

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00201404 and IN00201144.</p> <p>Complaint IN00201404 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223.</p> <p>Complaint IN00201144 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: June 2, 2016.</p> <p>Facility number: 000346 Provider number: 155543 AIM number: 100288320</p> <p>Census bed type: SNF/NF: 28 Total: 28</p> <p>Census payor type: Medicare: 1 Medicaid: 27 Total: 28</p> <p>Sample: 4</p> <p>These deficiencies reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0223 SS=D Bldg. 00	<p>QR completed by 11474 on June 3, 2016.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from mental abuse for 1 of 4 residents reviewed regarding abuse (Resident B, CNA #1). This deficient practice had the potential to effect 1 of 3 residents reviewed for abuse allegations.</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 6/2/16 at 8:22 a.m. The diagnoses included, but were not limited to, schizoaffective disorder, primary optic atrophy, blindness, major depression and chronic obstructive pulmonary disease. The most recent Annual Minimum Data</p>	F 0223	<p>This plan of correction constitutes the written allegation of compliance for the deficiency cited. However submission of Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirement established by state and federal law. Hickory Creek at Huntington desires this Plan of Correction to be the facility's Allegation of Compliance effective 6/24/2016. (Complaint-IN00201404) F 223 It is the policy and standard of care for this facility that all residents are free of abuse and neglect. 1. What corrective action will be</p>	06/24/2016

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	<p>Set (MDS) assessment, dated 2/18/16, indicated Resident B was cognitively intact with a BIMS (Brief Interview for Mental Status Score) of 15.</p> <p>Resident B had a current, 5/27/16, care plan problem/need regarding being totally blind. Approached to this problem included, but were not limited to, "I will receive orientation to my surroundings as needed."</p> <p>Resident B had a current, 3/18/16, care plan problem/need regarding urinary incontinence. Approaches to this problem included, but were not limited to, "I will be assisted with clothing changes as needed."</p> <p>Review of an Incident Report Form, dated 5/26/16, indicated CNA #1 was in the bathroom with Resident B following an incontinent bowel episode. The report indicated CNA #1 was having Resident B clean the feces off the floor. CNA #1 then instructed Resident B to throw the paper towel away. Resident B missed the waste basket and CNA #1 instructed Resident B to pick up the paper towel and throw it in the waste basket again. CNA #1 was immediately suspended pending an investigation.</p> <p>During the internal investigation by the</p>		<p>accomplished for residents affected?</p> <p>On May 26, 2016, resident B was assessed for any noted injuries as well as interviewed by Administrator in Training, Director of Nursing and Social Services for signs or symptoms of mental anguish with none noted. CNA #1 was immediately suspended pending investigation of abuse. The family and physician of resident B were notified. All staff was immediately in-serviced regarding Hickory Creek policies and procedures along with state regulations pertaining to abuse. After investigation of staff and CNA #1 it was determined that alleged abuse was substantiated and CNA #1 was terminated from position on June 1, 2016.</p> <p>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?</p> <p>All residents in this home have the potential to be affected, but no other resident has been identified as being affected by this practice. All interviewable residents were interviewed by Social Services and the Administrator in Training, for any indications of abuse. Residents not alert or identified with cognitive delays were assessed for signs and symptoms of abuse. If any future allegations of abuse are made, as per facility policy and practice, the Administrator will be notified immediately and any resident involved will be examined and/or interviewed to ensure they are secure and having their needs met appropriately. The Administrator will notify the state agency of the</p>	

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	<p>Administrator in Training (AIT), statements were obtained from staff who overheard or observed the incident.</p> <p>Review of the staff statements, provided by the AIT on 6/2/16 at 3:44 p.m., indicated Dietary Aide #2 was delivering lunch trays to resident rooms when she walked by the bathroom of Resident B. She indicated she could hear Resident B talking to CNA #1. Resident B was heard asking "if that was good" as she walked by. She then heard CNA #1 say "almost." Dietary Aide #2 did not witness the incident, only heard the conversation.</p> <p>Another statement provided by the Activity Director (AD), indicated she observed CNA #1 standing outside Resident B's bathroom, while Resident B was cleaning up his bowel movement off the floor. She indicated CNA #1 asked Resident B to throw the paper towel away twice and was talked to like a "child" when he asked "is that the trash can?" The AD indicated Resident B exited the bathroom with what appeared to be trash or ruined clothes.</p> <p>CNA #1 provided a written statement related to the incident to the AIT. CNA #1 indicated Resident B was coming out of his room to eat lunch when she noticed</p>		<p>allegation and an investigation will be initiated at that time. If any staff member is identified as being involved in the allegation, he/she will be immediately suspended and may be subject to termination, pending an investigation. Once the investigation is completed the Administrator and management staff will follow-up as needed with training or monitoring activities as deemed necessary by the investigation findings.</p> <p>3. What measures will be put into place to ensure this practice does not recur?</p> <p>All staff were re-educated on May 27, 2016, regarding Hickory Creek policies and procedures as well as state guidelines that outline and describe different forms of abuse including but not limited to physical, sexual, mental, verbal and financial abuse. All newly hired employees are also to be trained concerning abuse as prior but with detailed examples by the Director of Nursing or designee. Abuse education will be conducted every 2 weeks x 6 months; then monthly x 6 months; then quarterly indefinitely. The Administrator or designee will monitor all education and in-services for compliance with each learning process to ensure all staff have participated. The facility will conduct Guardian Angel Rounds, which are to be conducted at least 5 times weekly, by the interdisciplinary management team. The results of these rounds will be brought to the next scheduled morning management meeting for review. However, if there are any indications of resident abuse or neglect, the Administrator will be notified immediately and the facility will follow as indicated in question #2. Any</p>	

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	<p>he had attempted to clean himself up, but was still a little dirty. She indicated she took Resident B back into the bathroom to both clean him and the bathroom up. She indicated Resident B wanted to clean up the bathroom, so she handed him some wipes and asked him to clean it, while she finished what she was cleaning. The statement was dated 5/26/16.</p> <p>During an interview on 6/2/16 at 3:35 p.m. the AIT indicated, while speaking with CNA #1 following the incident, she felt CNA #1 did not understand that making Resident B clean the bathroom was wrong. She indicated CNA #1 was terminated from employment</p> <p>Review of CNA #1's employee file indicated she was provided with the required abuse, dementia and resident right's training.</p> <p>Review of a current facility policy, dated 12/1999 and revised 9/10, provided by the AIT on 6/2/16 at 8:40 a.m., indicated the following:</p> <p>"STANDARD Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion.</p>		<p>allegations will be investigated immediately and all staff re-inserviced if needed between education schedules.</p> <p>4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Administrator, DON and/or SSD will bring the results of resident concerns, including all allegations of abuse and neglect, to the monthly QAA committee meeting, for further review and recommendations for process improvement. If any recommendations are made, the DON or other designated IDT member will follow through and report the results of those recommendations at the next scheduled QAA meeting. This will continue on an on-going basis.</p> <p>DATE OF COMPLIANCE: 6/24/2016</p>	

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	<p>DEFINITIONS</p> <p>ABUSE: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.</p> <p>...Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation...."</p> <p>This federal tag relates to Complaint IN00201404.</p> <p>3.1-27(a)(1)</p>			