. The Discharge Summary indicated client #1's "Discharge Diagnoses included, but were not limited to,</p> <ol style="list-style-type: none"> 1. Pneumonia. 2. Respiratory Failure. 3. Obstructive Sleep Apnea. 4. Mental Retardation with behavioral 						

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 03/20/2014
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	
W000149	<p>component.</p> <p>5. Obesity.</p> <p>6. Dysphagia...." The Discharge Summary indicated "...REASON FOR ADMISSION: The patient had an upper respiratory infection for the previous several days. and upon awakening on the day of her admission, she was found to be extremely tachypneic (r 483.420(d)(1)</p> <p>STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the 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 03/20/2014	
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>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.</p> <p>3. Observations were conducted at the facility on 3/11/14 between 3 PM and 4:30 PM.</p> <p>___ At 3:10 PM client #29 was in the west hall shower room with CNA (Certified Nursing Assistant) #1. Client #29 was nude and semi-reclined in a shower chair near the shower, not under running water. Client #29 lay at an angle in the shower chair, his head was positioned to the left side of the chair and his feet and legs dangled to the right side of the chair. Client #29 had no support for his legs or feet and his toes and fingers had a bluish/purple tint. Client #29 winced and made facial expressions, keeping his arms close to his body and across his chest each time CNA #1 touched him. Client #29 was asked "Are you ok?" Client #29 stared at CNA #1 and made no verbal response and continued to wince. CNA #1 reached beneath and under client #29's chair to wash his buttocks. CNA #1 could not see what she was wiping while doing this and when CNA #1 pulled her hand up from under client #29's shower chair, the wash cloth had bright red blood on it. CNA #1 was asked, "Is that blood?" and "Where did that come from?" CNA #1 stated, "It's blood and I don't know why</p>	W000149	<p><u>1. What corrective action will be done by the facility?</u> Resident #21 remains in a reclining geri-chair with a pelvic stabilizing belt. A wedge is used behind his back for meals. He has a care/risk plan with interventions relating to his current level of mobility, as well as interventions for prevention of future injuries. A mechanical lift with assistance of 2 staff is being used for all transfers. The staff has been trained on bathing the resident while keeping the cast dry. The nurse who did not assess Resident #21 after his seizure and did not document the seizure has received disciplinary action. The nurses will be re-trained on assessment after injuries and documentation of unusual events, such as seizures. In addition, staff has been re-trained on the expectation of complete documentation on all documents, including the 15 minute checks. The Administrator has developed and is using a different format for investigations that includes different sections to be taken under consideration when doing an investigation in an attempt to improve the depth and content of any investigation that is done, including those of allegations of neglect abuse, and/or injuries of unknown</p>	04/19/2014			

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 03/20/2014	
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>he's bleeding." CNA #1 indicated she was not aware of client #29 having any skin issues, open sores and/or dressing on him at the time of the shower and stated, "When I'm done, I'll have to have the nurse look at him."</p> <p>__At 3:20 PM CNA #1 and CNA #3 used a mechanical lift and put client #29 back in bed. A pull sheet was not on the bed prior to client #29 being put in the bed. Without a pull sheet on the bed, CNA #1 and CNA #3 pulled client #29 from side to side, one hand on his bottom and one hand on his shoulders, pulling and rolling him from side to side to position him.</p> <p>__At 3:25 PM LPN #8 removed the remainder of the dressing that was on client #8's bottom and said, "He [client #29] has a gluteal fold (also known as the buttocks crack) tear. We've been retraining everyone to use the turn sheets to turn him from side to side." LPN #8 indicated client #29's gluteal tear was caused by staff physically pulling on client #29's buttocks to turn him from side to side and from the friction of the sheets. Client #29 had a small open area that was bleeding and a larger area that was older and pink in color. LPN #8 left the room to get a dry dressing.</p> <p>__At 3:29 PM, the LPN returned. CNA #1 rolled client #29 to his left side and LPN #8 applied a new dressing to his gluteal cleft.</p>		<p>source. The content of the new investigation tool contains such things as: synopsis of the event, including specific details of the event itself and those who were involved in it or witnessed it; employees, residents, and other people interviewed; any identification of abuse or neglect and any necessary follow up done at that time; medical records reviewed; personnel records reviewed; chart/care plan review; employee time cards reviewed; other pertinent documents reviewed; physical evidence reviewed; summary of event based on results of interviews, document reviews, and physical evidence; conclusion based on evidence that supports the conclusion of the investigation. Changes in residents' conditions, including physician telephone orders are brought by the DON to the morning interdisciplinary management meeting which occurs at least 5 times a week for review by the IDT (interdisciplinary team) and development of recommendations and interventions to meet the residents' condition changes. The QIDPs attend this meeting and will update their records and care/risk plans to address the residents' change in status as had been done with Resident #21. Resident #1 continues to refuse to use her Bi-Pap. The respiratory</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 03/20/2014
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>__ During this observation, CNA #1 did not provide client #29 privacy/dignity. CNA #1 did not use a bath blanket or towel to provide client #29 privacy, dignity and warmth while showering the client. CNA #1 did not ensure the client was positioned appropriately in the shower chair and did not ensure client #29's body temperature and circulation were maintained during the shower process.</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 3/11/14 at 2:36 PM.</p> <p>__ The 12/2/13 report indicated "[LPN #6] reported [client #29] had a stage 2 pressure ulcer to left lower buttock. No exudate (lesions or areas of inflammation), tunneling (channels of a wound which extend into subcutaneous tissue or muscle), or depth was noted. Area measured 3 cm (centimeter) x 1 cm. No signs or symptoms of distress were noted...The resident has a pressure relieving mattress on his bed and cushion in his wheelchair. The resident is only up for meals. The current treatment is Bactroban (antibiotic cream) every shift until healed. Weekly skin checks by licensed staff and skin checks by nurse aides on shower days are conducted...."</p> <p>__ The 12/9/13 report indicated the</p>		<p>services vendor has been contacted once and brought a different mask for the resident to use. She continues to refuse the use of this new mask, so the vendor has been contacted again to see if there is any other alternative that might be acceptable to the resident. These efforts are documented in the resident's clinical record. Resident #1 is on 15 minute checks during naps and at night, so that staff can assess her respiratory status as she sleeps. Her lung sounds, oxygen saturation levels, and temperature are being assessed every shift and documented in the clinical record. The physician will be notified if the assessment results in a concern related to her current status. Her ISP has been updated to address the resident's refusal to wear the Bi-Pap mask, and a care/risk plan has been developed for her dysphagia and to show the interventions and monitoring that staff is doing when the resident is sleeping and napping. A care plan has been developed regarding the resident's dry skin issues and related treatment. Her dry skin issues have improved at this time. The CNAs and nurses have been instructed on the use of a draw/turn sheet to turn Resident #29 from side to side without adding undo pressure or stress to his gluteal area. Nursing staff has been instructed 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 03/20/2014	
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>pressure ulcer was discovered on 12/2/13 and a head to toe assessment was conducted during his shower on 11/29/13. The report indicated client #29 was repositioned and turned every 2 hours and documented on the client's CNA ADL flow sheet. The follow-up report indicated client #29 is "...non-ambulatory and requires Hoyer Lift transfer in an out of bed and wheelchair...The resident was sleeping on a pressure relieving mattress at the time the area was found. A new specialty mattress was ordered and is in place on the resident's bed. The resident sits in a cushion wheelchair with a cushion in the seat...." The follow up report indicated client #29 had not had a pressure ulcer in the past year. The follow up report indicated facility staff were trained on "decub care prevention" on 10/7/13.</p> <p>Client #29's record was reviewed on 3/13/14 at 6 PM. Client #29's record indicated diagnoses of, but not limited to, Alzheimer's Disease, Arthritis, Right Sided Hemiplegia (paralysis of one side of the body) and Deep Vein Thrombosis (a blood clot in a major vein). Client #29's record indicated client #29 used a wheelchair for mobility, a Hoyer lift for transfers and required staff assistance for all mobility, repositioning, toileting and bathing. Client #29's record indicated a</p>		<p>providing privacy during showers for all residents, including #29, as well as identifying and using the correct size shower chair for each resident. Thenurses have been re-in-serviced on the need for complete documentation of medications and treatments as ordered by the physician. The facility is now documenting the specific times that a resident, such as #29, is turned and repositioned, the position the resident was placed in at the time of the repositioning, and what, if any, supports are used to make sure that the resident was comfortable and in good body alignment when repositioned. The facility staff has been in-serviced on the need to document toileting efforts as they occur for each resident. Resident #29's care plan has been updated to include interventions such as the use of a draw/turn sheet when repositioning Resident #29, positioning devices used in bed and in wheelchair to prevent skin issues, adaptive equipment needed for positioning during showers and appropriate positioning during showers to prevent injury to skin and circulation. Please see W154 related to investigation of allegations of abuse, neglect, and injuries of unknown source for residents #2, #21, #31, #45, #54, and #56.</p> <p><u>2. How will the facility identify other residents having the</u></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 03/20/2014	
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>history of skin breakdown, recurring gluteal tears and issues with skin integrity. Client #29's record indicated:</p> <p>Client #29's 9/12/13 Assessments Of Other Skin Abnormalities indicated "Open area to coccyx 3 cm (centimeter) x 3 cm x 0.2." The assessment form indicated the area was excoriated and gaulded. The 9/12/13 assessment indicated the area on 9/20/13 was at "...2 cm x 0.2 cm. Tx (treatment) continues et (and) appears to be effective." The assessment indicated on 9/27/13. "Area healed."</p> <p>Client #29's 12/2/13 Weekly Pressure Ulcer/Deep Tissue Injury Assessment indicated client #29 had a stage 2 pressure ulcer which measured 3 cm x 1 cm. The 12/2/13 form indicated a PUSH Tool (Pressure Ulcer Scale for Healing Tool) score of 6. The form indicated on 12/9/13 client #29's pressure ulcer was still a stage 2 but measured .6 cm x .2 cm x .1 (depth). The assessment indicated no tunneling, undermining and/or exudate was present. Client #29's 12/16/13 weekly assessment indicated the area was healed and the nurses would continue to monitor for 2 more weeks. The 12/23/13 assessment indicated "No area healed (sic)."</p>		<p><u>potential to be affected by the same practice and whatcorrective action will be taken?</u> All residents who have seizures, havedysphagia or respiratory issues, have skin issues and are dependent upon staffor turning and repositioning, including during showers have the potential tobe affected. If the Administrator, DON, or any member of the IDT managementteam observes or finds a concern in any of these areas, he/she will address thesituation immediately to ensure the resident's safety and notify the DON andAdministrator if they are not already involved. Once the resident is taken careof, the Administrator will begin an immediate investigation regarding thepotential abuse or neglect that may have occurred and will report the issue tothe state agencies as required. The DON will begin re-training all staffinvolved and will address the situation with progressive disciplinary action upto and including termination of employment as deemed necessary by the resultsof the investigation.</p> <p><u>3.What measures will be put into place to ensure this practice does not recur?</u> The DON will review the focus charting, 24hour report, and physician telephone orders at least 5 days a week during eachtour of duty. She will bring that information to the morning IDT managementmeeting for review</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 03/20/2014
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 #29's Treatment Records (TRs) indicated:</p> <p>__ In September 2013, client #29 received Bactroban for an open area to his coccyx on 9/13/13. The 9/13 TR indicated client #29 received Clotrim/Beta Cream topically to lower abdomen fold and groin area "as a palliative measure due to gaulding."</p> <p>__ In October 2013, client #29 continued to receive Bactroban for treatment of the open area to the client's coccyx. The TR indicated client Clotrim/Beta cream was being used as a PRN (as needed) ointment for skin issues.</p> <p>__ In November 2013, client #29's Bactroban for his coccyx was discontinued on 11/24/13. The TR indicated client #29 continued to be treated for gaulded areas on his lower abdomen/groin and received Lotrimin Cream two times a day for his left arm pit gaulding.</p> <p>__ In December 2013, client #29 received treatments for a gluteal cleft and Bactroban to his left lower buttock every shift until healed.</p> <p>Client #29's 2014 physician's orders indicated the following (not all inclusive):</p> <p>__ 1/15/14 "Duoderm to Gluteal Cleft (groove between the buttock which runs below the sacrum to the perineum) Q</p>		<p>and discussion with the IDT. Any interventions that are reformulated will be added to the care/risk plan and ISP at that time. The DON will note those changes on the CNA assignment sheets and the 24 hour report so that oncoming shifts will be made aware of the changes. The DON or designee will monitor by means of the "Staff Treatment of Residents – W149, W154, W240 & W252" audit format least 5 days a week. The DON will bring the results of the audits to the next scheduled morning IDT management meeting for review and further discussion. Any issues will be addressed as indicated in question #2. The DON or designee will also document their response and immediate action taken on the audit form itself for those things found as not being in compliance at the time of the audit.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of her audit to the monthly QA committee meeting for review and recommendations for further process improvement. Any recommendations will be followed through by the DON or designee, with results brought back to the next month's QA committee for consideration. 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 03/20/2014	
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>(every) 3 days et (and) PRN (as needed) x (times) 15 days to open areas." ___ 12/2/13 "Bactroban to left buttock every shift for pressure ulcer until healed." ___ 12/2/13 "Bactroban to gluteal cleft every shift for gluteal split until healed." ___ 2/7/14 "Granulex to buttocks twice daily for 14 days." ___ 2/27/14 "Discontinue Granulex. Opsite cover to... gluteal fold after placement of Bactroban." ___ 3/14/14 "Mupirocin Cream - Apply topically to gluteal cleft every shift for gluteal spilt. Mupirocin Cream -Apply topically to left buttock every shift for pressure ulcer until healed."</p> <p>Client #29's Nurses Notes indicated the following (not all inclusive): ___ 9/12/13 Client #29 "has open area to coccyx 3 cm x 0.2 cm. No S/S (signs/symptoms) of pain or distress noted. Staff educated on turning patient..." ___ 9/27/13 "Area to coccyx noted on 9-12-13 healed. Skin sheet stopped." ___ 12/2/13 "Resident has a stage 2 pressure ulcer to left lower buttocks. No depth or tunneling noted. No exudate noted. Area is 3 cm x 1 cm. Resident has a gluteal split to gluteal cleft. T (temperature) 98 PR (pulse rate) 72-16 BP (blood pressure) 122/74. Resident</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 03/20/2014
--	---	--	---

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>resting in bed. DON (Director of Nursing) assessed area...Treatment initiated for Bactroban to both areas...No signs or symptoms of distress noted." __12/3/13 "...Res (resident) is up only for meals to relieve pressure Tx to coccyx et buttock done per MD order...." __12/4/13 "...Open area remains to buttock and coccyx. 0 (zero) distress noted. Currently resting in bed. Turned per staff." __12/5/13 "...Open area remains to buttock (with) continuing treatment...." __12/6/13 "...Open areas to buttocks remain with no drainage noted. Tx applied. No s/s of pain or discomfort...." __12/7/13 "...Open areas remain to buttocks. Tx continues et appears effective." __12/9/13 "Area on lower (L) (left) buttock has now separated into 2 superficial areas. Area A measures 0.6 x 0.2 x 0.1. Area B measures 0.6 x 0.2 x 0.1. Epithelial (tissue that covers the whole surface of the body) tissue present in center of wound. 0 drng (drainage). 0 odor. Tx cont's (continues). Flovent mattress present on bed. Res (up) for meals only. Turned & repositioned q (every) 2 (hours) when in bed. Res. expresses 0 sx (symptoms) of pain. Res. incont (incontinent)of B&B (bowel and bladder). Incont care provided (after) each incont episode. Res. checked for</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 03/20/2014
--	---	--	---

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>incont q 2 (hours) & prn/ Will cont. to monitor." __ 12/10/13 "...Open area remains to (L) buttocks (with) 0 drainage. Tx continues et appears effective." __ 12/11/13 "...Area remains to lt (left) buttocks, tx completed as ordered...." __ 12/12/13 "...Tx to inner buttocks et (L) buttocks continues. Healing appropriately (with) 0 drainage." __ 12/13/13 "Area to inner buttock remains open 0.2 cm scab intact to (R) buttocks. Tx continues." __ 12/13/13 "...Resident resting in bed. Tx applied to buttocks area. healing (sic) with no signs and symptoms of infection noted." __ 12/14/13 "...Area to L buttock remains...." __ 12/15/13 "...Area to left buttocks remain and Tx applied. No s/s of infection or drainage noted...." __ 12/16/13 at 12:20 AM, "...Area to left buttocks remains with no s/s of infection...." __ 12/16/13 at 3:27 PM, "...Area to buttocks is healed. No s/s of pain/distress noted." __ 12/17/13 "...Area to Buttock healed...." __ 12/18/13 "...Area to buttocks healed...." __ 12/19/13 "...Tx continues to buttocks. (Down) for bedrest...." __ 12/20/13 "...Area to buttocks healed...." __ 12/24/13 "...Area to buttocks remains</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 03/20/2014
--	---	--	---

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>healed." __ 12/15/13 "...Area to buttocks remains healed." __ 12/26/13 "...Buttocks remain healed." __ 12/27/13 "Skin flow sheet initiated 12/5/13 resolved." __ 1/15/14 "[Name of doctor] here, Assessed Gluteal Cleft (with) new orders noted." __ 1/15/14 at 11:40 AM, 60 day review completed by MD. 0 new N.O. (new orders) at this time." __ 2/25/14 "Skin assessment completed. 1.5 cm x 0.1 cm and 0.5 cm x 0.1 cm __ 2/26/14 "Split to coccyx 0.7 cm x 1.5 cm. Tx (Granulex) applied. Area healing." __ 2/27/14 "Tx applied to buttocks...." __ 2/27/14 "[Name of doctor] updated of condition. New orders noted for Bactroban with Opsite." __ 2/27/14 "OT (Occupational Assessment) completed to ensure hips are placed all the way back in w/c (wheelchair) when transferred and up." __ 2/28/14 "Tx done to gluteal cleft, area pink, healing...." __ 3/1/14 "...Tx to gluteal area continues...." __ 3/2/14 "Tx remains in place for area to gluteal area. No s/s of pain or distress noted. Specialty mattress in place. Res (resident) repositioned q 2h (every two hours)."</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 03/20/2014
--	---	--	---

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>__3/3/14 "Area to gluteal cleft remains...."</p> <p>__3/4/14 "Open area remains to buttocks...."</p> <p>__3/4/14 "Seen by [name of doctor], 60 day review done, no new orders."</p> <p>__3/5/14 "Open area to buttocks remains...."</p> <p>__3/6/14 "Open area remains to coccyx...."</p> <p>__3/7/14 "Open area remains to coccyx. No drainage noted. No s/s of pain or distress noted."</p> <p>__3/8/14 "Open area remains to coccyx area, no redness or drainage noted, tx continues."</p> <p>__3/9/14 "Resident resting in bed area to coccyx remains and tx continues...."</p> <p>__3/10/14 "Open area remains to buttocks/coccyx.... MD reviewed labs...."</p> <p>__3/11/14 3 "Tx completed to buttocks after shower complete area noted as bleeding slightly. No s/s of infection noted."</p> <p>__3/12/14 "Remains open area on buttocks. Applied Bactroban and dressing...."</p> <p>__3/13/14 "Area remains to buttocks. No s/s of pain or distress noted. Dressing remains intact."</p> <p>Client #29's 12/2/13 Episodic Care Plan Open Area indicated client #29 was being treated for a stage 2 pressure ulcer and 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 03/20/2014	
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>gluteal split "which was along the client's middle part of the buttock (crack)." The Episodic care plan indicated: "#1 Pressure Ulcer #2 Gluteal Split Site: #1 lower left buttock Size: 3 cm x 1 cm Stage:2 Appearance: Pink Site: #2 gluteal cleft Size: 5 cm x 0.1 cm Stage: 0 Appearance: Long Split to gluteal cleft (non pressure)...Will have s/s of healing without complication by 12/9/13. Keep area clean & dry. Keep off affected area as much as possible. Change position at least every 2 hours... Pressure relieving mattress Dc'd (discontinued) 12-5-13. Devices for pressure relief to feet & other areas. Cushion in W/C (wheelchair). Diet as ordered... Monitor for s/s infection (fever, drainage, odor, color change, etc.) Monitor site every shift. Notify MD as needed with status changes. Tx as ordered by MD. Universal Precautions. Other: Up for meals only Specialty mattress on bed 12/5/13. DON to do weekly assessment &</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 03/20/2014
--	---	--	---

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>PUSH Score</p> <p>Weekly skin checks on shower days."</p> <p>Client #29's 2/27/14 IDT (Interdisciplinary) Care Plan indicated "I'm [client #29] at risk for skin breakdown. I have very limited sensory perception. I'm occasionally moist. I have limited physical activity, I need assistance to change position. I'm at risk for friction and shearing.... Staff will turn and reposition at least q (every) 2 hours. Staff will toilet me [client #29] routinely and keep me clean and dry. I have a pressure relieving mattress and pressure relieving cushion in my chair. Complete my weekly skin assessment. My [client #29] Braden assessment is completed quarterly. Notify my doctor of any change in my condition. I receive Arginaid (a nutritional supplement) with meals."</p> <p>Client #29's 3/11/14 Episodic Care Plan Open Area indicated client #29 was being treated for a "slit/gluteal fold 0.2 x 1.0 wide and 0.2 deep" The Episodic care plan indicated the following:</p> <p style="padding-left: 40px;">"Keep area clean & dry. Keep off affected area as much as possible. Change position at least every 2 hours... Pressure relieving mattress.</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 03/20/2014	
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>Diet as ordered. Medications as ordered for wound healing. Monitor for s/s infection (fever, drainage, odor, color change, etc.). Monitor site every shift. Notify MD as needed with status changes. Tx as ordered by MD. Universal Precautions. Staff to assist in repositioning with special attention to this area."</p> <p>Client #29's physician's orders for February/March 2014 indicated client #29 was to have Opsite (a transparent waterproof dressing) to the area on his gluteal fold twice a day after placement of the Bactroban for a gluteal tear. Client #29's TR indicated nursing services failed to ensure the Opsite was applied in the AM on March 5 and 12, 2014 and in the PM on March 5, 6, 7, 10 and 11, 2014.</p> <p>Client #29's 2013/2014 Treatment Records (TRs) indicated client #29 was to be repositioned every two hours. Client #29's March TR indicated the staff were to "Turn/Reposition Q (every) 2 hours I-Independent, D=Dependent and A=Assist on the even hours..." The form indicated the facility staff documented the client's repositioning once per shift; "NOCS (night shift), DAYS and EVES"</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 03/20/2014
--	---	--	---

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 #29's TRs for January, February and March 2014 indicated the facility staff did not reposition and/or document client #29 was repositioned every 2 hours on DAYS for January 1, 4, February 6, 19, 26, March 4, 5 and 11, 2014 and on EVES for January 2, 5, 6, 7, February 14, 19, 28, March 1, 2, 6 and 7, 2014. The facility's method of documentation provided no verification of specific times of when the client was repositioned, the position the client was placed in at time of repositioning and what supports were used or required to ensure the client was comfortable and in good body alignment with no pressure areas.</p> <p>Client #29's BEDREST/BLADDER Records for January and February 2014 indicated client #29 was to be toileted every two hours. The records indicated the facility staff did not toilet client #29 every two hours on January 1, 6, February 1, 5, 6, 11, 12, 17, 19, 23 and 28, 2014.</p> <p>Client #29's Episodic Care Plans and IDT Care Plan for skin issues failed to include the use of the turn sheet and what positioning supports that were to be used to position client #29 while in his bed and/or wheelchair to prevent recurring skin issues. Client #29's care plans failed to include the adaptive equipment needed for positioning while showering and how</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 03/20/2014
--	---	--	---

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>the staff were to position client #29 while showering due to the client's history of skin breakdown, gluteal tears and circulatory issues.</p> <p>Interview with CNA #1 on 3/11/14 at 3:20 PM indicated she was the shower aide. CNA #1 stated there were 3 shower chairs of different sizes and the one she had used for client #29 was the largest one and the one she "grabbed at the time" to use for client #29's shower. CNA #1 indicated the chair did not provide support for client #29's legs while showering. CNA #1 stated, "This is how I always shower the clients."</p> <p>During interview with the DON (Director of Nurses) on 3/11/14 at 12 PM, the DON indicated all clients with skin integrity issues and were cited at the annual recertification of 1/15/14 through 2/3/14 now have IDT care plans to address skin integrity and the nurses are to do daily assessments/documentation of the skin issues until the areas were healed and the DON would do a weekly assessment.</p> <p>During interview with the DON on 3/13/14 at 4:30 PM, the DON indicated all clients that were unable to reposition themselves were to be repositioned every two hours on the even hour and then the staff would initial one time in the TAR</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 03/20/2014
--	---	--	---

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>(Treatment Administration Book) for the 8 hour shift to signify the repositioning was done every two hours on the even hours. The DON was asked how do you know what position the staff placed the client in at what time and what supports were used to maintain body alignment and to reduce pressure areas. The DON indicated specific times and position were not documented. The DON stated "The nurses are supposed to check to make sure all clients were being repositioned." The DON was asked how can the nurses know every client's position and in what position they were in two to four hours prior to know the clients were being provided adequate repositioning and supports unless the nurse checked the clients every two hours and the nurse or the staff documented the time, the position the client was in and the supports that were used to ensure the client was in good body alignment without any pressure areas. The DON again indicated the nurses are supposed to check to make sure the clients are being repositioned. The DON indicated the staff (the CNAs and the nursing staff) did not document specific positioning of the clients in the records. The DON indicated the CNAs initialed once per shift to signify the turning was being done every two hours on the evening shift. The DON indicated client #29's skin integrity care plan</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 03/20/2014	
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>indicated the client was to be turned every two hours on the even hours. The plan did not include specific directions to the staff as to the supports needed to ensure correct body alignment and to ensure no pressure areas to the client.</p> <p>During interview with the DON on 3/13/14 at 6 PM, the DON indicated the CNA/shower aide should have been aware of client #29's skin condition prior to bathing him. The DON indicated the CNAs were to provide every client with privacy while showering by covering the clients with a towel or bath blanket and uncovering sections of the client's body at a time. The DON indicated clients were to be positioned comfortably into the shower chairs prior to the procedure and provided privacy, dignity and comfort throughout the process. The DON stated the CNAs "need to be retrained" in the proper technique of bathing a client.</p> <p>The facility's policy and procedures were reviewed on 3/11/14 at 1:37 P.M. The facility's 9/10 policy entitled Resident Mistreatment, Neglect, Abuse & 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</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 03/20/2014
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>involuntary seclusion." The 9/10 policy defined Neglect 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 of resident care and services to assure that care is provided as needed by the residents...."</p> <p>This federal tag relates to complaint #IN00135402.</p> <p>This deficiency was cited on 2/3/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(a)</p>				