

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 02/19/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
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F0000	<p>This visit was for the Investigation of Complaint IN00124113.</p> <p>Complaint IN00124113 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225 and F226.</p> <p>Survey dates: February 18 and 19, 2013</p> <p>Facility number: 000284 Provider number: 155424 AIM number: 100290690</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census payor type: Medicaid: 31 Other: 3 Total: 34</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/25/13 by Suzanne</p>	F0000	<p>This Plan of Correction constitutes the written allegation of 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 15, 2013.</p>	

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

TITLE

(X6) DATE

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

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	Williams, RN			
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F0223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure a resident was not subjected to sexual abuse by another resident (#A) for 1 of 3 residents reviewed for abuse in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 2-18-13 at 10:55 a.m. Her diagnoses included, but were not limited to, multiple sclerosis, bipolar disorder, depression, psychosis (nonspecified), borderline personality disorder, and organic brain syndrome. Her most recent Minimum Data Set (MDS) assessment, dated 1-8-13, indicated she had severe cognitive impairment. It indicated she did not walk, and was dependent on 1 to 2 persons for transferring from bed to chair and chair to bed, for personal hygiene and bathing needs, as well as toileting needs. She required extensive assistance with eating.</p>	F0223	<p>F223</p> <p>It is the standard and policy of this facility that the resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. It is the standard of this facility to not allow verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>The facility would like noted that LPN #1 is a Registered Nurse.</p> <p><u>What corrective action will be done by this facility?</u></p> <p>Resident #A was seen by the facility's psychologist for a counseling session on 2/19/13. The facility psychologist spoke to Resident #A at length and Resident #A gave a verbal commitment to not engage in any inappropriate sexual activity with any resident. There have been no incidents since that time. Resident #B was seen by the</p>	03/15/2013	

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	<p>Resident #A's clinical record was reviewed on 2-18-13 at 12:57 p.m. His diagnoses included, but were not limited to, dementia with agitation, depression and cerebrovascular accident (stroke or CVA). His most recent MDS assessment, dated 12-10-12, indicated he was cognitively intact, did not walk, but used a wheelchair to move about his room and facility independently, required extensive assistance of 1 person with transfer from bed to chair, dressing and bathing, and was dependent on 1 person with toileting needs, but was independent with eating, except for set up of the meals.</p> <p>Nursing notes, dated 2-9-13 at 7:55 a.m. and identified as an IDT (interdisciplinary team) note, indicated on this date at 6:40 a.m., Resident #B "was touched inappropriately by another resident...This resident had breast contacted with other resident's hand. Residents immediately separated."</p> <p>In interview with CNA #1 on 2-19-13 at 10:10 a.m., she indicated on that morning, she had assisted Resident #B up into her chair and the resident was sitting in her chair in the hallway, between the resident's room and the</p>		<p>facility's psychologist on 2/19/13. The facility psychologist states that Resident #B "appears stable and for the most part uninjured physically and emotionally at this juncture". Both residents will continue to be monitored daily by all staff.</p> <p>All employees will be re-in-serviced on the facility Abuse Protocol to include but not be limited to the resident's right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion and misappropriation of resident property and that employees of this facility are not to use or allow verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion by March 11, 2013.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>- All residents have the potential to be affected, but particularly those residents with dementia, who are confused, unable to freely communicate, have behavioral symptoms and totally dependent residents. No other residents have been identified as being affected by this practice.</p>				

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	<p>nurse's station, but facing away from the nurse's station. She indicated as she was walking down the hall, toward Resident #B, she observed Resident #A in his wheelchair, with his wheelchair adjacent to Resident #B's chair. She indicated as she walked by the nurse's station, she tapped on the desk top in order to get the attention of the two staff members at the nurse's station. She indicated as she approached the two residents, she observed Resident #A remove his hand from down the top of Resident #B's gown. She indicated as she approached the residents, "I said, '[name of Resident #A],' he began removing his hand from down her gown and he said, 'I wasn't doing anything,' or 'I didn't do anything.' He immediately wheeled himself towards the dining room." She indicated LPN #1 later informed her she had observed Resident #A remove his hand from Resident #B's gown.</p> <p>In interview with LPN #1 on 2-19-13 at 1:40 p.m., she indicated on 2-9-13, she was at the nurse's station when CNA #1 walked by and "smacked the desk to get my attention. I looked up and saw [name of Resident #A] pulling his hand out of [name of Resident #B]'s shirt...When [name of CNA #1] got there, she may have</p>		<p>If any abuse is suspected or observed, the staff person involved will remove the resident form the situation immediately. Once the resident is safe, the staff person will notify the Administrator who will begin an immediate investigation into the occurrence.</p> <p><u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>During re-in-services, staff will be reminded that any allegation of verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion, including misappropriation of resident's property must be reported immediately in accordance with the facility's abuse protocols, and not reporting is also considered abuse/neglect. They will also be re-trained to immediately remove and/or protect the resident form the observed or suspected abuser.</p> <p>During routine Guardian Angel Rounds that occur at least 5 days a week, Department Managers will inquire with their assigned residents regarding the overall atmosphere of the nursing home and whether the resident has any concerns. Concerns of possible abuse will be brought to the Administrators attention immediately.</p>				

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	<p>said something along the line of 'That's not appropriate.' He responded with, 'What.' We sent him on his way." She indicated she examined Resident #B after the event and the examination was negative.</p> <p>In interview with LPN #2 on 2-18-13 at 2:55 p.m., she indicated on 2-9-13, she did not observe the interaction between Resident #A and #B, but was present immediately after the event. She indicated Resident #B was very quiet that morning, prior to and after the event. She indicated the resident did not yell or comment about the event. She indicated she was wearing a "mumu" type gown. She indicated she immediately contacted the Administrator and Director of Nursing by phone to inform them of what had occurred.</p> <p>This Federal tag relates to Complaint IN00124113.</p> <p>3.1-27(a)(1)</p>		<p><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The Department Managers will complete his/her guardian angel rounds twice daily. During those rounds any concerns of possible abuse will be brought to the Administrator's attention immediately. The Administrator will investigate any allegation of alleged abuse. All allegations will continue to be reported to the Indiana State Department of Health.</p> <p>The QA committee will continue to review the investigations of allegations of reported abuse during the monthly QA meeting. Any recommendations the committee has in regard to the investigation process and outcomes will be followed through and implemented by the appropriate department. That department manager will report the results of that implementation at the next scheduled QA committee meeting.</p> <p>This process will continue on an ongoing basis.</p>		

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F0225	F225	03/15/2013			

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	<p>review, the facility failed to ensure an allegation of abuse was reported to other state agencies and the residents involved were monitored to ensure their safety during the investigation, for 2 of 3 residents reviewed for abuse in a sample of 3 related to a sexual abuse allegation. (Residents #A and #B)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 2-18-13 at 12:57 p.m. His diagnoses included, but were not limited to, dementia with agitation, depression and cerebrovascular accident (stroke or CVA). His most recent Minimum Data Set (MDS) assessment, dated 12-10-12, indicated he was cognitively intact, did not walk, but used a wheelchair to move about his room and facility independently, required extensive assistance of 1 person with transfer from bed to chair, dressing and bathing, and was dependent on 1 person with toileting needs, but was independent with eating, except for set up of the meals.</p> <p>Resident #B's clinical record was reviewed on 2-18-13 at 10:55 a.m. Her diagnoses included, but were not limited to, multiple sclerosis, bipolar</p>		<p>It is the standard and policy of this facility that all allegations of abuse are reported to other state agencies and residents involved in these allegations are monitored during the investigation.</p> <p>The facility would like noted that LPN #1 is a Registered Nurse.</p> <p><u>What corrective action will be done by the facility?</u></p> <p>Resident #A was seen by the facility's psychologist for a counseling session on 2/19/13. The facility psychologist spoke to Resident #A at length and Resident #A gave a verbal commitment to not engage in any inappropriate sexual activity with any resident. There have been no incidents since that time. Resident #B was seen by the facility's psychologist on 2/19/13. The facility psychologist states that Resident #B "appears stable and for the most part uninjured physically and emotionally at this juncture". Both residents will continue to be monitored daily by all staff.</p> <p>John Delfer, APS was notified of the incident between resident #A and resident #B on 2/19/13. Licensed nursing staff will be re-educated on the facility's Change of Condition policy and procedure which addresses documentation of incidents</p>		

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	<p>disorder, depression, psychosis (nonspecified), borderline personality disorder, and organic brain syndrome. Her most recent Minimum Data Set (MDS) assessment, dated 1-8-13, indicated she had severe cognitive impairment. It indicated she did not walk, and was dependent on 1 to 2 persons for transferring from bed to chair and chair to bed, for personal hygiene and bathing needs, as well as toileting needs. She required extensive assistance with eating.</p> <p>Nursing notes for Resident #B, dated 2-9-13 at 7:55 a.m. and identified as an IDT (interdisciplinary team) note, indicated on this date at 6:40 a.m., the resident "was touched inappropriately by another resident...This resident had breast contacted with other resident's hand. Residents immediately separated."</p> <p>In interview with CNA #1 on 2-19-13 at 10:10 a.m., she indicated on that morning, she had assisted Resident #B up into her chair and the resident was sitting in her chair in the hallway, between the resident's room and the nurse's station, but facing away from the nurse's station. She indicated as she was walking down the hall, toward Resident #B, she observed Resident #A in his wheelchair, with</p>		<p>between residents. In addition, the nurses and nursing assistants will be re-trained on the documentation required when using the 15 minute observation checklist.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>- A review of the nurse's notes indicates all current resident change of condition issues is currently being charted on appropriately. No other resident was affected by this alleged deficient practice.</p> <p><u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>- When an unusual occurrence or an incident of alleged abuse occurs the Administrator and/or designee will report the incident to other state agencies when applicable. All incidents will be brought before the monthly QA committee for review and to ensure the appropriate state agencies have been contacted.</p> <p>When a change of condition occurs including an unusual occurrence or incident of alleged abuse those residents affected will be placed on the nursing staffs 24 Hour Report – Resident</p>		

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	<p>his wheelchair adjacent to Resident #B's chair. She indicated as she walked by the nurse's station, she tapped on the desk top in order to get the attention of the two staff members at the nurse's station. She indicated as she approached the two residents, she observed Resident #A remove his hand from down the top of Resident #B's gown. She indicated as she approached the residents, "I said, '[name of Resident #A],' he began removing his hand from down her gown and he said, 'I wasn't doing anything,' or 'I didn't do anything.' He immediately wheeled himself towards the dining room." She indicated LPN #1 later informed her she had observed Resident #A remove his hand from Resident #B's gown.</p> <p>In interview with LPN #1 on 2-19-13 at 1:40 p.m., she indicated on 2-9-13, she was at the nurse's station when CNA #1 walked by and "smacked the desk to get my attention. I looked up and saw [name of Resident #A] pulling his hand out of [name of Resident #B]'s shirt...When [name of CNA #1] got there, she may have said something along the line of 'That's not appropriate.' He responded with, 'What.' We sent him on his way." She indicated she examined Resident #B after the event</p>		<p>Condition Change form. The Director of Nursing and/or designee will review this form at least 5 days a week along with daily nurse's notes and resident orders to ensure any change of condition is being charted on appropriately.</p> <p><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>- The Administrator and/or designee will contact the appropriate state agencies when an incident has occurred. All incidents will be reviewed by the monthly QA committee to ensure the proper state agencies have been contacted.</p> <p>The Director of Nursing and/or designee will review the 24 Hour Report – Resident Condition Change form daily (M-F) along with nurse's notes and orders to ensure any change of condition is being charted on appropriately. This review will be discussed with the IDT team daily (M-F) during the daily management meeting. Any recommendations made by the IDT will be placed on the 24 Hour Report – Resident Condition Change form. The CAN assignment sheets will be updated as needed to reflect any pertinent changes in the resident's plan of care.</p>		

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	<p>and the examination was negative.</p> <p>In interview with LPN #2 on 2-18-13 at 2:55 p.m., she indicated on 2-9-13, she did not observe the interaction between Resident #A and #B, but was present immediately after the event. She indicated Resident #B was very quiet that morning, prior to and after the event. She indicated the resident did not yell or comment about the event. She indicated she was wearing a "mumu" type gown. She indicated she immediately contacted the Administrator and Director of Nursing by phone to inform them of what had occurred.</p> <p>On 2-18-13 at 10:14 a.m., the Administrator provided a copy of a reportable event which she had phoned to the Indiana State Department of Health on 2-9-13 at 7:38 p.m.. This reportable event indicated on 2-9-13 at 6:40 a.m., Resident #A was wheeling himself to the main dining room when he stopped by Resident #B who was sitting in the hallway in her geriatric chair. It indicated, "[Name of Resident #A] stopped by [name of Resident #B] and reached his hand under her gown and felt her breast."</p> <p>In interview with the Administrator on</p>		This process will continue on an ongoing basis.				

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	<p>2-18-13 at 10:50 a.m., she indicated she did not send this same information or copies of the same information to the area Ombudsman or Adult Protective Services. In interview with the Administrator on 2-18-13 at 2:15 p.m., she indicated her investigation was conducted as "an unusual occurrence, not a sexual abuse" investigation. She indicated she approached the investigation in this manner, "Since both [residents] had been care planned for these [sexual] behaviors." In interview with the Administrator on 2-19-13 at 3:30 p.m., she indicated she was following her facility's reporting policy. She indicated, "From what this says, it looks like I would only make a report to APS [Adult Protective Services] if there is harm. [Name of resident] did not seem to recall what happened, so it would be hard to say harm occurred."</p> <p>On 2-18-13 at 10:14 a.m., the Administrator provided a copy of a reportable event which she had phoned to the Indiana State Department of Health on 2-9-13 at 7:38 p.m. This reportable event indicated on 2-9-13 at 6:40 a.m., Resident #A was wheeling himself to the main dining room when he stopped by Resident #B who was</p>						

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	<p>sitting in the hallway in her geriatric chair. It indicated, "[Name of Resident #A] stopped by [name of Resident #B] and reached his hand under her gown and felt her breast... [Name of Resident #A] was placed on 15 minute checks for 48 hours...discontinued the 48 hour checks on 2-11-13 at 8:00 a.m."</p> <p>Review of a document entitled, "15 Minute Observation Checklist" for Resident #A indicated the 15 minute observations were initiated on 2-9-13 at 7:00 a.m. and continued until 11:45 p.m. The document was blank from 2-10-13 at 12:00 a.m. until 2-10-13 at 6:00 a.m. Documentation of observations were recorded on 2-10-13 at 6:00 a.m. until 6:00 p.m. The document was blank from 2-10-13 at 6:15 p.m. until 11:45 p.m. There was not a document for 15 minute observations for 2-11-13.</p> <p>In interview with the Administrator on 2-19-13 at 2:40 p.m., she indicated, "The 15 minute check log has an entire shift missing documentation, the night shift for the night of 2-10-13. I put a call out to the nurse. She told me that he was in fact in bed, like normal. He normally goes to bed before supper and is there until he gets up for breakfast."</p>						

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	<p>In interview with LPN #1 on 2-19-13 at 1:40 p.m., she indicated, "I hadn't checked on him every 15 minutes...No one had put [name of Resident #A] being on 48 hour 15 minute checks on the pertinent charting board."</p> <p>Review of the "15 Minute Observation Checklist" indicated LPN #1 had initialed observations on Resident #A on 2-9-13 from 6:15 p.m. until 11:45 p.m., but not for the remainder of her shift from 12:00 a.m. until 6:00 a.m. on 2-10-13 or on 2-10-13 from 6:15 p.m. until 2-11-13 at 6:00 a.m.</p> <p>On 2-19-13 at 3:20 p.m., the Director of Nursing (DON) provided a copy of the "24 Hour Report" for 2-9-13 and 2-10-13. This document indicated a handwritten notation for both dates for Resident #A which indicated 15 minute checks were being conducted. This document indicated Resident #B was receiving an antibiotic for a cellulitis on the 2-9-13 report and on 2-10-13, it indicated she was on an antibiotic for pneumonia. There was not any notation regarding the incident between Resident #A and Resident #B on the 24 hour report for either date. This document was signed by LPN #1 and LPN #2.</p>			

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	<p>Nursing notes for Resident #A indicated a notation on 2-9-13 at 8:00 a.m. from the IDT regarding this resident inappropriately touching Resident #B's breast. Additional documentation was present the same date at 7:30 a.m. and at 2:00 p.m. regarding the incident. The next entry was dated 2-10-13 at 1:00 p.m. which indicated no further issues related to this incident. The next entry was dated 2-12-13 at 1:00 a.m., which did not reference the incident. Social service notes regarding this incident were dated 2-11-13, 2-12-13 and 2-15-13.</p> <p>The IDT note from 2-9-13 at 7:55 a.m. at 6:40 a.m., for Resident #B indicated the resident "was touched inappropriately by another resident...This resident had breast contacted with other resident's hand." Nursing notes on 2-9-13 at 1:00 p.m. did not reference the incident. The next 3 entries, dated 2-11-13, identified as late entries for 2-9-13 at 7:00 a.m., 2-9-13 and untimed and 2-10-13 and untimed, were signed by LPN #2 in reference to the incident. There were no entries present for the night shift, after the event, on 2-9-13, 2-10-13 or 2-11-13. Social service notes regarding this incident were</p>			
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	<p>dated 2-10-13, 2-11-13, 2-12-13 and 2-13-13.</p> <p>In interview with the DON on 2-19-13 at 3:20 p.m., he indicated he expects any resident who is on the 24 hour report should be charted on each shift. He indicated this incident occurred on the weekend which has nursing coverage with 12 hour shifts.</p> <p>On 2-18-13 at 10:14 a.m., the Administrator provided a copy of a policy entitled, "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property, " with a revision date of 9-2010 and identified as the current policy in use. This policy indicated, under Section J. Investigation: "All allegations will be thoroughly investigated and measures will be taken to prevent further potential abuse while the investigation is in progress." This policy indicated, under Section M. Reporting: "Written results of investigations (including criminal, abuse, neglect, injuries of unknown etiology and misappropriation of property) are reported by the administrator to other officials in accordance with local, state, and federal law (including the state survey and certification agency, APS, etc.) within five (5) working days of the incidents."</p>				

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	<p>On 2-18-13 at 10:14 a.m., the Administrator provided a copy of a policy entitled, "Accident/Incident/Reportable/State Officials-Indiana," with a revision date of 10-2011 and identified as the current policy in use. This policy indicated, "This facility will make sure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of the resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures..."</p> <p>This Federal tag relates to Complaint IN00124113.</p> <p>3.1-28(e)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure their abuse prohibition policy and procedure was implemented, related to the failure to ensure an allegation of abuse was reported to other state agencies and the residents involved were monitored to ensure their safety during the investigation, for 2 of 3 residents reviewed for abuse in a sample of 3 related to a sexual abuse allegation. (Residents #A and #B)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 2-18-13 at 12:57 p.m. His diagnoses included, but were not limited to, dementia with agitation, depression and cerebrovascular accident (stroke or CVA). His most recent Minimum Data Set (MDS) assessment, dated 12-10-12, indicated he was cognitively intact, did not walk, but used a wheelchair to move about his room and facility independently, required extensive assistance of 1 person with transfer</p>	F0226	<p>F226</p> <p>It is the standard and policy of this facility that all allegations of abuse are reported to other state agencies and residents involved in these allegations are monitored during the investigation.</p> <p>The facility would like noted that LPN #1 is a Registered Nurse.</p> <p><u>What corrective action will be done by the facility?</u></p> <p>Resident #A was seen by the facility's psychologist for a counseling session on 2/19/13. The facility psychologist spoke to Resident #A at length and Resident #A gave a verbal commitment to not engage in any inappropriate sexual activity with any resident. There have been no incidents since that time. Resident #B was seen by the facility's psychologist on 2/19/13. The facility psychologist states that Resident #B "appears stable and for the most part uninjured physically and emotionally at this juncture". Both residents will continue to be monitored daily by all staff.</p>	03/15/2013			

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	<p>from bed to chair, dressing and bathing, and was dependent on 1 person with toileting needs, but was independent with eating, except for set up of the meals.</p> <p>Resident #B's clinical record was reviewed on 2-18-13 at 10:55 a.m. Her diagnoses included, but were not limited to, multiple sclerosis, bipolar disorder, depression, psychosis (nonspecified), borderline personality disorder, and organic brain syndrome. Her most recent Minimum Data Set (MDS) assessment, dated 1-8-13, indicated she had severe cognitive impairment. It indicated she did not walk, and was dependent on 1 to 2 persons for transferring from bed to chair and chair to bed, for personal hygiene and bathing needs, as well as toileting needs. She required extensive assistance with eating.</p> <p>Nursing notes for Resident #B, dated 2-9-13 at 7:55 a.m. and identified as an IDT (interdisciplinary team) note, indicated on this date at 6:40 a.m., the resident "was touched inappropriately by another resident...This resident had breast contacted with other resident's hand. Residents immediately separated."</p> <p>In interview with CNA #1 on 2-19-13</p>		<p>John Delfer, APS was notified of the incident between resident #A and resident #B on 2/19/13. Licensed nursing staff will be re-educated on the facility's Change of Condition policy and procedure which addresses documentation of incidents between residents. In addition, the nurses and nursing assistants will be re-trained on the documentation required when using the 15 minute observation checklist.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>- A review of the nurse's notes indicates all current resident change of condition issues is currently being charted on appropriately. No other resident was affected by this alleged deficient practice.</p> <p><u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>- When an unusual occurrence or an incident of alleged abuse occurs the Administrator and/or designee will report the incident to other state agencies when applicable. All incidents will be brought before the monthly QA committee for review and to</p>		

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	<p>at 10:10 a.m., she indicated on that morning, she had assisted Resident #B up into her chair and the resident was sitting in her chair in the hallway, between the resident's room and the nurse's station, but facing away from the nurse's station. She indicated as she was walking down the hall, toward Resident #B, she observed Resident #A in his wheelchair, with his wheelchair adjacent to Resident #B's chair. She indicated as she walked by the nurse's station, she tapped on the desk top in order to get the attention of the two staff members at the nurse's station. She indicated as she approached the two residents, she observed Resident #A remove his hand from down the top of Resident #B's gown. She indicated as she approached the residents, "I said, '[name of Resident #A],' he began removing his hand from down her gown and he said, 'I wasn't doing anything,' or 'I didn't do anything.' He immediately wheeled himself towards the dining room." She indicated LPN #1 later informed her she had observed Resident #A remove his hand from Resident #B's gown.</p> <p>In interview with LPN #1 on 2-19-13 at 1:40 p.m., she indicated on 2-9-13, she was at the nurse's station when CNA #1 walked by and "smacked the</p>		<p>ensure the appropriate state agencies have been contacted.</p> <p>When a change of condition occurs including an unusual occurrence or incident of alleged abuse those residents affected will be place on the nursing staffs 24 Hour Report – Resident Condition Change form. The Director of Nursing and/or designee will review this form at least 5 days a week along with daily nurse's notes and resident orders to ensure any change of condition is being charted on appropriately.</p> <p><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>- The Administrator and/or designee will contact the appropriate state agencies when an incident has occurred. All incidents will be reviewed by the monthly QA committee to ensure the proper state agencies have been contacted.</p> <p>The Director of Nursing and/or designee will review the 24 Hour Report – Resident Condition Change form daily (M-F) along with nurse's notes and orders to ensure any change of condition is being charted on appropriately. This review will be discussed with the IDT team daily (M-F) during the daily management meeting.</p>		

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	<p>desk to get my attention. I looked up and saw [name of Resident #A] pulling his hand out of [name of Resident #B]'s shirt...When [name of CNA #1] got there, she may have said something along the line of 'That's not appropriate.' He responded with, 'What.' We sent him on his way." She indicated she examined Resident #B after the event and the examination was negative.</p> <p>In interview with LPN #2 on 2-18-13 at 2:55 p.m., she indicated on 2-9-13, she did not observe the interaction between Resident #A and #B, but was present immediately after the event. She indicated Resident #B was very quiet that morning, prior to and after the event. She indicated the resident did not yell or comment about the event. She indicated she was wearing a "mumu" type gown. She indicated she immediately contacted the Administrator and Director of Nursing by phone to inform them of what had occurred.</p> <p>On 2-18-13 at 10:14 a.m., the Administrator provided a copy of a reportable event which she had phoned to the Indiana State Department of Health on 2-9-13 at 7:38 p.m.. This reportable event indicated on 2-9-13 at 6:40 a.m.,</p>		<p>Any recommendations made by the IDT will be placed on the 24 Hour Report – Resident Condition Change form. The CAN assignment sheets will be updated as needed to reflect any pertinent changes in the resident's plan of care.</p> <p>This process will continue on an ongoing basis</p>				

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	<p>Resident #A was wheeling himself to the main dining room when he stopped by Resident #B who was sitting in the hallway in her geriatric chair. It indicated, "[Name of Resident #A] stopped by [name of Resident #B] and reached his hand under her gown and felt her breast."</p> <p>In interview with the Administrator on 2-18-13 at 10:50 a.m., she indicated she did not send this same information or copies of the same information to the area Ombudsman or Adult Protective Services. In interview with the Administrator on 2-18-13 at 2:15 p.m., she indicated her investigation was conducted as "an unusual occurrence, not a sexual abuse" investigation. She indicated she approached the investigation in this manner, "Since both [residents] had been care planned for these [sexual] behaviors." In interview with the Administrator on 2-19-13 at 3:30 p.m., she indicated she was following her facility's reporting policy. She indicated, "From what this says, it looks like I would only make a report to APS [Adult Protective Services] if there is harm. [Name of resident] did not seem to recall what happened, so it would be hard to say harm occurred."</p>						

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	<p>On 2-18-13 at 10:14 a.m., the Administrator provided a copy of a reportable event which she had phoned to the Indiana State Department of Health on 2-9-13 at 7:38 p.m. This reportable event indicated on 2-9-13 at 6:40 a.m., Resident #A was wheeling himself to the main dining room when he stopped by Resident #B who was sitting in the hallway in her geriatric chair. It indicated, "[Name of Resident #A] stopped by [name of Resident #B] and reached his hand under her gown and felt her breast... [Name of Resident #A] was placed on 15 minute checks for 48 hours...discontinued the 48 hour checks on 2-11-13 at 8:00 a.m."</p> <p>Review of a document entitled, "15 Minute Observation Checklist" for Resident #A indicated the 15 minute observations were initiated on 2-9-13 at 7:00 a.m. and continued until 11:45 p.m. The document was blank from 2-10-13 at 12:00 a.m. until 2-10-13 at 6:00 a.m. Documentation of observations were recorded on 2-10-13 at 6:00 a.m. until 6:00 p.m. The document was blank from 2-10-13 at 6:15 p.m. until 11:45 p.m. There was not a document for 15 minute observations for 2-11-13.</p>			

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	<p>In interview with the Administrator on 2-19-13 at 2:40 p.m., she indicated, "The 15 minute check log has an entire shift missing documentation, the night shift for the night of 2-10-13. I put a call out to the nurse. She told me that he was in fact in bed, like normal. He normally goes to bed before supper and is there until he gets up for breakfast."</p> <p>In interview with LPN #1 on 2-19-13 at 1:40 p.m., she indicated, "I hadn't checked on him every 15 minutes...No one had put [name of Resident #A] being on 48 hour 15 minute checks on the pertinent charting board."</p> <p>Review of the "15 Minute Observation Checklist" indicated LPN #1 had initialed observations on Resident #A on 2-9-13 from 6:15 p.m. until 11:45 p.m., but not for the remainder of her shift from 12:00 a.m. until 6:00 a.m. on 2-10-13 or on 2-10-13 from 6:15 p.m. until 2-11-13 at 6:00 a.m.</p> <p>On 2-19-13 at 3:20 p.m., the Director of Nursing (DON) provided a copy of the "24 Hour Report" for 2-9-13 and 2-10-13. This document indicated a handwritten notation for both dates for Resident #A which indicated 15 minute checks were being conducted.</p>						

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	<p>This document indicated Resident #B was receiving an antibiotic for a cellulitis on the 2-9-13 report and on 2-10-13, it indicated she was on an antibiotic for pneumonia. There was not any notation regarding the incident between Resident #A and Resident #B on the 24 hour report for either date. This document was signed by LPN #1 and LPN #2.</p> <p>Nursing notes for Resident #A indicated a notation on 2-9-13 at 8:00 a.m. from the IDT regarding this resident inappropriately touching Resident #B's breast. Additional documentation was present the same date at 7:30 a.m. and at 2:00 p.m. regarding the incident. The next entry was dated 2-10-13 at 1:00 p.m. which indicated no further issues related to this incident. The next entry was dated 2-12-13 at 1:00 a.m., which did not reference the incident. Social service notes regarding this incident were dated 2-11-13, 2-12-13 and 2-15-13.</p> <p>The IDT note from 2-9-13 at 7:55 a.m. at 6:40 a.m., for Resident #B indicated the resident "was touched inappropriately by another resident...This resident had breast contacted with other resident's hand." Nursing notes on 2-9-13 at 1:00 p.m.</p>						

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	<p>did not reference the incident. The next 3 entries, dated 2-11-13, identified as late entries for 2-9-13 at 7:00 a.m., 2-9-13 and untimed and 2-10-13 and untimed, were signed by LPN #2 in reference to the incident. There were no entries present for the night shift, after the event, on 2-9-13, 2-10-13 or 2-11-13. Social service notes regarding this incident were dated 2-10-13, 2-11-13, 2-12-13 and 2-13-13.</p> <p>In interview with the DON on 2-19-13 at 3:20 p.m., he indicated he expects any resident who is on the 24 hour report should be charted on each shift. He indicated this incident occurred on the weekend which has nursing coverage with 12 hour shifts.</p> <p>On 2-18-13 at 10:14 a.m., the Administrator provided a copy of a policy entitled, "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property, " with a revision date of 9-2010 and identified as the current policy in use. This policy indicated, under Section J. Investigation: "All allegations will be thoroughly investigated and measures will be taken to prevent further potential abuse while the investigation is in progress." This policy indicated, under Section M. Reporting: "Written</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 02/19/2013	
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>results of investigations (including criminal, abuse, neglect, injuries of unknown etiology and misappropriation of property) are reported by the administrator to other officials in accordance with local, state, and federal law (including the state survey and certification agency, APS, etc.) within five (5) working days of the incidents."</p> <p>On 2-18-13 at 10:14 a.m., the Administrator provided a copy of a policy entitled, "Accident/Incident/Reportable/State Officials-Indiana," with a revision date of 10-2011 and identified as the current policy in use. This policy indicated, "This facility will make sure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of the resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures..."</p> <p>This Federal tag relates to Complaint IN00124113.</p> <p>3.1-28(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 02/19/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
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