

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  04/10/2013
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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W000000	<p>This visit was for a PCR (Post Certification Revisit) to the PCR completed on 2/25/13 to the investigation of complaint #IN00119541 completed on 12/11/12.</p> <p>This visit was done in conjunction with a PCR to a pre-determined full recertification and state licensure survey completed on 2/25/13.</p> <p>Complaint #IN00119541: Not Corrected.</p> <p>Dates of Survey: 4/3/13, 4/4/13, 4/5/13, 4/8/13, 4/9/13 and 4/10/13.</p> <p>Facility number: 000614 Provider number: 15G068 AIM number: 100272120</p> <p>Surveyors: Keith Briner, Medical Surveyor III- Team Leader Kathy Wanner, Medical Surveyor III (4/3/13)</p>	W000000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Hickory Creek at Gaston desires this Plan of Correction to be considered the facilities Allegation of Compliance	

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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	<p>to 4/5/13 and 4/8/13) Susan Reichert, Medical Surveyor III (4/3/13 to 4/5/13 and 4/8/13)</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2. Quality Review completed 4/12/13 by Ruth Shackelford, Medical Surveyor III.</p>			

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, interview and record review, for 1 of 10 sampled clients (#57), the facility failed to provide ongoing client specific training which enabled employees to perform duties effectively and competently in regards to wheelchair positioning, transferring, monitoring, and supervision of client #57 to prevent further injury to his legs.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/3/13 at 12:26 PM. The review indicated the following:</p> <p>-BDDS report dated 4/3/13 indicated, "4/2/13 at 5:45 PM, staff were assisting to transport [client #57] in wheelchair. [Client #57's] left leg slipped off foot box and bumped another resident's wheelchair causing an open area. Nursing assessed and immediately applied pressure and notified MD (Medical Director). Orders received to send [client #57] to ER (Emergency Room) for evaluation and treatment. At 10:50 PM [client #57] returned to facility with 7 sutures intact to lower left leg and order (sic) antibiotic for 7 days. [Client #57] was placed on focus charting to</p>	W000189	<p>***What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Occupational Therapy has done an assessment on Client #57 and his footbox. They worked in conjunction with the AET (adaptive equipment technician) to assure that Client #57's footbox was appropriate. He has a new footbox based on recommendations. This foot box does not allow him to move his legs outside of the footbox, thereby ensuring that he will not harm his legs. He also has new cushions in his chair allowing him to sit upright more and requiring less repositioning. He states he is comfortable and likes his new equipment. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients who have medical changes could be affected. Those who have injuries will be assessed for the need to update their careplan and educate the staff on how to care for those injures by the DON. ***What measures will be put into place or what systemic changes the facility</p>	05/01/2013			

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	<p>be closely clinically monitored by licensed nursing staff."</p> <p>-BDDS report dated 3/8/13 indicated, "[Client #57] was being assisted by staff to be repositioned in wheel chair and inadvertently his lower right leg made contact with wheel chair and caused an open area. [Client #57] has skin which can tear easily. A nurse was called (sic) assessed his injury and orders were received to sent (sic) to ER for sutures. He returned from ER with sutures...." The 3/8/13 BDDS report indicated, "Wheel chair and foot box have been assessed and additional padding has been added to assist to eliminate this from happening in the future."</p> <p>QMRP (qualified mental retardation professional) notes for client #57, dated 10/23/12 at 2:05 P.M. were reviewed on 4/3/13 at 6:35 P.M. The QMRP notes indicated "In response to nursing notes from 10/17/12 re: laceration on leg resulting in ER visit. As the CNA's (sic) (certified nurse aide) were assisting [client #57] in to bed, they were removing his pants and it appears that the zipper made contact with his calf which in turn caused a laceration. [Client #57] has very thin skin which tears easily. [Client #57] was sent to the ER where he received sutures...."</p> <p>Observations were conducted in the facility on 4/3/13 from 4:45 PM through 6:00 PM. At 4:47 PM client #57 was in the dining room in a wheelchair with his feet elevated in the foot box/rest of his wheel chair. Client #57 had</p>		<p>will make to ensure that the deficient practice does not recur. Nurses have been re-educated regarding the importance of updating the plan of care if there has been an injury or change with any client. The DON will follow up with an audit based on information obtained from the nursing 24 hr report to assure that careplans are updated and that all staff have been educated regarding any changes. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place. The results of the audit will be discussed during the monthly QA committee meetings to assure that we are in compliance. This will be ongoing.</p>		

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	<p>one pillow under each foot while his feet rested in the foot box. Client #57's wheel chair had blue foam and duct tape on the metal wheelchair frame connecting the foot box to the chair underneath his right leg. Client #57's foot boxes had sides to them with the pillows positioned on the top of the foot box preventing client #57's legs from sitting down in the foot box. Client #57's legs were not in the foot box. Client #57's legs were on top of the pillows on top of the foot box. At 5:23 PM client #57's right leg slid off of the pillow and caused his right leg to move off the right side of the foot box. At 5:24 PM the right pillow was hanging down from the foot box and touching the floor. Client #57's right leg was hanging off the side of the wheel chair and out of the foot box with the pillow. At 5:26 PM QMRP #1 asked client #57, "How are you doing [client #57]?" as she walked past him. QMRP #1 did not reposition client #57's right leg back into the foot box. At 5:40 PM QMRP #1 approached client #57 and asked if he was okay. Client #57's right leg was out of his foot box and hanging off the side of the wheel chair. QMRP #1 did not reposition client #57's right leg back into the foot box. CNA (Certified Nursing Aide) #1 and DSP (Direct Support Professional) #1 were both in the dining area where client #57 was seated throughout the observation period. At 5:43 PM QMRP #2 entered the dining room area. QMRP #2 did not reposition client #57's right leg back into the foot box. At 5:46 PM LPN (Licensed Practical Nurse) #1 came into the dining room area. LPN #1 did not reposition client</p>			

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	<p>#57's right leg back into the foot box. Client #57's right leg was out of the foot box and hanging outside the wheel chair from 5:23 PM through 6:00 PM.</p> <p>CNA #1 was interviewed on 4/3/13 at 6:15 PM. CNA #1 indicated she had moved client #57 from the dining area to the program area. When asked how client #57 was seated/positioned in his wheel chair when she entered the dining area to move him, CNA #1 indicated client #57's right leg was hanging outside the foot box on the side of the wheel chair. When asked how often/frequent client #57's legs slipped out of the foot box, CNA #1 stated, "A lot, daily." When asked what staff should do when they see client #57's leg outside of the foot box, CNA #1 stated, "[Client #57's] leg should be put back on the wheel chair. Back into the foot box." When asked why staff should put client #57's leg back into the foot box, CNA #1 stated, "So, he doesn't get hurt again. [Client #57] hurt his right leg about a month and a half ago. [Client #57] opened the side of his foot and had to get stitches. I think [client #57] did the same thing last night (4/2/13) to his other leg (left leg)." When asked about monitoring client #57 to prevent further injury, CNA #1 stated, "I key in on it more than I'm supposed to. I was here when it happened the first time." CNA #1 indicated there were no protocols or training in place to monitor client #57's legs in relation to his foot box. CNA #1 stated, "[Client #57]'s legs get hurt easy. If they are outside the foot box he can get hurt again."</p>						

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	<p>LPN #1 was interviewed on 4/3/13 at 6:20 PM. LPN #1 indicated she had been the nurse in charge of monitoring the dining area on 4/3/13. When asked if client #57 had recent or current injuries, LPN #1 stated, "Yes. [Client #57] has had sutures twice." When asked how client #57 has been monitored since the 4/2/13 injury, LPN #1 stated, "I called the PCP (Primary Care Physician) last night. [Client #57's] very hard to treat due to the rest of his condition. They are modifying his wheel chair's foot box. [CNA #2] handles the wheel chairs. [Client #57] is on focused charting. It includes taking routine vitals, assessing for signs and symptoms of infection." When asked if focused charting included positioning client #57's legs, LPN #1 stated, "It does. We look at positioning at the beginning of the shift and then as needed." When asked if client #57's positioning was charted/documented in focused charting notes, LPN #1 stated, "No, it's not charted." When asked what should occur if client #57's leg is observed outside of the foot box/hanging outside of the wheel chair, LPN #1 stated, "It should be repositioned back." When asked the reason why client #57's leg should be repositioned back inside the foot box if observed out, LPN #1 stated, "It is my understanding the foot rest/foot box was ordered today." When asked if client #57 was at risk for further injury to his legs when/if they are outside of the foot box, LPN #1 stated, "Yes."</p> <p>DON (Director of Nursing) #1 was</p>						

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	<p>interviewed on 4/3/13 at 6:25 PM. DON #1 stated, "[Client #57] has Lymphedema which makes it easy for his skin to tear." DON #1 indicated client #57's foot box recommendations were for his safety. When asked what staff should do if client #57's legs are observed outside of the foot box of his wheel chair, DON #1 stated, "They should put them back in." When asked why staff should place client #57's legs back into the foot box of the wheel chair when observed out, DON #1 indicated to prevent further injury to his legs. When asked if staff should know to reposition client #57's legs, DON #1 stated, "Yes." When asked if staff failed to reposition client #57's legs, DON #1 stated, "Absolutely." DON #1 stated, "The foot box is part of [client #57's] positioning for his safety and comfort." DON #1 indicated client #57 did not have a specific care plan to address when and how staff were to monitor client #57's legs and/or when to reposition his legs if outside of the foot box.</p> <p>CNA #4 was interviewed on 4/4/13 at 7:52 A.M. When asked about client #57's feet/legs, CNA #4 stated, "Yes, the foot box is too small and they ordered a new one and we haven't got it yet. You will need to ask [CNA #2] about his wheelchair. We pick his leg/feet back up and reposition them in the chair because it would cut off circulation and his legs would get sore. We were told this morning, well we were always told to put his legs back in place. When I started I was trained by another lady (un-named) on how to put him in his chair. If I put him in his chair</p>			

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	<p>he doesn't slide down and you never see his legs hang over. I have never seen or had any specific training or saw a protocol on how to place him in his chair."</p> <p>Client #57's record was reviewed on 4/3/13 at 6:35 P.M. Client #57's record indicated he had an ISP (Individual Support Plan) dated 9/11/12. Client #57's ISP indicated "No longer able to self correct posture with/when the situation requires him to do so in the wheelchair." Client #57's ISP did not include a client specific protocol for staff to know how to complete transfers, wheelchair positioning, or how/when to monitor placement of client #57's feet/legs. Client #57's PO (physician's order) signed and dated by his PCP on 3/27/13 including a therapy services note dated 4/20/11 indicated client #57 was to "Be positioned in custom wheelchair tilt in space head rest, elevating leg rest with calf protectors and pelvic stabilizer."</p> <p>QMRP notes dated "3/18/13 1:25 P.M.: "In response to nursing notes from 3/7/13 re: skin tear resulting in ER visit. [Client #57] returned to facility with sutures in place to lower right leg. Nursing to continue with skin integrity plan. Wheelchair and foot box assessed and additional padding added. Will continue to monitor."</p> <p>Nursing notes dated 3/7/13 at 11:50 P.M. "[Name] guardian called to update on residents return from ER and informed of the 7 (seven) sutures that were placed in</p>			

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	<p>resident's right lower leg...." 3/19/13 "[Name PCP] updated of condition of wound c\ (with) sutures. New orders received to keep sutures in x 8 + (eight additional days) and apply bacitracin (antibiotic ointment) BID (twice daily)." Client #57's nursing note dated 11/28/12 indicated, "[CNA #2] has ordered new foot box for resident-awaiting arrival."</p> <p>The DON was interviewed again on 4/5/13 at 1:12 P.M. The DON stated if client #57 had been assessed by OT, PT or had a wheelchair assessment she would have to look in her "tickler" file to see when it was completed. The DON indicated she had trained staff earlier in the day on how to position and monitor client #57's legs when he was in his wheelchair.</p> <p>Client #57's record did not include documentation of protocols or plans on how to position him in his wheelchair, how to position his legs/feet in the foot box, how to transfer client #57 to/from his wheelchair or how/when to monitor client #57's position and the position of his legs/feet when in wheelchair. There was no documentation available for review to indicate staff had been trained on client #57's specific needs prior to the 4/5/13 training.</p> <p>This deficiency was cited on 2/25/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-13(b)(1) 3.1-13(b)(2)</p>						

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