

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 06/01/2012
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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W0000	<p>This visit was for investigation of complaint #IN00108110.</p> <p>Complaint #IN00108110 - Substantiated, no deficiencies related to the allegation(s) are cited.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: May 31 and June 1, 2012.</p> <p>Facility Number: 000614 Provider Number: 15G068 AIMS Number: 100272120</p> <p>Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 6/8/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, for 1 of 3 sampled clients (client B), the Condition of Participation of Client Protections was not met as the facility neglected to implement their neglect policy to ensure client B was monitored according to her fall risk plan to ensure she was not injured while walking without assistance.</p> <p>Findings include:</p> <p>Please refer to W149. The facility failed to implement their neglect policy, for 1 of 3 sampled clients (client B). The facility neglected to ensure client B's fall risk plan was followed to prevent an injury which resulted in a fracture requiring hospitalization and surgical repair of the fracture.</p> <p>3.1-28(a)</p>	W0122	<p>W122 Client Protections The facility has been diligent in its efforts to protect the welfare and dignity of all residents of the facility. Inherent in the philosophy of the ICFMR regulations residents are to be allowed the freedom to move about in their home with as little restriction as possible. The facility has utilized numerous interventions to minimize the risk of injury to residents while still affording them the opportunity to move about freely in their home, the freedom to interact with peers who share their home and to afford them privacy and independence. The facility has also provided on-going in-service to staff to minimize the risk of injury to residents from falls. See response at W149 related to resident B injury sustained on 5/3/12.</p>	07/01/2012

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W0149	<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>Based on record review and interview, the facility failed to implement their neglect policy, for 1 of 3 sampled clients (client B). The facility neglected to ensure client B's fall risk plan was followed, to prevent an injury which resulted in a fracture that required hospitalization and surgery for repair of the fracture.</p> <p>Findings include:</p> <p>On 05/31/12 at 10:24 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>05/03/12: A BDDS report submitted 05/04/12 for an incident on 05/03/12 at 7:00 PM indicated the following regarding client B: "Resident sent to [name of hospital] ER (Emergency Room) for evaluation of right leg. Resident had been assisted to room by staff to assist in preparation for bed. At 7:00 PM nursing was notified that resident was on floor in room complaining of right leg pain. Nursing immediately assessed, notified MD</p>	W0149	<p>W149 It is the policy of the facility to develop and implement written policies and procedures to prohibit mistreatment, abuse or neglect of a resident, including implementation of measures to protect residents who are at risk of falls. On 5/3/12 resident B was on her bed after staff had assisted her to her room from the Training Center. The staff person who assisted resident B stayed with her and monitored her ambulation with rolling walker from her classroom until she was in her bed. Her pajamas were laid out and the staff that assisted her left resident B in her room to assist another resident. The staff person did indicate that she forgot to arm the bed alarm. There was no intent or carelessness noted as staff person followed the fall risk strategies until resident B was in her bed. The staff involved was thanked for her honesty related to the bed alarm. She was given disciplinary action and is not employed at this time related to her own personal needs. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The staff person involved was provided with disciplinary action for not arming</p>	07/01/2012	

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	<p>(Medical Doctor) and order received to send for further evaluation. Resident assessed and diagnosed with fracture to right femur and surgery scheduled."</p> <p>05/11/12: A BDDS follow-up report dated 05/11/12 indicated, "This is a follow up report, related to [client B's] admission to [hospital] for evaluation of right leg pain. She has returned home after successful surgery to her right femur...She underwent surgery to maintain via nailing (sic)...Just prior to her fall resident had been assisted to room by staff to assist in preparation for bed...Once they arrived in her bedroom staff assisted her in getting her pajamas out and turned her bedcovers down. She was in bed when the staff left to assist other residents. Staff was providing the required level of supervision for [client B], as staff remained with her as she walked from her training room to her bedroom until she was in bed, but forgot to activate the bed alarm. Approximately, 10 minutes after [client B] retired to bed nursing was notified that resident was on floor in room near bed, complaining of right leg pain. Resident stated she fell. It is possible that she stepped in some food as there was a scant amount of food present near her bed where she fell but it is not clear is this caused her to fall...".</p>		<p>the bed alarm. Resident B has moved to a room closer to the nurse station and now has a different bed alarm that activates automatically when resident B lies down and eliminates the potential for human error of forgetting to arm the alarm. When resident B is in her bed she has a staff person assigned to remain in close proximity to her room should she attempt to get up. Staff will be re-trained for each resident who has a fall risk plan. How will the facility identify other residents having the potential to be affected by the same deficient practice? The facility has assessed all residents for fall risk, and thus is able to identify those residents with the potential to be affected by this practice. What measures will be put in place or what systemic change will the facility make to ensure that the deficient practice does not recur? Efforts will be made to keep the environment clear of any obstacles that may contribute to a resident fall. Bed alarms will be monitored by management staff during random checks to ensure they are working properly and being used properly. During Administrative Rounds program areas are checked for open egress, and to assess if staff monitoring is in place in accordance with fall risk plans. The results of the Administrative rounds and the bed alarm checks</p>				

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	<p>05/18/12: A BDDS follow-up report dated 05/18/12 indicated, "...Prior to the fall [client B] was able to ambulate independently with a rolling walker. Staff were present with her when she ambulated in order to provide verbal prompts. She generally has not initiated waking (sic) with-out (sic) staff in the past but on occasion may have gotten up to get an item...The staff who assisted her to bed that evening was staff member [name]. She was given disciplinary action and was off work until disciplinary action and re-training occurred. [Staff] is no longer employed here at this time."</p> <p>05/04/12: Investigation Interview with staff #1 indicated, "She stated she assisted [client B] and [client E] over to the main facility at approximately 7:20 PM. She left [client E] in Program A and then walked with [client B] from Program A to her room. She indicated that [client B] appeared to (sic) ambulating as usual which I questioned her about this. [Staff #1] indicated that when she arrived in [client B's] room that she assisted her getting her pajamas out and helped [client B] onto her bed. She also turned down [client B's] covers. She stated that she forgot to turn on [client B's] bed alarm. I told her I appreciated her honesty. We discussed how important it is to do a mental checklist prior to leaving a</p>		<p>will be reviewed at the next scheduled morning management meeting for identification of any unsolved issues and to make sure that any needed correction is put in place as soon as possible.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur, and what quality assurance measures will be used to monitor the effectiveness of the interventions? The Administrator will bring the results of the Administrative Rounds to the QA Committee. The Administrator and Department managers will follow through on any recommendations given and will report the results of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.</p>		

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	<p>resident. She indicated that she did not work with [client B] at bedtime very often and that might have been why she forgot...."</p> <p>Client B's records were reviewed on 05/31/12 at 1:45 PM. Client B's record review included review of the following dated documents:</p> <p>04/13/11: Episodic Care Plan Falls document indicated client B was assessed as at high risk for falls and her adaptive equipment included a roller walker and bed alarm.</p> <p>01/12/12: ISP (Individualized Service Plan) indicated client B's fall risk plan was as follows:</p> <ol style="list-style-type: none"> 1. Train Safety Goal daily. "Use walker when walking." 2. Use wheelchair to transport. 3. May be in class in a chair with staff present in the room. 4. May walk with walker with staff beside her. 5. Staff must accompany her to the toilet. 6. Take her to the toilet about every 2 hours or more frequently if she asks. 7. Bed alarm when in bed. 8. Keep a staff on east ends on midnights. <p>These are the guidelines developed by the Interdisciplinary Team (IDT).</p>						

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	<p>03/29/12: Episodic Care Plan Falls document indicated the cause of the fall was, "missed chair." "Remind/encourage res[ident] to 'look for' chair prior to being seated."</p> <p>05/2012: Physician Orders indicated an order for, "ambulation with rollator (walker) with staff to provide verbal cues to slow pace to (sic) safety." "Bed Alarm."</p> <p>05/04/12: Progress Notes indicated, "IDT reviewed nursing notes dated 5/3/12. At 7:00 PM, 5/3/12 [client B] had crossed over from Training Center. Staff assisted [client B] to her room and set [client B's] pajamas on the bed and left [client B] alone. [Client B] attempted to dress herself and fell, breaking her leg."</p> <p>The agency policy dated 05/2012 on "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property" was reviewed on 05/31/12 at 11:00 AM. The policy indicated neglect was defined: "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>						

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	<p>On 05/31/12 at 3:45 PM, an interview was conducted with the DON (Director of Nursing). The DON indicated client B was at risk for falls and had physician orders for a roller walker. The DON indicated staff was to be with her and a bed alarm was used when the client was in bed. She also indicated staff #1 neglected to follow client B's fall risk plan when she failed to activate the bed alarm. The lack of alert to the staff resulted in client B's fall which resulted in a fracture requiring surgical intervention.</p> <p>3.1-28(a)</p>			