

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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
F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint # IN00141249</p> <p>Complaint IN00141249 substantiated with Federal deficiencies cited at F-323.</p> <p>Survey dates: February 11, 12, 13, and 14, 2014</p> <p>Facility number: 284 Provider number: 155424 AIM number: 100290690</p> <p>Survey team: Angela Selleck, RN - TC Deb Barth, RN Kim Davis, RN Jason Mench, RN Karen Koeberlein, RN</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 1 Medicaid: 30 Other: 2</p>	F000000	<p>This Plan of Correction consitutues the written allegation fo compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exist or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. Hickory Creek at Columbus desires this Plan of Correction to be considered the facility's allegation of Compliance . Compliance is effective March 7, 2014</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiencystatement ending with an asterisk (*) denotes a defecency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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
F000248 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 21, 2014.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide activities for one of one resident reviewed for activities (Resident # 40).</p> <p>Findings Include:</p> <p>The clinical record of Resident # 40 was reviewed on 2/11/14 at 11:15 a.m. The record indicated the resident's diagnoses included, but were not limited to, Intracranial Hemorrhage, Depression, Pain, Craniotomy, Anxiety, and Dementia with Behavioral Disorder.</p> <p>The Admission Activity Assessment,</p>	F000248	F248 – It is the policy of this facility to provide an ongoing program of activities for every resident. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A new activity assessment for resident #40 was completed on 2/17/14. The assessment was completed with the help of resident #40's mother. Resident #40's one to one care plan has been updated to reflect her new activity assessment that was completed on 2/17/14. Resident #40 will continue to have one to one visits at least weekly and Guardian Angel visits at least 5 days a	03/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203		
(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>dated 6/3/13 was reviewed. The Assessment provided no information regarding the resident's activity pursuit patterns. The assessment provided only the resident's name, date of birth, physical status, and a cooperative attitude.</p> <p>The Admission Activity note, dated 6/13/13, indicated Resident #40 was unable to speak, but could answer. The note further indicated the resident had a lot of limitations preventing group activities. The note indicated the resident music, animals, being around others, and family.</p> <p>The note indicated music and visits with the facility pets would be provided.</p> <p>The most recent activity progress note dated 12/10/13, indicated Resident #40 enjoyed being read to and music. The activity note indicated the resident would be read to and invited to music programs.</p> <p>The Care Plan dated 12/19/13, indicated Resident #40 preferred to stay in the room and was at risk for decreased socialization. The Care Plan interventions included, Activity Director visits as the resident desired, family visits, staff conversation with care, encourage resident to attend activities, and reading to the resident.</p>		<p>week. Resident number #40 "Individual Programming" form had the following documented on it: 2/4/14, 20 minutes spent reading a book, 2/6/14, 20 minutes spent reading a book, 2/10, 15 minutes spent visiting and having conversation, on 2/12 and 2/13, 5 minutes were spent with resident #40 doing guardian angel rounds. 2/13/14, 2 hours spent visiting with mother. The ISDH surveyors did not ask for an activity policy and procedures. The facility's policy and procedure for one to one visits does not specify how many one to one visits a resident should have per week. On the 2567 there are several time observations noted for resident #40. Some of these times indicate no staff member was present during those times. There is no way to know if these times are accurate. The ISDH surveyors were not present in the resident #40s room during these times nor were they standing outside of resident #40s room. The administrator and management staff made many rounds during these times and were in and out of the resident #40s during these times as were nursing staff. Resident #40 also received all three therapy disciplines during the week of 2/11-2/14. Speech therapy worked with resident #40 on 2/12 for 45 minutes. The physical therapist saw resident #40 on 2/13/14 for 60 minutes and the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203		
(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 following observations were made of Resident #40:</p> <p>2/11/14 : 10:45 a.m. - 11:30 a.m., in room, in bed, crying with no music playing, no staff present</p> <p>2/11/14 : 2:00 p.m.- 4:00 p.m. in bed, in room, crying, no music playing, no television on A music activity was being held in the dining room.</p> <p>2/12/14: 8:55 a.m., in bed, crying out, no music playing, no television on</p> <p>2/12/14: 10:15 a.m., in bed, crying</p> <p>2/12/14: 2:15 p.m., in bed, crying, room mates television is on</p> <p>2/12/14: 3:40 p.m.-4:00 p.m., in bed, crying, roommate's television on, no staff present, had kicked off blankets.</p> <p>2/13/14: 8:00 a.m. in geri chair, in room, crying</p> <p>2/13/14: 8:15 a.m. in the assist dining room for breakfast</p> <p>2/13/14: 8:45 a.m.- 10:30 a.m., in bed in room, crying</p> <p>2/13/14: 11:50 a.m.-12:15 p.m., sitting in main dining room, in geri chair, crying. Resident # 1 was seated close to Resident #40, Resident #1 repeatedly asked Resident #40, "What's wrong, what's wrong?"</p> <p>Resident # 1 called out to Resident #40 " Hey that's enough, what's wrong?"</p> <p>2/13/14: 12:20 p.m. - 12:30 p.m., sitting in geri chair in assist dining room eating,</p>		<p>occupational therapist saw Resident #40 on 2/11 for 23 minutes, 2/12 for 23 minutes and 2/13 for 38 minutes. The facility is questioning the relevance of stating the Administrator spent 5 minutes with resident #40 on 2/12/14 and 2/13/14. The ISDH surveyors could not possibly know if the Administrator spent more time with resident #40 because they were not at her bedside the whole time. How are other resident having the potential to be affect by the deficient practice will be identified and what corrective action will be taken? No other resident has been affected by this deficient practice. An audit was completed of all residents' activity assessments. New assessments were completed as needed. An audit was done of all resident activity care plans, including one to one care plans. Any changes needed were made at that time to the resident's activity preferences. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Residents will continue to have activity assessments completed upon admission, annually and upon a significant change. Information from those assessments will be placed on the resident's activity care plan. The care plan will be reviewed quarterly and as needed and any changes in resident's</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>2/13/14: 2:00 p.m.- 4:00 p.m., in bed in room, crying, family visiting</p> <p>The facility animals were not observed in the resident's room daily from 2/11/14 through 2/14/14.</p> <p>The Director of Nursing (DoN) was interviewed on 2/11/14 at 11:30 a.m. The DoN indicated, crying was Resident #40's way of communicating with staff. She indicated if the resident saw new or different people in the facility, the resident would cry. The DoN indicated the resident cried when her family came to visit as well.</p> <p>The Activity Director was interviewed on 2/12/14 at 3:10 p.m. The Activity Director indicated Resident # 40 enjoyed being read to.</p> <p>The Activity Director (AD) presented the "Individual Programming" for Resident # 40 on 2/13/14 at 12:30 p.m. The document indicated on 2/4/14 and 2/16/14, the Activity Director read a book to the resident for 20 minutes. On 2/10/14, the AD visited for 15 minutes with the resident. On 2/12/14 and 2/13/14, the administrator spent 5 minutes with the resident each day.</p> <p>The Activity Director was interviewed on</p>		<p>activity preferences will be made to the care plan at that time. The one to one log for residents and the individual resident activity calendars will be reviewed weekly by the Administrator at the weekly Standards of Care meeting. Any issues noted during this review will be brought before the QA committee. How will the corrective action be monitored to ensure the deficient practice will no recur? Resident individual activity calendars and one to one logs will be reviewed by the Administrator at the weekly Standards of Care meeting. Any issues noted during this will review will be brought before the QA committee.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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
F000250 SS=E	<p>2/13/14 at 3:15 p.m. The Activity Director indicated she was new to the position. She was enrolled in the Activity Director training in March 2014. She further indicated there were no one on one activities for Resident # 40 prior to 2/4/2014. She indicated the resident did not attend the music program.</p> <p>The administrator was interviewed on 2/14/14 at 10:00 a.m. The administrator indicated the Activity Director was new to the position. The administrator further indicated she met with the AD every Friday.</p> <p>3.1-33(b)(1) 3.1-33(b)(8)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to provide a Behavior Management Program to monitor the behaviors of 7 of 7 residents reviewed for behavior</p>	F000250	F250 – Provision of Medically Related Social Services It is the standard of this facility that medically –related social services are provided to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident. What corrective action will be	03/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>management (40, 14, 13, 38, 2,15, 32).</p> <p>Findings Include:</p> <p>1. The clinical record of Resident # 40 was reviewed on 2/11/14 at 11:15 a.m. The record indicated the resident's diagnoses included, but were not limited to, Intracranial Hemorrhage, Depression, Pain, Craniotomy, Anxiety, and Dementia with Behavioral Disorder.</p> <p>The Quarterly Minimum Data Set Assessment (MDS) dated 12/10/13, indicated Resident #40 had no memory impairment, no signs of delirium, and displayed no behaviors.</p> <p>The Care Plan dated 12/19/13 indicated Resident #40 had trouble with communication, a diagnosis of Depression, and had periods of anxiousness and restlessness. The Care Plan interventions included, offer comfort, try to find out why the resident is crying or restless and resolve, encourage activities, and notify the doctor as needed. A Care Plan dated 8/26/13 and reviewed on 12/19/13, indicated " I have cried out loudly, and screamed out for unknown reasons". The Care Plan interventions included, try to find out why and resolve if possible, encourage to calm down, offer comfort,</p>		<p>accomplished for those resident found to be affected by the deficient practice? Resident #40 behavior management program was reviewed on 2/25/14. No changes were made to her behavior management program. Resident #40's pain assessment was updated. Resident #14 behavior management program was reviewed on 2/25/14. No changes were made at this time. A 3 night sleep study was completed on Resident #14 which concluded she slept fine through the night. Resident #13 behavior management program was reviewed on 2/25/14. Resident #13 garbled speech and talking to people was added to his program. A care plan was implemented for this behavior. The 2567 states the SSD "looks through the book at least monthly". This is not an accurate quote. The SSD stated she looked through the book weekly. The 2567 also states that the SSD said the behavior committee did not meet to discuss the administration of the Zyprexa. The SSD indicated to the surveyor that the usage of the medication was discussed the next morning during the management daily stand up meeting. She also indicated that the facility psychologist was notified of the incident and did come into the building to see Resident #13. Resident #38' seroquel was decreased on</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>reassurance, quiet area, and redirect the resident's attention.</p> <p>The Social Service notes were reviewed. Notes dated 12/30/13 and 1/28/13 indicated the resident was crying. The notes indicated sometimes she wants to lay down and sometimes the resident doesn't know why she was crying. Both notes indicated reassurance was provided by the Social Service Director. The last Social Service Note was dated 1/28/14.</p> <p>The December 2013, January 2014, and February 2014 Behavior Logs were reviewed. There were no behaviors reported on the logs.</p> <p>The following observations were made of Resident #40: 2/11/14 : 10:45 a.m. - 11:30 a.m., in room, in bed, crying with no music playing, no staff present 2/11/14 : 2:00 p.m.- 4:00 p.m. in bed, in room, crying, no music playing, no television on A music activity was being held in the dining room. 2/12/14: 8:55 a.m., in bed, crying out, no music playing, no television on 2/12/14: 10:15 a.m., in bed, crying 2/12/14 at 2:15 p.m., in bed, crying, room mates television is on 2/12/14: 3:40 p.m.-4:00 p.m., in bed, crying, roommates television on, no staff</p>		<p>2/20/14. A behavior management program was implemented for her on 2/25/14. Resident #2 behavior management program was reviewed on 2/25/14 and no changes were made at this time. Resident #2's Paxil was decreased on 2/20/14. Review of Resident #2 behavior management program again on 3/4/14 and changes were made to this resident's plan. Resident #15's Zyprexa was reduced on 2/20/14. A behavior program was not implemented for resident #15. If behaviors are seen a program will then be implemented. Resident #32's behavior management program was reviewed on 2/25/14 with changes made. How other resident having the potential to be affected by the same deficient practice will be identified ad what corrective action will be taken? An audit was completed of all resident behavior monitoring programs. Changes were made as needed. This was completed on 2/25/14. Gradual dose reductions were completed as needed on residents on 2/18/14. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice doesn't reoccur? All staff was inserviced on the behavior management program on 2/19/14. Staff was re-educated on proper documentation of resident behaviors and the use of the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>present, has kicked off blankets 2/13/14: 8:00 a.m., in geri chair in room, crying, and moving around in the chair 2/13/14 at 8:15 a.m., in the assist dining room for breakfast 2/13/14: 8:45 a.m.- 10:30 a.m., in bed in room, crying 2/13/14: 11:50 a.m.-12:15 p.m., sitting in main dining room, in geri chair, crying. Resident # 1 repeatedly asked Resident #40, "What's wrong, what's wrong?" Resident # 1 called out to Resident #40 " Hey that's enough, what's wrong?" 2/13/14: 12:20 p.m. - 12:30 p.m., sitting in geri chair in assist dining room eating, 2/13/14: 2:00 p.m.- 4:00 p.m., in bed in room, crying, family visiting</p> <p>On 2/13/14 at 8:50 a.m., Resident #40 was crying out from the bed. While delivering laundry to the resident, laundry person #10 asked the resident why she was crying. Laundry person #10 asked the resident if she was in pain. Resident #40, indicated "yes".</p> <p>The laundry/housekeeping/maintenance supervisor was interviewed on 2/13/14 at 9:30 a.m. The supervisor indicated his staff was instructed to report to the nurse if a resident requested medicine.</p> <p>During an interview with LPN #11 on 2/13/14 at 10:00 a.m.,LPN #11 indicated</p>		<p>behavior management binder, including documenting the circumstances surrounding the behavior, the interventions attempted that were unsuccessful and the interventions that were successful. The behavior management program binder is reviewed daily during the department manager's morning meeting. Any new issues or behaviors noted at that time for any residents will be discussed by the interdisciplinary team, with recommendations for revisions or additions to the resident's behavior management program and care plan, including changes in interventions. How the corrective action will be monitored to ensure the deficient practice will not recur? In addition to the morning management meeting review of the behavior management program, the SSD will bring the results of the daily reviews and any follow up to the monthly QA committee meeting for further review and recommendation. The SSD will be responsible for follow up on any recommendations made by the committee. The QA committee may decide to forgo the SSD's reporting of behaviors after 60 days of 100% compliance is achieved. However, even when the reporting requirement has been stopped the process of the IDT review at the morning meetings and weekly Standards of Care meetings will continue on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>she was not told about Resident #40 complaining of pain.</p> <p>During an interview with laundry person #10 on 2/13/14 at 10:15 a.m., laundry person #10, indicated she did not report Resident #40's complaints of pain.</p> <p>The Director of Nursing (DoN) was interviewed on 2/11/14 at 11:30 a.m. The DoN indicated, crying was Resident #40's way of communicating with staff. She indicated if the resident saw new or different people in the facility, the resident would cry. The DoN indicated the resident cried when her family came to visit as well.</p> <p>The Social Service Director (SSD) was interviewed on 2/13/14 at 9:35 a.m.. During the interview, the SSD indicated the facility "Behavior Log" book is kept at the nurse's station. She indicated the book was there for any staff to use to report a behavior. The SSD indicated if a staff member sees a behavior, the staff member is to document the behavior in the Behavior Book. The SSD indicated she had taught the staff the staff how to complete the book, but she has to instruct staff repeatedly, because the forms don't always get completed. The SSD indicated she "...looks through the book at least monthly...". The SSD indicated</p>		an ongoing basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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 facility Behavior Committee meets once a month and resident behaviors are reviewed at that time. The SSD indicated she had talked with Resident #40 on 2/13/14 at 8:30 a.m. She indicated Resident #40 was crying because she wanted to lay down. The SSD indicated she had instructed staff to look Resident #40 in the eyes while speaking with her.</p> <p>2. The clinical record of Resident # 14 was reviewed on 2/13/14 at 9:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, Dementia, Arthritis, and Anxiety.</p> <p>The February Physician orders signed on 2/6/14, included an order dated 1/25/14 for 25 milligrams (mgs) of Trazadone (antidepressant) to be given at night for trouble sleeping.</p> <p>The Care Plan dated 1/23/14, indicated Resident #14 had episodes of being awake much of the night. The Care Plan interventions included, a calm, quiet sleeping environment, check comfort level, keep clean and dry, encourage activities in the day time, find out what's causing the difficulty sleeping and resolve.</p> <p>One Nursing Note dated 12/24/13 at 2:00</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>a.m., indicated the resident was awakened at 12:30 a.m. for personal care and was still awake at 1:30 a.m.</p> <p>There was no other documentation in the nursing notes regarding the resident's lack of sleeping.</p> <p>The Social Service Notes indicated no information about the resident's inability to sleep.</p> <p>The January 2014 and February 2014 Behavior Monitoring Logs indicated did not address sleep or nonpharmacological interventions to assist the resident to sleep.</p> <p>Certified Nursing Assistant (CNA) # 12 was interviewed on 2/13/14 at 2:40 p.m. The CNA indicated Resident #14 usually is ready for bed right after supper and still in bed at 10:00 p.m.</p> <p>CNA #13 was interviewed on 2/14/14 at 9:00 a.m. The CNA indicated Resident #14 is usually out of bed when her shift starts at 6:00 a.m.</p> <p>The Social Service Director (SSD) was interviewed on 2/14/14 at 9:30 a.m. Further information was requested regarding the use of the antidepressant, Trazadone for sleep, documentation of the resident's sleep patterns and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>information regarding nonpharmacological interventions to assist the resident to sleep.</p> <p>3. The clinical record of Resident #13 was reviewed on 2/12/14 at 8:35 a.m. The record indicated the resident's diagnoses included, but were not limited to, Mental Retardation, Diabetes, Depression, Schizoaffective Disorder, and Bipolar Mood Disorder.</p> <p>The February Physician Orders signed on 2/6/14, indicated, 400 milligrams (mgs) of Seroquel (antipsychotic) twice a day, 75 mgs of Zoloft (antidepressant) once a day, and 5 mgs of Zyprexa (antipsychotic) as needed for mood behaviors.</p> <p>A telephone order dated 1/25/14 indicated, 10 mgs of Zyprexa every four hours as needed for increased agitation.</p> <p>A nursing note dated 1/25/14 at 9:10 a.m. indicated, "... Eye twitch and talking to invisible people. Garbled speech. Unclear as to what resident is trying to say. Zyprexa administered around 6:15 a.m., non effective. Continues to talk to self and invisible people....".</p> <p>A nursing note dated 1/25/14 at 12:00 p.m., indicated the resident received the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>10 mg of Zyprexa.</p> <p>A nursing note dated 1/25/14 at 1:30 p.m., indicated the resident was sleeping.</p> <p>The January 2014 Behavior Log was reviewed on 2/12/14 at 8:40 a.m. The log indicated no behaviors were documented in January 2014.</p> <p>The "Behavior Monitoring Log" did not include a behavior of garbled speech, or talking to people who were not there.</p> <p>The Care Plan reviewed on 11/19/13, did not include a Care Plan for garbled speech or talking to people who were not there.</p> <p>The Social Service Director (SSD) was interviewed on 2/13/14 at 9:35 a.m.. During the interview, the SSD indicated the facility "Behavior Log" book is kept at the nurse's station. She indicated the book was there for any staff to use to report a behavior. The SSD indicated if a staff member sees a behavior, the staff member is to document the behavior in the Behavior Book. The SSD indicated she had taught the staff the staff how to complete the book, but she has to instruct staff repeatedly, because the forms didn't always get completed. The SSD indicated she "...looks through the book</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>at least monthly...". The SSD indicated the facility Behavior Committee meets once a month and residents behaviors are reviewed at that time. The SSD indicated residents receiving psychoactive medications are not always monitored by the Behavior Committee. She indicated the residents are monitored only if behaviors are displayed. She indicated the committee does discuss gradual dose reductions in the meetings. The SSD further indicated the facility Behavior Policy did not include monitoring for residents receiving psychoactive medications or the gradual dose reductions of psychoactive medications dose reductions in the meetings. The SSD further indicated the facility Behavior Policy did not include monitoring for residents receiving psychoactive medications or the gradual dose reductions of psychoactive medications. The SSD indicated the committee had not met and discussed the administration of Zyprexa for Resident #13.</p> <p>4. The clinical record of Resident # 38 was reviewed on 2/12/14 at 9:35 a.m. The record indicated the resident's diagnoses included, but were not limited to, Anxiety, Dementia, and Psychosis due to Parkinson's medication use.</p> <p>The February Physician orders signed on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>2/10/14, indicated, an order dated 11/20/12 for 0.25 milligrams (mgs) of Xanax (antianxiety) three times a day for anxiety, an order dated 10/30/12 for 20 mgs Celexa (antidepressant) daily for depression, and an order dated 10/19/12 for 25 mg Seroquel twice daily for Psychosis.</p> <p>A Care Plan dated 2/13/14, indicated Resident #38 "...had some confusion and hallucinations such as talking to people who are not present...". The Care Plan interventions included, redirection, comfort, current events, and medications.</p> <p>A Care Plan dated 2/13/14 indicated, Resident #38 "had some agitation and restlessness". The Care Plan interventions included, speaking in a calm manner, find out the reason for the agitation and resolve, encourage activities, redirection, and medications.</p> <p>A Psychological Consultation, completed by the Psychologist, dated 11/29/13, indicated the resident's family member did not want changes made to Resident # 38's medications. The consultation indicated the resident was regularly reviewed by the facility Behavior Committee.</p> <p>The Social Service Director (SSD) was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>interviewed on 2/13/14 at 9:45 a.m. The SSD indicated residents receiving psychoactive medications are not always monitored by the Behavior Committee. She indicated the residents are monitored only if behaviors are displayed. She indicated the committee does discuss gradual dose reductions in the meetings. The SSD further indicated the facility Behavior Policy did not include monitoring for residents receiving psychoactive medications or the gradual dose reductions of psychoactive medications dose reductions in the meetings. The SSD further indicated the facility Behavior Policy did not include monitoring for residents receiving medications or the gradual dose reductions of psychoactive medications.</p> <p>Review of the facility Behavior Reports and Logs on 2/14/14 at 9:15 a.m., indicated no behavior Monitoring for Resident #38.</p> <p>The SSD was interviewed on 2/14/14 at 9:20 a.m. The SSD indicated there was no Behavior Tracking for Resident # 38. The SSD indicated there had been no Gradual Dose Reductions attempted for Resident #38</p> <p>5. The clinical record for Resident # 2 was reviewed on 2/12/14 at 2:00 p.m. The resident had diagnoses which</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>included, but were not limited to: advanced multiple sclerosis, recent fracture of femur, and bipolar disorder.</p> <p>Review of physician order rewrites, dated 2/6/14, indicated the resident was receiving Divalproex 250 mg (milligrams) bid (twice daily) for bipolar disorder and Paxil 40 mg. daily for sexual acting out.</p> <p>Review of the behavior monitoring log, on 2/13/14 at 8:20 a.m., indicated no behaviors had been witnessed or recorded for the months of January and February, 2014. There were no behaviors recorded for the month of December, 2013. The resident was being tracked for making sexually inappropriate comments, cussing, taking food off other resident's plates, and taking her clothes off. The behavior log for November, 2013 indicated CNA# 1 had witnessed the resident making sexual comments on 11/2/13 at 6 p.m. There were no interventions listed as being effective or noneffective. There were no indications of any interventions having been tried. There was no indication as to any precursor of the behavior, who had been involved in the incident, or what the resident had actually stated.</p> <p>The behavior monitoring record, undated,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>included the following interventions for the behavior of "making sexually inappropriate comments: "a. Ask resident to stop the behavior; b. Assist resident away from others; c. Try to redirect resident's attention; d. Try to involve resident in activities; e. Remind resident the behavior is not appropriate."</p> <p>Interview with the Maintenance Director, on 2/13/14 at 9 a.m., indicated the resident had made sexually inappropriate comments to him. He indicated, when she made those kind of statements, he reported them to the Director of Nursing or Social Services Director usually in the morning department head meeting. He indicated he did not remember how long ago that had been.</p> <p>The care plan, dated 10/21/11, indicated the resident had a problem of "verbal sexually inappropriate behavior to staff and visitors." The care plan indicated it had been updated on 6/11/13. The interventions included "Ask me to stop the behavior; assist me away from other residents; try to redirect my attention; try to involve me in activities; remind me the behavior is not appropriate; observe me for sexually inappropriate behaviors (added 2/9/13); and ask me to not encourage other residents to act inappropriately (added 2/9/13)." There</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>was no indication ay interventions had been changed or added.</p> <p>The Social Services Director was interviewed on 2/13/14 at 1:30 p.m. She indicated the resident did have behaviors of being sexually inappropriate. She was unaware of the last time the resident had made any comments. She had not been informed of any time the resident had made sexually inappropriate comments to the Maintenance Director. She could not recall when the last time was that the resident had made such comments.</p> <p>The Social Services Director further indicated any staff could document a resident's behavior in the behavior log. The staff should also include what interventions had been used to address the behaviors. She also indicated the care plans and interventions were updated at each behavior meeting, depending on what behaviors had occurred. The behavior meeting took place only once a month. She indicated the resident's care plan would be reviewed at the upcoming meeting.</p> <p>The requested most recent psychologist consultation, dated 2/19/13, indicated the resident had been involved in a resident to resident altercation without any physical or emotional injury. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>resident was not assessed on a regular basis by the psychologist, as indicated by the Administrator and Social Services Director on 2/13/14 at 1:30 p.m.</p> <p>Review of the Psychotropic Medication Log, provided by the Social Services Director, on 2/14/14 at 1:30 p.m., indicated the resident had her Paxil dosage increased on 2/19/13 from 20 mg. to 40 mg. The dosage was reviewed for gradual dose reduction (GDR) on 8/24/13 and again on 11/21/13. A "contraindicate GDR" note was placed under comments on the form directly across from each date.</p> <p>The following statement, dated 11/21/13, was in the clinical record to explain the contraindication for the GDR: "The above named Patient's case was discussed at length in today's behavior management meeting. This patient is currently taking the psychotropic medication Paxil. This medication assists in maintaining this patient's highest level of psychosocial well-being. Further dosage reduction will adversely affect the Patient's behavior. No further dose reduction at this time should be pursued as evidenced by the MD's Dated Signature below." This form was signed by the attending physician.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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 Social Service Director, during the interview on 2/13/14 at 1:30 p.m., indicated Resident # 2 would not be evaluated for a dosage reduction of her Paxil since she had two failed GDR attempts even though she had not demonstrated any inappropriate behaviors for three months. She indicated the facility did not have a policy for when to reduce drugs if no behaviors had occurred.</p> <p>6. The clinical review for Resident #15 was reviewed on 2/13/14 at 2:30 p.m. The Minimum Data Set (MDS) Quarterly Review, dated 1/17/14, indicated the resident was not cognitively impaired. Current diagnoses included, but were not limited to, psychosis due to Parkinson's medication use, confusion, debilitated patients, dementia, edema, chronic obstructive pulmonary disease, urinary tract infection and asthma.</p> <p>The resident was currently receiving the following medication, on a daily basis Zyprexa (Antipsychotic) originally ordered on 8/24/2013.</p> <p>During an interview with the Social Service Director on 2/13/14 at 3:03 p.m., she stated "...resident is stable, she is alert and oriented. No signs or symptoms of confusion... Last behavior was in November of 2012. Resident has been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>stable since." The Social Service Director also indicated Resident #15 did not have a behavior monitoring log.</p> <p>During an interview with the Social Service Director on 2/14/14 at 10:35 a.m., she indicated Resident #15 had not seen the psychologist for two years; the last consult was in October 2012.</p> <p>A psychologist consultation note dated 10/30/12, was provided by the Social Service Director on 2/14/14 at 10:38 a.m. and indicated the last time Resident #15 had been assessed by the psychologist was on 10/30/12.</p> <p>No further documentation was provided by the facility as of exit on 2/14/14.</p> <p>7. Resident #32's clinical record was reviewed on 2/12/14 at 2:23 p.m.</p> <p>Current diagnoses included, but were not limited to, depression, Schizoaffective disorder and anxiety.</p> <p>Resident #32's chart was found to not have any behaviors charted for 5 behaviors listed including, "Behavior #1. Yelling, cussing at others, Behavior #2. Threatening to kill herself, Behavior #3 Throwing items at others, Behavior #4. Pushing others, and Behavior #5. Threatening to hit others" for 3 months of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203		
(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>behavior logs reviewed.</p> <p>During an Interview with the Social Service Director on 2/13/14 at 12:40 p.m., she indicated the Residents behaviors and the interventions used for those behaviors were not being charted on the behavior flow sheets by staff at the time the Resident had behaviors. The Social Service director indicated Resident #32 had exhibited the behaviors listed on the Residents Behavior Monitoring Record, and she talks to here about her behaviors during her meetings with the Resident.</p> <p>In a policy provided by the Administrator on 2/14/14 at 3:00 p.m., dated October 2007:</p> <p>"POLICY: It is the policy of this facility that residents who exhibit negative behavior problems will be included in the behavior management and monitoring program. This program is designed to accommodate(sic) individual needs and maintain Residents dignity, while managing behavioral symptoms..."</p> <p>"...the following residents will be included in the behavior monitoring system..."</p> <p>"...2. Continuously yells, screams, or</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>paces if these behaviors cause an impairment in functional capacity; or</p> <p>3. Experiences psychotic symptoms not exhibited as dangerous behaviors or as screaming, yelling or pacing, but which causes the resident distress or impairment in functional capacity..."</p> <p>"...5. The interventions that guide the staff on how to deal with a problem behavior when it occurs will be found on the Behavior Monitoring Record. The Behavior Log form will be used to document each observed episode of the targeted behavior. It will record the following information: date, time, behavior, precipitating events, staff interventions, and outcome..."</p> <p>"...6. Behavior summaries will be documented on Section A and C on the Monthly Behavior & Psychotropic Medication Summary & Meeting form. the Monthly Behavior & Psychotropic Medication Summary & Meeting form will be completed for each resident prior to the Behavior and Psychotropic Medication Meeting. The Behavior Summary (Section A) will be reviewed by the Behavior Committee and Utilized to revise behavior management plans and to make recommendations(sic) regarding medication changes. Completed behavior</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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			
F000279 SS=D	<p>summaries will be placed on the resident's medical record or in a binder in the SSD office. If the resident discharges from the facility, the Monthly Behavior & Psychotropic Medication Summary & Meeting form will be placed into the resident's permanent chart..."</p> <p>3.1-34(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review,</p>	F000279	F279 – Develop Comprehensive Care PlansIt is the standard of	03/07/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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 facility failed to ensure a comprehensive care plan was developed for attention seeking behaviors for 1 of 7 residents reviewed for behaviors in a total sample of 17 residents reviewed for care plans. (Resident #32)</p> <p>Findings include:</p> <p>Resident #32 clinical record was reviewed on 2/12/14 at 2:23 p.m.</p> <p>Current diagnoses included, but were not limited to, depression, schizoaffective disorder and anxiety.</p> <p>Resident #32 had an unwitnessed fall without injury on 2/8/14 at 1:50 a.m., which was reported to staff by the resident walking out to the nurses station and telling the nurse that she fell. Vitals were taken and Resident #32 was assess and there were no injuries.</p> <p>During an interview with the Director of Nursing (DoN) on 2/13/14 at 10:12 a.m., she indicated the facility set up a Neuro Psychiatric Consult for the Resident for May, 2014 to address her possible attention seeking behavior in regards to her unwitnessed fall on 2/8/14 at 1:30 a.m.. The DoN also indicated the facility did not have a care plan in place to address the residents possible attention</p>		<p>this facility to ensure a comprehensive care plan is developed for each resident, including those with attention seeking behaviors. What corrective action will be accomplished for those residents found to have affected by the deficient practice? Resident #32 was care planned for attention seeking behavior on 2/13/14.</p> <p>How other resident having the potential to be affected by the same deficient practice will be identified ad what corrective action will be taken? An audit was completed on 3/4/14 on all residents who display attention seeking behavior to ensure he or she has appropriate care plan in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice doesn't reoccur? Resident behaviors will be reviewed daily 5 times a week at the Morning Management Meeting. If a new behavior has occurred, a care plan and behavior monitoring plan will be implemented at that time. The IDT will continue to monitor care plans during the weekly care plan meeting and as new behaviors are identified. In addition, the IDT will review all residents with behaviors at the monthly behavior committee meeting to make sure that all are addressed and care planned, including attention seeking behaviors. How the corrective action will be monitored</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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
F000280 SS=D	<p>seeking behavior.</p> <p>Resident #32's health care plan lacked any information related to possible attention seeking behavior.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview,</p>	F000280	<p>to ensure the deficient practice will not recur? The SSD or designee will monitor behaviors at least 5 days a week. New behaviors will be discussed with the IDT team as indicated above. A care plan will be put into place as a new behavior is documented. The SSD will complete monthly audit of new behaviors. She will bring those audits to the monthly QA committee meeting for review for the next 60 days. After 60 days the QA committee may decide to stop the requirement for reporting results if 100% compliance has been achieved.</p>	03/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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 facility failed to revise 2 of 7 care plans reviewed for residents regarding behavior management in a sample of 17 residents whose care plans were reviewed. (Resident # 2 and)</p> <p>Findings include:</p> <p>1. The clinical record for Resident # 2 was reviewed on 2/12/14 at 2:00 p.m. The resident had diagnoses which included, but were not limited to: advanced multiple sclerosis, recent fracture of femur, and bipolar disorder.</p> <p>Review of physician order rewrites, dated 2/6/14, indicated the resident was receiving divalproex 250 mg (milligrams) bid (twice daily) for bipolar disorder and Paxil 40 mg. daily for sexual acting out.</p> <p>Review of the behavior monitoring log, on 2/13/14 at 8:20 a.m., indicated no behaviors had been witnessed or recorded for the months of January and February, 2014. There were no behaviors recorded for the month of December, 2013. The resident was being tracked for making sexually inappropriate comments, cussing, taking food off other resident's plates, and taking her clothes off. The behavior log for November, 2013 indicated a CNA# 1 had witnessed the resident making sexual comments on</p>		<p>planning It is the standard of this facility that residents participate in their planning of care and treatment. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #2's behavior program for sexually inappropriate comments was reviewed on 2/25/14 and no changes were made at that time. Review of resident #2's sexually inappropriate comments was reviewed again on 3/4/14 and this behavior has been discontinued. Resident #2's care plan for sexually inappropriate comments was discontinued on 2/25/14. Resident #40's care plan for crying out loudly and screaming out was updated on 3/4/14 with new interventions. Resident #40's pain assessment was update. The facility would like noted on the 2567 it states Resident #40's MDS completed on 12/10/13 indicates the resident has no memory impairment. The BIMs score for resident #40 on this MDS is a 3 which indicates memory impairment. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? An audit of residents who have care plans for behaviors was completed on 3/5/14. New interventions were put into place as needed. What measures will be put into place or what systemic</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>11/2/13 at 6 p.m. There were no interventions listed for being effective or noneffective. There were no indications of any interventions having been tried. There was no indication as to any precursor of the behavior, who had been involved in the incident, or what the resident had actually stated.</p> <p>The behavior monitoring record, undated, included the following interventions for the behavior of "making sexually inappropriate comments: "a. Ask resident to stop the behavior; b. Assist resident away from others; c. Try to redirect resident's attention; d. Try to involve resident in activities; e. Remind resident the behavior is not appropriate."</p> <p>Interview with the Maintenance Director, on 2/13/14 at 9 a.m., indicated the resident had made sexually inappropriate comments to him. He indicated, when she made those kind of statements, he reported them to the Director of Nursing or Social Services Director usually in the morning department head meeting. He indicated he did not remember how long ago that had been.</p> <p>The care plan, dated 10/21/11, indicated the resident had a problem of "verbal sexually inappropriate behavior to staff and visitors." The care plan indicated it</p>		<p>changes will be made to ensure that the deficient practice? Resident behaviors will continue to be discussed during the daily management stand up meeting. During this time the interdisciplinary team will update a resident's care plan with a new intervention if a behavior has occurred. The interdisciplinary team will continue to review behavior care plans during the weekly care plan meeting. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The interdisciplinary team will monitor all care plans for updates when behaviors occur. New interventions will be discussed with the interdisciplinary team as indicated above. A care plan and/or new intervention will be put into place if a behavior occurs.</p> <p>The SSD will complete a monthly review of behaviors to ensure care plans are in place with an updated invention. She will bring this review to the QA Committee for review for the next 60 days. After 60 days the QA Committee may decide to stop the requirement for reporting the results if 100% compliance has been reported; however, the process of bringing behaviors to the morning management stand up meeting for review, discussion, and development/updating of related care plans will continue on an ongoing basis.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>had been last updated on 6/11/13. The interventions included "Ask me to stop the behavior; assist me away from other residents; try to redirect my attention; try to involve me in activities; remind me the behavior is not appropriate; observe me for sexually inappropriate behaviors (added 2/9/13); and ask me to not encourage other residents to act inappropriately (added 2/9/13)." There was no indication any interventions had been changed or added since 2/9/13.</p> <p>The Social Services Director was interviewed on 2/13/14 at 1:30 p.m. She indicated the resident did have behaviors of being sexually inappropriate. She was unaware of the last time the resident had made any comments. She had not been informed of any time the resident had made sexually inappropriate comments to the Maintenance Director. She could not recall when the last time was that the resident had made such comments.</p> <p>The Social Services Director further indicated any staff could document a resident's behavior in the behavior log. The staff should also include what interventions had been used to address the behaviors. She also indicated the care plans and interventions were updated at each behavior meeting, depending on what behaviors had occurred. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>behavior meeting took place only once a month. She indicated the resident's care plan would be reviewed at the upcoming meeting.</p> <p>2. The clinical record of Resident # 40 was reviewed on 2/11/14 at 11:15 a.m. The record indicated the resident's diagnoses included, but were not limited to, Intracranial Hemorrhage, Depression, Pain, Craniotomy, Anxiety, and Dementia with Behavioral Disorder.</p> <p>The Quarterly Minimum Data Set Assessment (MDS) dated 12/10/13, indicated Resident #40 had no memory impairment, no signs of delirium, and displayed no behaviors.</p> <p>The Care Plan dated 12/19/13 indicated, Resident #40, had trouble communication, a diagnosis of Depression, and had periods of anxiousness and restlessness. The Care Plan interventions included, offer comfort, try to find out why the resident is crying or restless and resolve, encourage activities, and notify the doctor as needed. A Care Plan dated 12/19/13, indicated " I have cried out loudly, and screamed out for unknown reasons". The Care Plan interventions included, try to find out why and resolve if possible, encourage to calm down,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203		
(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>offer comfort, reassurance, quiet area, and redirect the resident's attention. The Care Plan was signed by the Care Plan team, but not updated to reflect changes in interventions for the behaviors of Resident #40.</p> <p>The Social Service notes were reviewed. Notes dated 12/30/13 and 1/28/13 indicated the resident was crying. The notes indicated sometimes she wants to lay down and sometimes the resident doesn't know why she was crying. Both notes indicated reassurance was provided by the Social Service Director. The last Social Service Note was dated 1/28/14.</p> <p>The December 2013, January 2014, and February 2014 Behavior Logs were reviewed. There were no behaviors reported on the logs.</p> <p>The following observations were made of Resident #40: 2/11/14 : 10:45 a.m. - 11:30 a.m., in room, in bed, crying with no music playing, no staff present 2/11/14 : 2:00 p.m.- 4:00 p.m. in bed, in room, crying, no music playing, no television on A music activity was being held in the dining room. 2/12/14: 8:55 a.m., in bed, crying out, no music playing, no television on 2/12/14: 10:15 a.m., in bed, crying</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>2/12/14 at 2:15 p.m., in bed, crying, room mates television is on</p> <p>2/12/14: 3:40 p.m.-4:00 p.m., in bed, crying, roommates television on, no staff present, has kicked off blankets</p> <p>2/13/14: 8:00 a.m., in geri chair in room, crying, and moving around in the chair</p> <p>2/13/14 at 8:15 a.m., in the assist dining room for breakfast</p> <p>2/13/14: 8:45 a.m.- 10:30 a.m., in bed in room, crying</p> <p>2/13/14: 11:50 a.m.-12:15 p.m., sitting in main dining room, in geri chair, crying. Resident # 1 repeatedly asked Resident #40, "What's wrong, what's wrong?" Resident # 1 called out to Resident #40 " Hey that's enough, what's wrong?"</p> <p>2/13/14: 12:20 p.m. - 12:30 p.m., sitting in geri chair in assist dining room eating,</p> <p>2/13/14: 2:00 p.m.- 4:00 p.m., in bed in room, crying, family visiting</p> <p>The Social Service Director (SSD) was interviewed on 2/13/14 at 9:35 a.m.. During the interview, the SSD indicated the facility "Behavior Log" book is kept at the nurse's station. She indicated the book was there for any staff to use to report a behavior. The SSD indicated if a staff member sees a behavior, the staff member is to document the behavior in the Behavior Book. The SSD indicated she had taught the staff the staff how to complete the book, but she has to instruct</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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
F000323 SS=G	<p>staff repeatedly, because the forms don't always get completed. The SSD indicated she "...looks through the book at least monthly...". The SSD indicated the facility Behavior Committee meets once a month and resident behaviors are reviewed at that time. The SSD indicated she had talked with Resident #40 on 2/13/14 at 8:30 a.m. She indicated Resident #40 was crying because she wanted to lay down. The SSD indicated she had instructed staff to look Resident #40 in the eyes while speaking to her. The SSD had not updated the Care Plan interventions since 12/19/13.</p> <p>3.1-35(b)(2)(B)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to protect a resident from a hip fracture and head laceration during a hoyer transfer for 1 of</p>	F000323	F323 It is the practice of this facility to ensure that the residents' environment remains as free of accident hazards as possible; and that each resident	03/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1 residents in a sample of 3 residents reviewed for accidents. (Resident C)</p> <p>Findings include:</p> <p>Social Services Director was interviewed on 2/11/14 at 3 p.m. She indicated Resident C had suffered a femur fracture in December, 2013. The fracture had been reported to the state agency.</p> <p>The clinical record for Resident C was reviewed on 2/12/14 at 2:30 p.m. The resident's diagnoses included, but were not limited to: multiple sclerosis, borderline personality disorder, depression, neurogenic bladder, psychosis, malignant ovary neoplasm, and morbid obesity.</p> <p>The physician orders, dated 2/4/13, indicated the resident was to be up with assist of two people in a geri chair via hoyer lift, up only for meals sitting and may participate in activities as tolerated.</p> <p>There was an order, dated 12/11/13, to x-ray both hips, knees, and left forearm.</p> <p>A nursing note, dated 12/10/13 at 8:15 p.m. read as follows: "cna transferring res per hoyer lift, strap came off of hook and res fell out of lift and landed face down on the floor of her room. Assessed</p>		<p>receives adequate supervision and assistance to prevent accidents. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. An order for an xray was obtained for Resident C as indicated in the statement of deficiency. The xray concluded Resident C had a nondisplaced supracondylar fracture of her left femur. An investigation was immediately initiated. Staff was interviewed and statements obtained. One on one check offs on mechanical lifts was initiated on 12/11/14 with no C.N.A.'s being allowed to work until completed. During an interview with D.O.N. and Administrator on 12/11/13 C.N.A. #5 and admitted to not following the facilities Hoyer Lift policy and procedure and was suspended pending investigation. C.N.A #5 was terminated on 12/13/13. An inservicing was held for nurses 12/11/13 and 12/24/13 in which education on transfers on the Hoyer lift, the facilities Hoyer lift policy and procedure and the C.N.A resident care guide. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state what action the facility took to correct the deficient practice for any client the facility identified as being affected. All residents being transferred by mechanical lifts have the potential to be affected by the same</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>res for injury, goose egg mid forehead, redness bilateral knees and left forearm. Neuro checks initiated and wnl (within normal limits). Transferred floor to bed with hoyer lift and 2 staff. MAE (moving all extremities) as prior to fall. c/o headache, prn tylenol given. b/p 108/62, t 97.9, p 65, r 20, MD and mother notified."</p> <p>The fall risk assessment, dated 11/1/13, indicated a score of 10 (>10 = high risk of falls) The fall risk assessment, dated 12/11/13, indicated a score of 12. A fall risk assessment, dated 12/27/13, was a score of 14.</p> <p>Observation of the resident being transferred by the hoyer lift was done on 2/13/14 at 9:30 a.m. CNA # 3 and & CNA #4 transferred the resident without any difficulty. There were no complaints from the resident.</p> <p>The Maintenance Director was interviewed on 2/13/14 at 9:00 a.m. He indicated he had checked over the hoyer after the resident had fallen and found no breaks or loose nuts or bolts. He indicated there was nothing wrong with mechanics of the lift.</p> <p>The facility provided an investigation of the fall incident on 2/13/14 at 8:30 a.m.</p>		<p>deficient practice. However, no other resident has been affected and it is our goal that with education and continued skills check off's that no other resident will be affected. Describe the steps or systematic changes the facility made or will make to ensure the deficient practice does not recur, including any in services, but this should also include any system changes you have made. It is our desire that this kind of accident never recurs. All nursing staff before working the floor will have completed a skills check off on mechanical lifts and annual check offs will continue. Assignment sheets continue to show mode of transfer on all residents and state when 2 staff are needed. Nurse staff have been inserviced on transfers, the Hoyer lift policy and procedure and the C.N.A. care guide. The DON will periodically observe staff performance as she is rounding in the facility, including observation of the CNAs as they are using the mechanical lifts. Any identified issues regarding the procedures for using the mechanical lift will be addressed at the time of observation – the DON and/or charge nurse will intervene immediately and make sure that the resident is safe. Once that is assured, the staff involved will be re-trained on the proper procedure and facility policy for using the mechanical lift.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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 investigation included a statement by CNA # 5., dated 12/11/13 at 2:50 p.m. It indicated the CNA "states she was transferring resident from her Jeri (sic) chair to her bed. CNA states that she was using the hoier by herself. When asked why she did not have another staff member present with her the CNA states I didn't think about it, everyone was busy, I just transferred her.' Asked CNA if she was aware of our facility policy regarding the hoier lift, cna stated yes. When asked CNA how resident fell, CNA stated she was unaware. She states she checked the hoier lift pad and it was in good condition. She placed the 4 straps on the hoier lift and began lifting her. She states she had her raised from the chair, she had not moved the hoier lift yet and the resident fell to the floor. She states she heard a 'click, click' but is unaware what caused that. She states resident fell forward to her knees and then fell completed forward to the floor...." She also indicated that all four straps were connected. Other staff were interviewed by phone and indicated they had not been involved in the transfer because CNA #5 had not asked for help.</p> <p>The CNA was terminated for not following the policy according to an interview with the Administrator on 2/13/14 at 9:45 am.</p>		<p>Progressive disciplinary action, up to, and including termination of employment, will be done for instances of continued noncompliance. Describe how the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e. what quality assurance program will be put into place. The DON will review the results of the monitoring activities and observations of mechanical lift transfers at the monthly Quality Assurance Committee meeting for three months. Any Committee recommendations for further process improvement will be followed up by the DON and the results of those recommendations will be brought back to the next monthly QA Committee meeting for further review and discussion. If there has been 100% compliance with the proper use of the mechanical lifts in the facility at the end of the 3 months, the QA Committee may decide to stop further review of this process with the committee; however, the observations of performance and follow up as indicated previously will continue on an ongoing basis.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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
--------------------	--	---------------	---	----------------------

F000329 SS=E	<p>The facility policy, titled "Hoyer Lift", dated 9/04 and revised 6/06, was provided by the Administrator on 2/14/2:00 p.m. It indicated the following: "All resident transfers that are done by means of a mechanical lift will be done with 2 nursing staff members (nursing assistants or nurses) in attendance at all times."</p> <p>This Federal tag relates to Complaint # IN00141249.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that</p>			
-----------------	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 5 of 5 sampled residents and 2 of 2 supplemental sampled residents reviewed for unnecessary medications were free from unnecessary psychoactive medications. This resulted from the facility's failure to use nonpharmacological approaches for behavior for 1 resident (Resident 40), the use of an antidepressant for sleep without monitoring sleep patterns (Resident 14), the use of antipsychotic medications without adequate indications (Residents 13 and 14), and to monitor and complete gradual dose reductions for 4 residents (Residents 2,15, 32, and 38).</p> <p>Findings Include:</p> <p>1. The clinical record of Resident # 40 was reviewed on 2/11/14 at 11:15 a.m. The record indicated the resident's diagnoses included, but were not limited to, Intracranial Hemorrhage, Depression, Pain, Craniotomy, Anxiety, and</p>	F000329	<p>F329 – Drug Regimen is free from unnecessary drugs It is the standard of this facility that residents are free from unnecessary drugs. What corrective action will be accomplished for those resident found to be affected by the deficient practice? Resident #40's Haldol was decreased on 2/14/14. The Lexapro and Ativan were decreased on 3/4/14. Resident #14's Trazadone was discontinued on 2/20/14. A 3 night sleep study was done and indicated resident had no trouble sleeping. Resident #14's care plan for being awake much of the night was discontinued on 2/25/14. The SSD did not state she had no further information regarding the use of Resident #14's use of Trazadone as indicated on the 2567. No further information was requested regarding the use of Resident #14's Trazadone from the SSD. The 2567 speaks of Resident #14's Seroquel that had been discontinued on 1/25/14. The 2567 states further information was requested but not provided.</p>	03/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>Dementia with Behavioral Disorder.</p> <p>The February 2014 Physician Orders signed on 2/6/14 indicated the resident's medications included, 10 milligrams (milligrams) of Lexapro (antidepressant) for tearfulness daily, 1 mg Haldol (nations) twice a day for Dementia with Behavioral Disorder, and 1 mg Ativan (antianxiety), three times a day for anxiety.</p> <p>The 2013 and 2014 Pharmacist reviews indicated "NR", meaning no recommendations for changes in medications.</p> <p>Review of the physician progress notes did not indicate dose reduction for the medications.</p> <p>The Quarterly Minimum Data Set Assessment (MDS) dated 12/10/13, indicated Resident #40 had no memory impairment, no signs of delirium, and displayed no behaviors.</p> <p>The Care Plan dated 12/19/13 indicated, Resident #40 was receiving the Lexapro, Haldol, and Ativan. The Care Plan interventions included monitoring for side effects. The Care Plan did not indicate dose reductions. The Care Plan did not include updated non</p>		<p>Per interview with staff members here on 2/14/14, no staff was questioned regarding the use of Resident #40's Seroquel or was information requested. Resident #13 behavior management program was reviewed on 2/25/14. Resident #13 garbled speech and talking to people was added to his program. The 2567 also states that the SSD said the behavior committee did not meet to discuss the administration of the Zyprexa. The SSD indicated to the surveyor that the usage of the medication was discussed the next morning during the management daily stand up meeting. She also indicated that the facility psychologist was notified of the incident and did come into the building to see Resident #13. Resident #38's Seroquel was decreased on 2/20/14. Resident #38's Xanax and Celexa were decreased on 3/5/14. A behavior management program was implemented for her on 2/25/14. Resident #2 behavior management program was reviewed on 2/25/14 and no changes were made at this time. Resident #2's Paxil was decreased on 2/20/14. Resident #15's Zyprexa was reduced on 2/20/14. A behavior program was not implemented for resident #15. If behaviors are seen a program will then be implemented. Resident #32's Abilify was decreased on 2/20/14 and the Cymbalta decreased on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>pharmacological interventions for treatment of Resident #40's behaviors.</p> <p>The Social Service notes were reviewed. Notes dated 12/30/13 and 1/28/13 indicated the resident was crying. The notes indicated sometimes she wants to lay down and sometimes the resident doesn't know why she was crying. Both notes indicated reassurance was provided by the Social Service Director. The last Social Service Note was dated 1/28/14. The Social Service notes did not indicate changes or adjustments for nonpharmacological approaches for the behaviors of Resident #40.</p> <p>The following observations were made of Resident #40: 2/11/14 : 10:45 a.m. - 11:30 a.m., in room, in bed, crying with no music playing, no staff present 2/11/14 : 2:00 p.m.- 4:00 p.m. in bed, in room, crying, no music playing, no television on A music activity was being held in the dining room. 2/12/14: 8:55 a.m., in bed, crying out, no music playing, no television on 2/12/14: 10:15 a.m., in bed, crying 2/12/14 at 2:15 p.m., in bed, crying, room mates television is on 2/12/14: 3:40 p.m.-4:00 p.m., in bed, crying, roommates television on, no staff present, has kicked off blankets</p>		<p>3/5/14. How other resident having the potential to be affected by the same deficient practice will be identified ad what corrective action will be taken? An audit was completed of all resident's psychoactive medications. Changes were made as needed. This was completed on 2/18/14. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice doesn't reoccur? All residents receiving psychotropic medications will be reviewed monthly by the interdisciplinary team. All residents who have not had a gradual dosage reduction of psychotropic medications per the federal regulation will be identified at that time. The physician will be notified of the need for a drug reduction. If the physician believes that there is a clinical contraindication for reducing the drug, he/she will be asked to document that rationale in the resident's clinical record. During subsequent reviews, the IDT will review each of these records to ensure there is documentation evident to indicate sufficient rationale to clinically contraindicate the reduction or that an order has been received to reduce the drug's dosage. How the corrective action will be monitored to ensure the deficient practice will not recur? The results of the reviews will be brought to the monthly QA</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>2/13/14: 8:00 a.m., in geri chair in room, crying, and moving around in the chair</p> <p>2/13/14 at 8:15 a.m., in the assist dining room for breakfast</p> <p>2/13/14: 8:45 a.m.- 10:30 a.m., in bed in room, crying</p> <p>2/13/14: 11:50 a.m.-12:15 p.m., sitting in main dining room, in geri chair, crying. Resident # 1 repeatedly asked Resident #40, "What's wrong, what's wrong?" Resident # 1 called out to Resident #40 " Hey that's enough, what's wrong?"</p> <p>2/13/14: 12:20 p.m. - 12:30 p.m., sitting in geri chair in assist dining room eating,</p> <p>2/13/14: 2:00 p.m.- 4:00 p.m., in bed in room, crying, family visiting</p> <p>The Director of Nursing (DoN) was interviewed on 2/11/14 at 11:30 a.m. The DoN indicated, crying was Resident #40's way of communicating with staff. She indicated if the resident saw new or different people in the facility, the resident would cry. The DoN indicated the resident cried when her family came to visit as well.</p> <p>The Social Service Director (SSD) was interviewed on 2/13/14 at 9:35 a.m.. During the interview, the SSD indicated the facility "Behavior Log" book is kept at the nurse's station. She indicated the book was there for any staff to use to report a behavior. The SSD indicated if a</p>		<p>meeting for 3 months for further review and recommendations. The QA committee will determine the continued frequency of the review after the 3 month time period once the facility has demonstrated 100% compliance. However, the review process at the clinical meetings and the monthly psychotropic drug review will continue on an ongoing basis.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>staff member sees a behavior, the staff member is to document the behavior in the Behavior Book. The SSD indicated she had taught the staff the staff how to complete the book, but she has to instruct staff repeatedly, because the forms don't always get completed. The SSD indicated she "...looks through the book at least monthly...". The SSD indicated the facility Behavior Committee meets once a month and resident behaviors are reviewed at that time. The SSD indicated she had talked with Resident #40 on 2/13/14 at 8:30 a.m. She indicated Resident #40 was crying because she wanted to lay down. The SSD indicated she had instructed staff to look Resident #40 in the eyes while speaking with her. The SSD indicated residents receiving psychoactive medications are not always monitored by the Behavior Committee. She indicated the residents are monitored only if behaviors are displayed. She indicated the committee does discuss gradual dose reductions. The SSD indicated the facility Behavior Policy did not include monitoring for residents receiving psychoactive medications or the gradual dose reductions of psychoactive medications in the meetings. The SSD further indicated the facility Behavior Policy did not include monitoring for residents receiving psychoactive medications or the gradual</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>dose reductions of psychoactive medications.</p> <p>2. The clinical record of Resident # 14 was reviewed on 2/13/14 at 9:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, Dementia, Arthritis, and Anxiety.</p> <p>The February Physician orders signed on 2/6/14, included an order dated 1/25/14 for 25 milligrams (mgs) of Trazadone (antidepressant) to be given at night for trouble sleeping.</p> <p>The Care Plan dated 1/23/14, indicated Resident #14 had episodes of being awake much of the night. The Care Plan interventions included: a calm, quiet sleeping environment, check comfort level, keep clean and dry, encourage activities in the day time, find out what's causing the difficulty sleeping and resolve.</p> <p>One Nursing Note dated 12/24/13 at 2:00 a.m., indicated the resident was awakened at 12:30 a.m. for personal care and was still awake at 1:30 a.m. There was no other documentation in the nursing notes regarding the resident's lack of sleeping.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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 Social Service Notes indicated no information about the resident's inability to sleep.</p> <p>The January 2014 and February 2014 Behavior Monitoring Logs indicated did not address sleep or nonpharmacological interventions to assist the resident to sleep.</p> <p>Certified Nursing Assistant (CNA) # 12 was interviewed on 2/13/14 at 2:40 p.m. The CNA indicated Resident #14 usually is ready for bed right after supper and still in bed at 10:00 p.m.</p> <p>CNA #13 was interviewed on 2/14/14 at 9:00 a.m. The CNA indicated Resident #14 is usually out of bed when her shift starts at 6:00 a.m.</p> <p>The Social Service Director (SSD) was interviewed on 2/14/14 at 9:30 a.m. Further information was requested regarding the use of the antidepressant, Trazadone for sleep, documentation of the resident's sleep patterns and information regarding nonpharmacological interventions to assist the resident to sleep.</p> <p>On 2/14/14 at 9:35 a.m., the SSD indicated she had no information regarding the use of Trazadone for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>Resident #14.</p> <p>The February 2014 Physician orders for resident #14, signed on 2/6/14, indicated an order for the antipsychotic, Seroquel dated 2/28/13. The medication was discontinued on 1/25/14.</p> <p>The " 2010 Nursing Spectrum Drug Handbook", on page 1007, indicated, "FDA Boxed Warning Elderly patients with dementia related psychosis... "Indications ...Schizophrenia...Acute manic episodes associated with bipolar 1 disorder... Depression associated with bipolar disorder...". "Precautions: use cautiously in: ...elderly or debilitated patients...".</p> <p>The Care Plan discontinued on 1/25/14 indicated, the administration of the antipsychotic, Seroquel. The Care Plan interventions included, observe for side effects.</p> <p>Further information regarding the use of the antipsychotic medication, Seroquel, was requested on 2/14/14 at 10:30 a.m.. No further information was provided.</p> <p>3. The clinical record of Resident #13 was reviewed on 2/12/14 at 8:35 a.m. The record indicated the resident's diagnoses included, but were not limited</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>to, Mental Retardation, Diabetes, Depression, Schizoaffective Disorder, and Bipolar Mood Disorder.</p> <p>The February Physician Orders signed on 2/6/14, indicated, 400 milligrams (mgs) of Seroquel (antipsychotic) twice a day, 75 mgs of Zoloft (antidepressant) once a day, and 5 mgs of Zyprexa (antipsychotic) as needed for mood behaviors.</p> <p>A telephone order dated 1/25/13 indicated, 10 mgs of Zyprexa every four hours as needed for increased agitation.</p> <p>A nursing note dated 1/25/14 at 9:10 a.m. indicated, "... Eye twitch and talking to invisible people. Garbled speech. Unclear as to what resident is trying to say. Zyprexa administered around 6:15 a.m., non effective. Continues to talk to self and invisible people....".</p> <p>A nursing note dated 1/25/14 at 12:00 p.m., indicated the resident received the 10 mg of Zyprexa.</p> <p>A nursing note dated 1/25/14 at 1:30 p.m., indicated the resident was sleeping.</p> <p>The January 2014 Behavior Log was reviewed on 2/12/14 at 8:40 a.m. The log indicated no behaviors were documented</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203		
(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>in January 2014.</p> <p>The "Behavior Monitoring Log" did not include a behavior of garbled speech, or talking to people who were not there.</p> <p>The Care Plan reviewed on 11/19/13, did not include a Care Plan for garbled speech or talking to people who were not there.</p> <p>The Social Service Director (SSD) was interviewed on 2/13/14 at 9:35 a.m.. During the interview, the SSD indicated the facility "Behavior Log" book is kept at the nurse's station. She indicated the book was there for any staff to use to report a behavior. The SSD indicated if a staff member sees a behavior, the staff member is to document the behavior in the Behavior Book. The SSD indicated she had taught the staff the staff how to complete the book, but she has to instruct staff repeatedly, because the forms didn't always get completed. The SSD indicated she "...looks through the book at least monthly...". The SSD indicated the facility Behavior Committee meets once a month and resident behaviors are reviewed at that time. The SSD indicated resident receiving psychoactive medications are not always monitored by the Behavior Committee. She indicated the residents are monitored only if</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>behaviors are displayed. She indicated the committee does discuss gradual dose reductions in the meetings. The SSD further indicated the facility Behavior Policy did not include monitoring for residents receiving psychoactive medications or the gradual dose reductions of psychoactive medications dose reductions in the meetings. The SSD further indicated the facility Behavior Policy did not include monitoring for residents receiving medications or the gradual dose reductions of psychoactive medications. The SSD indicated the committee had not met and discussed the administration of Zyprexa for Resident #13.</p> <p>4. The clinical record of Resident # 38 was reviewed on 2/12/14 at 9:35 a.m. The record indicated the resident's diagnoses included, but were not limited to, Anxiety, Dementia, and Psychosis due to Parkinson's medication use.</p> <p>The February Physician orders signed on 2/10/14, indicated, an order dated 11/20/12 for 0.25 milligrams (mgs) of Xanax (antianxiety) three times a day for anxiety, an order dated 10/30/12 for 20 mgs Celexa (antidepressant) daily for depression, and an order dated 10/19/12 for 25 mg Seroquel twice daily for Psychosis.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>A telephone order dated 6/20/13, indicated " No dose reduction of Xanax, Celexa, or Seroquel at this time. Res (resident) at highest level of psycho-social well being on current doses".</p> <p>A telephone order dated 10/16/13 indicated, "Pt (patient) currently takes psychotropic meds Xanax et (and) Celexa. No reduction needed @ this time".</p> <p>Neither telephone order was accompanied by an assessment. The 10/16/13 order did not address the Seroquel.</p> <p>A Psychological Consultation, completed by the Psychologist, dated 11/29/13, indicated the resident's family member did not want changes made to Resident # 38's medications. The consultation indicated the resident was regularly reviewed by the facility Behavior Committee.</p> <p>The Social Service Director (SSD) was interviewed on 2/13/14 at 9:45 a.m. The SSD indicated residents receiving psychoactive medications are not always monitored by the Behavior Committee. She indicated the residents are monitored</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>only if behaviors are displayed. She indicated the committee does discuss gradual dose reductions in the meetings. The SSD further indicated the facility Behavior Policy did not include monitoring for residents receiving psychoactive medications or the gradual dose reductions of psychoactive medications in the meetings. The SSD further indicated the facility Behavior Policy did not include monitoring for residents receiving medications or the gradual dose reductions of psychoactive medications.</p> <p>Review of the facility Behavior Reports and Logs on 2/14/14 at 9:15 a.m., indicated no behavior Monitoring for Resident #38.</p> <p>The SSD was interviewed on 2/14/14 at 9:20 a.m. The SSD indicated there was no Behavior Tracking for Resident # 38. The SSD indicated there had been no Gradual Dose Reductions attempted for Resident #38</p> <p>5. The clinical record for Resident # 2 was reviewed on 2/12/14 at 2:00 p.m. The resident had diagnoses which included, but were not limited to: advanced multiple sclerosis, recent fracture of femur, and bipolar disorder.</p> <p>Review of physician order rewrites, dated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>2/6/14, indicated the resident was receiving Divalproex 250 mg (milligrams) bid (twice daily) for bipolar disorder and Paxil 40 mg. daily for sexual acting out.</p> <p>Review of the behavior monitoring log, on 2/13/14 at 8:20 a.m., indicated no behaviors had been witnessed or recorded for the months of January and February, 2014. There were no behaviors recorded for the month of December, 2013. The resident was being tracked for making sexually inappropriate comments, cussing, taking food off other resident's plates, and taking her clothes off. The behavior log for November, 2013 indicated CNA# 1 had witnessed the resident making sexual comments on 11/2/13 at 6 p.m. There were no interventions listed for being effective or noneffective. There were no indications of any interventions having been tried. There was no indication as to any precursor of the behavior, who had been involved in the incident, or what the resident had actually stated.</p> <p>The behavior monitoring record, undated, included the following interventions for the behavior of "making sexually inappropriate comments: "a. Ask resident to stop the behavior; b. Assist resident away from others; c. Try to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>redirect resident's attention; d. Try to involve resident in activities; e. Remind resident the behavior is not appropriate."</p> <p>Interview with the Maintenance Director, on 2/13/14 at 9 a.m., indicated the resident had made sexually inappropriate comments to him. He indicated, when she made those kind of statements, he reported them to the Director of Nursing or Social Services Director usually in the morning department head meeting. He indicated he did not remember how long ago that had been.</p> <p>The care plan, dated 10/21/11, indicated the resident had a problem of "verbal sexually inappropriate behavior to staff and visitors." The care plan indicated it had been updated on 6/11/13. The interventions included "Ask me to stop the behavior; assist me away from other residents; try to redirect my attention; try to involve me in activities; remind me the behavior is not appropriate; observe me for sexually inappropriate behaviors (added 2/9/13); and ask me to not encourage other residents to act inappropriately (added 2/9/13)." There was no indication any interventions had been changed or added since 2/9/13.</p> <p>The Social Services Director was interviewed on 2/13/14 at 1:30 p.m. She</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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 resident did have behaviors of being sexually inappropriate. She was unaware of the last time the resident had made any comments. She had not been informed of any time the resident had made sexually inappropriate comments to the Maintenance Director. She could not recall when the last time was that the resident had made such comments.</p> <p>The Social Services Director further indicated any staff could document a resident's behavior in the behavior log. The staff should also include what interventions had been used to address the behaviors. She also indicated the care plans and interventions were updated at each behavior meeting, depending on what behaviors had occurred. The behavior meeting took place only once a month. She indicated the resident's care plan would be reviewed at the upcoming meeting.</p> <p>The requested most recent psychologist consultation, dated 2/19/13, indicated the resident had been involved in a resident to resident altercation without any physical or emotional injury. The resident was not assessed on a regular basis by the psychologist, as indicated by the Administrator and Social Services Director on 2/13/14 at 1:30 p.m.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>Review of the Psychotropic Medication Log, provided by the Social Services Director, on 2/14/14 at 1:30 p.m., indicated the resident had her Paxil dosage increased on 2/19/13 from 20 mg. to 40 mg. The dosage was reviewed for gradual dose reduction (GDR) on 8/24/13 and again on 11/21/13. A "contraindicate GDR" note was placed under comments on the form directly across from each date.</p> <p>The following statement, dated 11/21/3, was in the clinical record to explain the contraindication for the GDR: "The above named Patient's case was discussed at length in today's behavior management meeting. This patient is currently taking the psychotropic medication Paxil. This medication assists in maintaining this patient's highest level of psychosocial well-being. Further dosage reduction will adversely affect the Patient's behavior. No further dose reduction at this time should be pursued as evidenced by the MD's Dated Signature below." This form was signed by the attending physician.</p> <p>The Social Service Director, during the interview on 2/13/14 at 1:30 p.m., indicated Resident # 2 would not be evaluated for a dosage reduction of her Paxil since she had two failed GDR</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>attempts even though she had not demonstrated any behaviors for three months. She indicated the facility did not have a policy for when to reduce drugs if no behaviors had occurred.</p> <p>6. The clinical record for Resident #15 was reviewed on 2/13/14 at 2:30 p.m. Current diagnoses included, but were not limited to, psychosis due to Parkinson's medication use, confusion, debilitated patient, dementia, edema, chronic obstructive pulmonary disease, urinary tract infection and asthma.</p> <p>The resident was currently receiving the following medication, on a daily basis Zyprexa (Antipsychotic) originally ordered on 8/24/2013.</p> <p>The chart indicated a GDR (Gradual Dose Reduction) on Zyprexa, being used as a antipsychotic was last completed on 8/24/13. A contraindication note for Zyprexa (Antipsychotic) was last completed on 11/21/13.</p> <p>A Psychologist consultation note dated 10/30/12, was provided by the Social Service Director on 2/14/14 at 10:38 a.m. and indicated the last time Resident #15 had been assessed by the Psychologist was on 10/30/12.</p> <p>During an interview with the Social</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203		
(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>Service Director on 2/13/14 at 3:03 p.m., she stated "...resident is stable, she is alert and oriented. No signs or symptoms of confusion... Last behavior was in November of 2012. Resident has been stable since."</p> <p>During an interview with the Administrator on 2/14/14 at 11:24 a.m., she indicated there was no further documentation to present for Gradual Dose Reductions.</p> <p>No further documentation was provided by the facility as of exit 2/14/14.</p> <p>7. Resident #32 clinical record was reviewed on 2/12/14 at 2:23 p.m.</p> <p>Current diagnoses included, but were not limited to, depression, schizoaffective disorder and anxiety.</p> <p>Resident #32 had current orders for Abilify (an atypical antipsychotic medication) 30 milligrams (mg), 1 tablet by mouth every day for schizoaffective disorder and Cymbalta (an antidepressant medication) 30mg capsule along with a 60mg capsule to equal 90 mg by mouth every morning for anxiety and depression.</p> <p>Resident #32's record had a contraindication letter for refusal of a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>GDR (Gradual Dose reduction) for the medication Abilify dated 8/20/13 and the Cymbalta dated 2/19/13 which were signed by the Physician, but lacked any assessment showing justification for refusal of GDR for either medication.</p> <p>In a policy titled "Medication-Unnecessary", provided by the Administrator on 2/14/14 at 3:00 p.m:</p> <p>"TAPERING OF A MEDICATION DOSE/GRADUAL DOSE REDUCTION (GDR)</p> <p>The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms..."</p> <p>"...If the resident's condition has not responded to treatment or has declined despite treatment, it is important to evaluate both the medication and the dose to determine whether the medication should be discontinued or the dosing</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>should be altered, whether or not the facility has implemented GDR as required, or tapering..."</p> <p>"...with in the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility will attempt a GDR in two (2) separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated..."</p> <p>"...For residents receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated if:</p> <p>The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or..."</p> <p>"...For as long as a resident remains on a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations(sic) for duration of use, the facility will attempt to taper the medication quarterly unless clinically contraindicated, as defined below:</p> <p>the continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any additional attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or..."</p> <p>"...During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two (2) separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated, as described below:..."</p> <p>3.1-48(a)(4)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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
F000353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to assure there were enough nursing staff to answer call lights without residents having to wait a long time for 5 of 14 residents interviewed and 1 of 3 family members interviewed. (Resident # 19, # 26, # 9, # 22, # 10 and family member for Resident # 38)</p> <p>Findings include:</p>	F000353	F353 – Sufficient 24 hour nursing staff per care plans The facility disagrees with the survey findings regarding this alleged deficiency and respectfully requests the face-to-face Informal Dispute Resolution process. It is the standard of this facility that sufficient nursing staff is provided to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident per their care plan. What corrective action will be	03/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1. Resident # 19 was interviewed on 2/11/14 at 2:45 p.m. and indicated he did not feel there was enough staff to meet residents' needs without having to wait a long time. He further indicated there were "not enough aides to address the resident concerns around here. I've had to wait an hour to get up in my chair or some need that it might have been. It's not the aides fault really, there is 35 people in here. It's hard to be in two places at once. There isn't enough of them."</p> <p>2. Resident # 26 was interviewed on 2/11/14 at 3:50 p.m. He indicated the "aides are getting their work done, but more times than not, they are working with only two aides." He indicated he believed they (the CNAs) needed more help because of all the work they have to do.</p> <p>3. Resident # 9 was interviewed on 2/11/14 at 2:30 p.m. She indicated she didn't get her water changed and there wasn't enough staff to answer call lights without having to wait a long time.</p> <p>4. Resident # 22 was interviewed on 2/11/14 at 2:15 p.m. She indicated the facility "need more CNA's because of the hoyer lift. It takes more time and these residents have a higher acuity. So we do</p>		<p>accomplished for those residents found to have been affected by the deficient practice? Residents #19, #26, #9, #28, #10 have been interviewed daily by their Guardian Angels starting 2/28/14 and have voiced no concerns regarding the facility having enough nursing staff to answer their call lights in a timely manner. Family member of resident #38 has been interviewed by the Administrator and currently has no concerns. How other residents having the potential to be affected will be identified and what corrective action will be taken? All residents have the potential to be affected, but no other residents have been identified at this time. Alert and oriented residents who have a BIMS score of 12 or greater have been interviewed by the Administrator and have expressed no concerns. What measures will be put into place to ensure that the deficient practice does not recur? During daily Guardian Angel rounds, if issues or concerns regarding the timeliness of call light answering are expressed by residents and/or family members a Resident/Family concern form will be filled out. The form will be forwarded to the Administrator and/or designee immediately. The concern will be investigated with a resolution and proper documentation completed. The concern will be discussed during</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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>wait too long at times."</p> <p>5. Resident # 10 was interview on 2/11/14 at 2:00 p.m. The resident answered "no" when asked if the facility had enough staff to meet the residents needs without having to wait a long time. She indicated they just need more help.</p> <p>6. The family member for Resident # 38 was interviewed on 2/12/14 at 10:00 a.m. He indicated the facility was short handed sometimes, usually around the noon or evening meal time.</p> <p>7. CNAs # 3, 4, 7, and 10 were interviewed on 2/13/14. The CNAs worked both the day shift and the afternoon shift. They indicated have worked "short", but were able to get most of the work done. One indicated that "you have to prioritize." Another indicated she was not able to pass water to the residents. Another indicated she stayed to get everything done even if she wasn't getting paid for the extra time. The fourth CNA indicated she was able to get her work done, just not as quickly as residents wanted.</p> <p>Review of the 672 form, completed by facility staff and returned on 2/11/14 at 10:30 am (resident census and conditions of residents) indicated 16 of 33 residents</p>		<p>the next daily stand up meeting for review of investigation and resolution. How the corrective action will be monitored to ensure the deficient practice will not recur? The Administrator will bring the Guardian Angel rounds and Resident/Family concern log to the monthly QA committee meeting for review of outcomes and any trends or patterns of concerns. Any recommendations made by the committee will be given be implemented. If there has been 100% compliance the end of the 3 months, the QA Committee may decide to stop further review of this process with the committee; however, the Guardian Angel rounds will continue on a daily basis.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>were dependent on staff for bathing, 11 of 33 residents were dependent on staff for transfers; 13 of 33 residents were dependent for dressing and toilet use; 15 of 33 residents were occasionally/frequently incontinent of bladder and on a toileting program; 30 of 33 residents were receiving preventive skin care; 3 residents had feeding tubes; 12 residents had a psychiatric diagnosis; 15 of 33 residents had a dementia diagnosis; and only five residents were independently mobile. The Administrator supplied a list showing 15 of 33 residents required the Hoyer lift for transfers.</p> <p>The Director of Nursing was interviewed about how she determined the amount of staff necessary to meet the residents' needs on 2/13/14 at 10:30 a.m. She indicated the number of staff was determined by a set ratio. This ratio of 2.5 staff per patient days had been determined by the facility corporation. She was not aware of any concerns by the residents with not enough staffing.</p> <p>The Director of Nursing shared the staffing ratio sheets which indicated the facility should have 3 CNAs or QMAs (qualified medications aide) for the day shift, 2 to 2 1/2 CNAs working the afternoon shift, and 1 CNA on the night</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(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			
F000356 SS=C	<p>shift. She indicated the nurse should make rounds with the CNA on the night shift since she had no medications to pass. The staffing ratio would increase if the census fell below 25 residents.</p> <p>3.1-17(a)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure posted nursing staff information was accurate and up to date for 1 of 4 days of the survey (2/11/14). This practice had the potential to affect 33 of 33 residents residing in the facility.</p> <p>Findings include:</p> <p>During initial tour on 2/11/14, at 9:15 a. m., the posted nursing staff information form was found to be posted with an incorrect date of 2/5/14.</p> <p>During a second tour of the facility on 2/11/14, at 9: 45 a. m., the posted nursing staff information form was found with the correct date of 2/11/14, and with inaccurate information for the licensed nursing staff currently working.</p> <p>During an interview on 2/11/14, at 9:45 a. m., the Director of Nursing indicated one CNA (certified nursing assistant), had phoned in ill, and the nursing staff information form had not yet been updated. She also indicated the posted nursing staff information form indicated</p>	F000356	<p>F356 – Posted Nurse Staffing Information It is the standard of this facility that a daily nursing staff form is posted with complete and accurate information. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No resident has been affect by this deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No residents have been affected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Nursing staff were educated on the “Staffing – Daily Posting” policy and procedure on February 19, 2014. The charge nurse will post the “Report of Nursing Staff Directly Responsible for Resident Care” on a daily basis at 5:00am. The Director of Nursing and/or designee will review the form for complete accuracy Monday through Friday. The weekend manager will review the form on the weekends. How the corrective action will be monitored to ensure</p>	03/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203		
(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	
F000371 SS=F	<p>an LPN (licensed practical nurse) is posted as working, when an RN (registered nurse) is actually working.</p> <p>Review of a current facility policy provided by the Administrator on 2/14/14 at 2:50 p. m., titled "Staffing- Daily Posting" indicated the following: "Policy: the number of licensed and unlicensed nursing staff directly responsible for direct care of residents, will be posted at the beginning of each shift in a designated, visible location within the facility, as directed by Federal regulations".</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or</p>		<p>the deficient practice will not recur? The Director of Nursing and/or designee will review the form for complete accuracy Monday through Friday. The weekend manager will review the form on the weekends. The review of the forms will be brought to the next morning meeting and any issues will be addressed at that time. How the corrective action will be monitored to ensure the deficient practice will not recur? The Director of Nursing and/or designee will review the form for complete accuracy Monday through Friday. The weekend manager will review the form on the weekends. The review of the forms will be brought to the next morning meeting and any issues will be addressed at that time. These reviews will be brought before the QA monthly committee meeting for the next 60 days. After 60 days the QA committee will make a recommendation if 100% compliance has been achieved that the daily reviews no longer need to be brought before the committee; however, the process to make sure the posted staffing is accurate will continue on an ongoing basis.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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>considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure the facility 1 of 1 stove, 1 of 2 ovens, 1 of 2 drip trays, and 1 of 1 knife were free of food particles. In addition the facility failed to ensure 3 of 3 large skillets were replaced when the Teflon coating was scratched. This failure had the potential to affect all residents living in the facility.</p> <p>Findings include:</p> <p>The Initial Kitchen Tour was conducted on 2/11/14 at 9:30 a.m. During the tour, a greasy looking debris was observed on the stove's back splash. One of the kitchen's oven's was opened. A large amount of black formed food debris, was observed on the bottom of the oven. To the right of the oven, attached under the stove top was a drip tray. The drip was covered with brown food crumbs. The white knife rack was attached to the wall beside the stove. Along the top of the knife rack was a brown, greasy film.</p> <p>Three large Teflon skillets hung on the skillet rack. All three skillets were dented. The Teflon on the inside of each pan was scratched exposing the silver bottom of the skillets.</p>	F000371	<p>F371 It is the policy of this facility to ensure that we store, prepare, distribute and serve food under sanitary conditions. 1. What corrective action will be accomplished for residents affected? No residents were identified as being negatively affected by this practice. The stove's back splash was cleaned on 2/13/14. The inside of the oven was wiped out on 2/13/14. The drip tray was cleaned of crumbs on 2/13/14. The knife rack was cleaned on 2/13/14 and it was removed to another area of the kitchen on 2/14/14. The Teflon pans were thrown away on 2/13/14 and new pans were purchased on 2/17/14. The facility would like to state for the record that there were only 2 Teflon pans not three Teflon pans found to have issues. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were identified as being affected by this practice. All dietary staff was in serviced on February 19, 2014 on general sanitation of the kitchen. They will be re-inserviced 3/4/2014 on general sanitation of the kitchen. 3. What measures will be put into place to ensure that this practice does not recur? The dietary</p>	03/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
---	---

(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 kitchen was again observed on 2/13/14 at 10:45 a.m. The same observations were again made.</p> <p>The Certified Dietary Manager (CDM) was interviewed. The CDM indicated she did have a cleaning schedule for the dietary staff to follow.</p> <p>The "Daily Cleaning Schedule" was presented by the CDM on 2/13/14 at 11:15 a.m. The schedule indicated the stove, drip pan, and knife rack were cleaned daily.</p> <p>The "Month Cleaning Schedule" was presented by the CDM on 2/13/14 at 11:15 a.m. The schedule indicated the kitchen oven had been cleaned three weeks in January and the first week of February.</p> <p>The CDM was interviewed on 2/13/14 at 11:15 a.m. The CDM indicated she planned to order new skillets to replace the dented, scratched skillets.</p> <p>3.1-21(i)(3)</p>		<p>manager will make daily rounds in the kitchen to observe the overall cleanliness of the kitchen and specifically the issues addressed in the 2567 for the next 30 days. The administrator will do a sanitation audit weekly. Any issues found will be addressed immediately. This audit will be reviewed at the next management's morning meeting. The Registered Dietician will continue to do monthly sanitation audits of the kitchen and issues noticed will be addressed when found. This audit will be reviewed at the monthly QA meeting. The QA committee will review daily observations and the weekly sanitation audits and decide when these observations and weekly audits can be discontinued. 4. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?Results of the monthly sanitation audit will be reviewed at the next day's management meeting with issues addressed. The dietary manager will ensure compliance with daily rounds of the kitchen. The sanitation audit will be reviewed at the QA meeting.</p>	