

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

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

F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00204617.</p> <p>Complaint IN00204617 - Substantiated. Federal/State deficiencies are cited at F223 & 226.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: August 2 and 3, 2016</p> <p>Facility number: 000421 Provider number: 155417 AIM number: 100288340</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 1 Medicaid: 27 Other: 5 Total: 33</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The Provider is requesting a face-to-face IDR regarding the alleged deficiency for F223 and F226. Please be advised that it is our intent to have this plan of correction also serve as our Allegation of Compliance. Compliance is effective on August 19,2016.Should you have questions regarding the Plan of Correction / Allegation of Compliance, then please do not hesitate to contact me.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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
F 0223 SS=G Bldg. 00	<p>Quality review completed by 34233 on August 7, 2016.</p> <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. Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse when a staff member raised her voice during a conversation with a resident for 1 of 3 residents reviewed for abuse. This deficient practice had the potential to affect 33 of 33 residents residing in the facility. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 8/2/16 at 2:20 p.m., the diagnoses included, but were not limited to, anxiety and depression. The annual MDS (Minimum Data Set) assessment, dated 6/21/16, indicated Resident #B had a BIMS (Brief Interview of Mental Status) score of 13, which signified intact cognition. The MDS also indicated it was</p>	F 0223	<p>We disagree with the deficiency determination and scope and severity of alleged deficiencies. This matter was a self-reported event by the Provider in compliance with Federal / State rules and regulations. F 223 The Provider is requesting a face-to-face IDR regarding this alleged deficiency. This Provider acknowledges that the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The Provider has established policies and procedures where by it conveys that no one should use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion towards the residents it serves. The Administrator of this facility has been the Administrator for nearly ten (10) years. The home has had three (3) deficiency free annual</p>	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170			
(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>very important to him/her to attend his/her favorite activities.</p> <p>The ISDH (Indiana State Department of Health) reportable, dated 7/7/16 at 3:45 p.m., included, but was not limited to, the following: "...Residents Involved... [Resident #B's name]...Staff Involved... [Administrators name]...Brief Description of Incident...7/7/2016 during a meeting in the Administrator's office involving the resident, Administrator and DON [Director of Nursing], between approximately 3:10PM to 4PM, the resident and Administrator engaged in a "heated" conversation. Both the resident and Administrator started to cry. The DON calmed the situation at which time the resident and Administrator apologized to each other. Once the resident left the Administrator's office [sic] the Director of Operations, [name of Director of Operations], was notified to the incident immediately...Immediate Action Taken...Resident has no immediate family and is considered her own responsible party. Attending physician notified of incident. The Administrator has been put on suspension, pending the results of the investigation..."</p> <p>The nurses note, dated 7/7/16 at 8:30 p.m., included, but was not limited to, the</p>		<p>surveys under the Administrators leadership and currently has an Indiana Report Card Score of zero (-0-) and is rated a 5 Star Nursing Home by Nursing Home Compare. Further, the interpretive guidelines issued by CMS define "Abuse" as the "willful" infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Further, "Verbal abuse" is defined as the use of oral, written or gestured language that "willfully" includes disparaging and derogatory terms to residents or their families. Yes, in this one specific incident, the Administrator did raise her voice during a conversation with Resident #B and the event was related to a very specific set of facts and circumstances as evident from the history of those involved. The "Meet-and-Greet" process that the Administrator has facilitated in this home has been common practice for approximately 1 and a half (1 1/2) years and is usually held two times a month. By virtue of this forum, the Administrator invites residents input, both positive and negative in manner to assist in producing suggestions for improvement. The Meet-and-Greets is not intended for a resident to complain and then be pulled aside later and berated about what they said. Rather, having these meetings</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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>following: "...Resident involved this afternoon in a verbal incident with a staff member..."</p> <p>The nurses note, dated 7/8/16 at 3:19 p.m., included, but was not limited to, the following: "...This nurse met with resident this am [a.m.] to assess for any further issues or concerns, or s/sx [signs/symptoms] of emotional distress r/t [related to] yesterday's [sic] incident...reports...afraid...going to have to leave the facility..."</p> <p>The typed statement from the DON, dated 7/7/16 and untimed, included, but was not limited to, the following: "At approximately 3:05 PM, [Administrators name] came to the nurses station and said [sic] "[DON's first name] [sic] "I need you in my office now please." Upon entering Administrator's office [sic] Resident [Resident #B's name] was sitting in wheel chair. Resident made comment [sic] "I guess I'll be in the pink book tomorrow."...After I shut the door and sat down, [Administrator's first name] looked at [Resident #B's first name] and said [sic] "We are here because you cannot behave the way you did in the dining room just now." (Slightly raised voice) [Resident #B's first name] replied [sic] "so I can't voice my opinion like everyone else." (Raised</p>		<p>demonstrates that the Administrator understands her responsibility towards the residents and buys into the fact that the facility is the residents' home. This process is one of the mechanisms in which the Administrator is trying to make the living arrangements as comfortable and livable as possible for the residents the facility serves. The Meet-and-Greet held on July 7 resulted in Resident #B becoming upset when other residents did not speak up in concurrence or support of Resident #B's own concerns, in particular, Resident #C. This created an atmosphere whereby Resident #B began to monopolize the meeting and due to other scheduled activities and events, the Administrator attempted numerous times to put closure to the meeting. Upon conclusion of the Meet-and-Greet, the Administrator did ask that Resident #B come to the office to discuss the events of the Meet-and-Greet, thusly asking the Director of Nursing to participate in the meeting. Admittedly by the Administrator, Director of Nursing and Resident #B, the conversation escalated and both resident #B and the Administrator raised their voices during the meeting. Resident #C was interviewed by the surveyor indicating "the door was shut and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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>voice) [Administrator's first name] and [Resident #B's first name] went back and forth multiple times, voices escalating, regarding the issues brought up at the Meet-and-Greet meeting. After the conversation started to escalate [sic] I looked at both [Resident #B's first name] and [Administrator's first name] and said [sic] "stop, please calm down... [Administrator's first name] made comments such as [sic] "you cannot sit in there at that meeting and tell me that I'm not fit to do this job or that I don't know what I'm doing." The conversation began to escalate again with voices raised...I looked at [Administrator's first name] and said [sic] "[Administrator's first name] stop, you need to stop" [sic] [Administrators first name] turned around in her desk chair and faced the opposite direction. I turned to [Resident #B's first name] to try to calm her down...I reassured [Resident #B's first name] that most of the concerns that she had brought up in the meeting in the dining room and the meeting with [Administrator's first name] in the office are not of her concern and not to get upset with something she's not involved with...."</p> <p>The typed statement for the Administrator, dated 7/7/16 and untimed, included, but was not limited to, the</p>		<p>I could still hear them in the dining room" and "further indicated it seemed like they were arguing and it was getting out of hand". It is doubtful as witnessed by the Director of Nursing that the noise level of the conversation reached that whereby Resident #C actually heard the conversation. Rather, Resident #C was positioned so that she could see through the window to the Administrator's office. Review of Resident #C's behavior plan # 2 indicates that the resident "has the potential to make false statements and exaggerate circumstances" and careplan indicates that the resident is care planned for embellishing and making up issues that do not exist. Resident #B often times indicates she is "afraid she will be asked to leave" and when so indicates is always reassured regardless of the circumstance that this is her home and she certainly would not be asked to leave. Care Plan states "I sometimes have delusional thinking, I believe things are true that are contrary to the reality. I do have a mental illness, depression and bipolar. I get nervous at times about bringing my concerns/issues to staff because I feel that they may get mad and make me leave the facility even though no one has ever said that to me." SS Progress Note dated 3-31-16 Resident B did express some</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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>following: "...walking back to my office, I saw [Resident #B's first name and initial of last name] ...and said to [him/her], I want to talk with you in the office...I started the meeting by telling [Resident #B's first name] that [his/her] behavior at the meeting was not ok...[Resident #B's first name] said something about me demanding that [he/she] come to my office and I replied that I asked you to come to my office. I replied that I didn't mean for [himher] to feel like that... [DON's first name] made a facial gesture and said [sic] "[Administrator's first name]" that made me consider, am I getting louder with my voice...Later in the conversation [sic] [Resident #B's first name] said [he/she] had hurt feelings and was tearful...After [Resident #B's first name] left the office, I said to {DON's first name}, that was not good...I then realized that my raising my voice in our meeting [sic] that this could be construed as very poor conduct or bordering on verbal abuse..."</p> <p>The typed interview, by the Director of Operations, for Resident #B, dated 7/7/16 and untimed, included, but was not limited to, the following: "...I asked the resident [Resident #B] to tell me what happened after the Group Meeting...Administrator said [sic] "I want to see you in my office now". [sic] When</p>		<p>delusional thinking where she feels the nursing home is going to dissolve and she will be out on the streets, reassured resident that this was not the case but she continues to be fixated on this. While the meeting ended up escalating, both the Administrator and Resident #B apologized to each other before Resident #B left the meeting. Upon conclusion of the meeting, the Administrator knew that the meeting and what had occurred did not go well and immediately notified her immediate supervisor, (Director of Operations), with the Director of Nursing present and self reported the event. The Administrator was suspended pending investigation on July 7, 2016. Director of Operations arrived at facility late afternoon on July 7, 2016 to submit initial report to ISDH, (reportable event) and begin investigation. Investigation continued through 7-11-16. Director of Operations met with Administrator on 7-7-16 and 7-11-16 and while the investigation did not support the fact that the Administrator's verbal exchange and raising of her voice was willful in nature, it was construed as failure to maintain acceptable standards of conduct and respect for others. The Administrator received formal counseling from the Director of Operations on 7-11-16. Conditions required from counseling included: the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170			
(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>I asked resident [Resident #B] what happened in the private meeting [sic] [he/she] said it got "heated". [sic] I asked the resident [Resident #B] if [he/she] felt intimidated by the Administrator. Resident [Resident #B] responded [sic] "Yes, I'm afraid she will ask me to leave"..."</p> <p>During an interview on 8/2/16 at 3:30 p.m., Resident #B indicated the Administrator tapped her finger on the hydration cart and stated, "I want you in my office now." Resident #B indicated the Administrator went and got the DON. Resident #B further indicated the Administrator stated, "Don't you ever talk to me like that or question my authority again!" Resident #B indicated he/she enjoyed the Meet-and-Greets, but was not attending any more of them because he/she got in trouble the last time he/she went. Resident #B also indicated he/she has been trying to lay low since the incident occurred.</p> <p>During an interview on 8/3/16 at 9:15 a.m., Resident #C indicated, about 3 weeks ago, the Administrator became overwhelmed and ended the Meet-and-Greet. Resident #C indicated the Administrator and [Resident #B's first name] got a little loud, but that was in her [Administrator] office. Resident #C</p>		<p>Administrator participate in short term counseling to deal with stress and/or anger management which was initiated on 7-13-16. And utilize techniques learned in Lean Six Sigma Training to problem solve issues instead of reacting immediately. The Director of Operations will continue to monitor the ADM stress level. The DON has been asked to keep the DO informed of any concerns. Although the Administrator and Resident have not had any prior issues like this situation, it has been recommended that the SSD or DON be present for any private meetings between these two parties. Follow-up report submitted to the ISDH on 7-11-16. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #B was immediately followed up with by the Director of Nursing to assure the resident did not sustain any harm. Resident #B voiced to the Director of Nursing that she was afraid she might have to leave the nursing home and she was reassured by the Director of Nursing and the Administrator that she would not. SS Progress Note dated 3-31-16 Resident did express some delusional thinking where she feels the nursing home is going to dissolve and she will be out on the streets, reassured resident</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170		
(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 door was shut and I could still hear them in the dining room. Resident #C further indicated it seemed like they were arguing and it was getting out of hand.</p> <p>During an interview on 8/3/16 at 10:09 a.m., the DON indicated, on 7/7/16, the Administrator asked her to come to her office, however, she was unaware of why. The DON indicated when she got to the Administrator's office, Resident #B was entering the office and she assisted him/her due to his/her wheel chair use. The DON indicated the Administrator told Resident #B, "this type of behavior will not be tolerated in this type of setting [referring to the Meet-and-Greet]." The DON indicated the conversation, after about 5 or 10 minutes, got heated. The DON indicated she knew the Administrator was upset and not backing down, so she told the Administrator to stop. The DON indicated the Administrator turned away and was crying hysterically and had "lost it." The DON further indicated the Administrator's voice and tone warranted being reported and her tone was probably not becoming of an Administrator.</p> <p>During an interview on 8/3/16 at 11:00 a.m., Resident #D indicated the Administrator got her feelings hurt at the</p>		<p>that this was not the case but she continues to be fixated on this. The Director of Operations also reassured the resident during an interview on 7-7-16 that she would not have to leave the facility. Additional follow-up by Social Services and other staff members have noted no real significant change in Resident #B's demeanor, etc. The Administrator and Resident cordially interact daily as prior to 7-7-16. 7-11-16, 7-12-16 and 7-15-16 Progress notes all indicate that resident is continuing at her baseline mood and behavior, Shows no signs or symptoms of distress, No concerns. Administrator and Resident cordially interact daily/weekly as prior to 7-7-16. All residents attend Meet N Greet as per their normal since 7-7-16. There have been two (2) Meet-and-Greets since July 7. While Resident #B has not participated, Resident #B usually only participates in the Meet-and-Greet every other month and the resident has been and will be invited to participate in the future should she desire.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents have the potential to be affected but it is highly unlikely given that this was an isolated incident involving only one resident. This Administrator</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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>Meet-and-Greet about 3 weeks ago and was really upset. Resident #D also stated, "I don't know why she got so upset. I thought that was why we had the meetings, to talk about concerns."</p> <p>During an interview on 8/3/16 at 3:32 p.m., the Administrator indicated she was leading the Meet-and-Greet that occurs twice monthly. The Administrator indicated Resident #B had multiple complaints and was wanting other residents to support him/her. The Administrator indicated Resident #B was mad and she was concerned that Resident #B and Resident #C were going to get into it. The Administrator indicated she tried to end the meeting, however, Resident #B kept on and was loud, angry and accusatory. The Administrator indicated she thought Resident #B's behavior care plan was to tell him/her when his/her behavior was unacceptable so she asked Resident #B to come to her office. The Administrator indicated she went and asked the DON to come to her office. The Administrator indicated she told Resident #B his/her behavior was not ok, and the Meet-and-Greet was not the time or place for the discussion Resident #B wanted to have. The Administrator indicated the conversation went back and forth and it did not go good. The Administrator indicated she</p>		<p>has had near ten (10) year spotless service to this nursing home and the residents it serves. The Director of Operations, Director of Nursing and Social Services Director will continue to monitor all residents for signs and symptoms of any distress.</p> <p>3. What measures will be put into place or what systematic changes made to ensure that the alleged deficient practice will not recur? Hickory Creek believes the Administrator should have been able to control the situation in a better manner. As a result proper disciplinary action has been taken. In addition, the Administrator has been asked to participate in short term counseling to deal with stress and/or anger management. The DO will continue to monitor the ADM stress level. The DON has been asked to keep the DO informed of any concerns. Although the Administrator and Resident have not had any prior issues like this situation, it has been recommended that the SSD or DON be present for any private meetings between these two parties. 4. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? What quality assurance program will be put into place? The Director of Operations, Director of Nursing and Social Services Director will continue to monitor all residents for signs and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170		
(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 a "freak out moment" and thought this isn't how this was suppose to happen. The Administrator indicated she heard the DON say stop. The Administrator indicated she was tearful, torn up and questioned herself regarding her tone of voice, at which point, she turned away and tried to analyze her emotions. The Administrator further indicated she thought she was following Resident #B's plan of care, and stated, "I was wrong, I messed up. I knew immediately things could have been handled differently."</p> <p>On 8/3/16 at 10:35 a.m., the Administrator provided a current copy of the document titled, "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property", dated February, 2015. It included, but was not limited to, the following: "...Standard...Residents will be free from mistreatment...abuse...verbal...Definitions ...Abuse...intimidation...This presumes that instances of abuse of all residents...cause physical harm, or pain or mental anguish...Verbal Abuse...oral...or gestured language..."</p> <p>This Federal tag relates to Complaint IN00204617</p> <p>3.1-27(b)</p>		<p>symptoms of any distress. The DO will continue to monitor the ADM stress level. The DONhas been asked to keep the DO informed of any concerns. Although the Administrator and Resident have not had any prior issues like this situation,it has been recommended that the SSD or DON be present for any private meetings between these two parties. The Administrator, DON, SSD or designee will complete weekly interviews for all current residents with a BIMS score of 13 and above,indicating cognitively intact. Interviews will be documented using the"Resident Interview Worksheet". All concerns/complaints will be documented per facility Policy and Procedure on the "Resident Concern form" for identification purposes and investigated for resolution. Documentation of facility response and resolution of the concerns will also be documented on the concern form.Resident weekly interviews will be completed for 12 consecutive weeks. After that time period the IDT will interview residents during the Guardian Angel Rounds about the appropriate comfort, respect and communication between staff and residents. The results will be reviewed at the monthly QA meeting for the next 60 days. After the 60 days the QA Committee may decide to stop the requirement for reporting</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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
F 0226 SS=G Bldg. 00	<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 policy and procedures were followed in ensuring a resident was free from verbal abuse by a staff member for 1 of 3 residents reviewed for abuse. This deficient practice had the potential to affect 33 of 33 residents residing in the facility. (Resident #B)</p> <p>Findings include:</p> <p>The typed statement for the Administrator, dated 7/7/16 and untimed, included, but was not limited to, the following: "...walking back to my office, I saw [Resident #B's first name and initial of last name] ...and said to [him/her], I want to talk with you in the office...I started the meeting by telling [Resident #B's first name] that [his/her] behavior at the meeting was not ok...[Resident #B's first name] said something about me</p>	F 0226	<p>results if 100% compliance has been achieved. By what date will the systemic changes be completed? 8-19-16</p> <p>We disagree with the deficiency determination and scope and severity of alleged deficiencies. This matter was a self-reported event by the Provider in compliance with Federal / State rules and regulations. F 226 The Provider is requesting a face-to-face IDR regarding thisalleged deficiency. This Provider has developed and implemented written policiesand procedures that prohibit mistreatment, neglect, and abuse of residents andmisappropriation of resident property. HCHF1 Policy # ADM-R002-1 with Revision Date: 2-2015provided surveyor at time of survey. We believe our policies and procedures were indeed followed,including that in essence the ADM immediately self reported herself. This Provider acknowledges that the resident has the rightto be free from verbal, sexual, physical, and mental abuse, corporalpunishment, and</p>	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170			
(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>demanding that [he/she] come to my office and I replied that I asked you to come to my office. I replied that I didn't mean for [him/her] to feel like that... [DON's first name] made a facial gesture and said [sic] "[Administrator's first name]" that made me consider, am I getting louder with my voice...Later in the conversation [sic] [Resident #B's first name] said [he/she] had hurt feelings and was tearful...After [Resident #B's first name] left the office, I said to {DON's first name}, that was not good...I then realized that my raising my voice in our meeting [sic] that this could be construed as very poor conduct or bordering on verbal abuse..."</p> <p>The nurses note, dated 7/7/16 at 8:30 p.m., included, but was not limited to, the following: "...Resident involved this afternoon in a verbal incident with a staff member..."</p> <p>The clinical record for Resident #B was reviewed on 8/2/16 at 2:20 p.m., diagnoses included, but were not limited to, anxiety and depression. The annual MDS (Minimum Data Set) assessment, dated 6/21/16, indicated Resident #B had a BIMS (Brief Interview of Mental Status) score of 13, which signified intact cognition.</p>		<p>involuntary seclusion. The Provider has established policies and procedures whereby it conveys that no one should use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion towards the residents it serves. The Administrator of this facility has been the Administrator for nearly ten (10) years. The home has had three (3) deficiencyfree annual surveys under the Administrators leadership and currently has anIndiana Report Card Score of zero (-0-) and is rated a 5 Star Nursing Home byNursing Home Compare. Further, the interpretive guidelines issued by CMS define“Abuse” as the “willful” inflictionof injury, unreasonable confinement, intimidation, or punishment with resultingphysical harm, pain or mental anguish. Further, “Verbal abuse” is defined asthe use of oral, written or gestured language that “willfully” includes disparaging and derogatory terms to residentsor their families. Yes, in this one specific incident, the Administrator didraise her voice during a conversation with Resident #B and the event wasrelated to a very specific set of facts and circumstances as evident from thehistory of those involved. The “Meet-and-Greet” process that the Administrator hasfacilitated in this home has been common practice for approximately 1 and a half (1 1/2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170			
(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>During an interview on 8/2/16 at 3:30 p.m., Resident #B indicated the Administrator tapped her finger on the hydration cart and stated, "I want you in my office now." Resident #B indicated the Administrator went and got the DON. Resident #B further indicated the Administrator stated, "Don't you ever talk to me like that or question my authority again!"</p> <p>During an interview on 8/3/16 at 9:15 a.m., Resident #C indicated, about 3 weeks ago, the Administrator became overwhelmed and ended the Meet-and-Greet. Resident #C indicated the Administrator and [Resident #B's first name] got a little loud, but that was in her [Administrator] office. Resident #C indicated the door was shut and I could still hear them in the dining room. Resident #C further indicated it seemed like they were arguing and it was getting out of hand.</p> <p>During an interview on 8/3/16 at 10:09 a.m., the DON indicated, on 7/7/16, the Administrator asked her to come to her office, however, she was unaware of why. The DON indicated when she got to the Administrator's office, Resident #B was entering the office and she assisted [him/her] due to [his/her] wheel chair use. The DON indicated the</p>		<p>years and is usually held two times a month. By virtue of thisforum, the Administrator invites residents input, both positive and negative in a manner to assist in producing suggestions for improvement. TheMeet-and-Greets is not intended for a resident to complain and then be pulledaside later and berated about what they said. Rather, having these meetingsdemonstrates that the Administrator understands her responsibility towards theresidents and buys into the fact that the facility is the residents' home. Thisprocess is one of the mechanisms in which the Administrator is trying to makethe living arrangements as comfortable and livable as possible for theresidents the facility serves. The Meet-and-Greet held on July 7 resulted in Resident #Bbecoming upset when other residents did not speak up in concurrence or supportof Resident #B's own concerns, in particular, Resident #C. This created anatmosphere whereby Resident #B began tomonopolize the meeting and due to other scheduled activities and events, theAdministrator attempted numerous times to put closure to the meeting. Upon conclusion of the Meet-and-Greet, the Administrator didask that Resident #B come to the office to discuss the events of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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>Administrator told Resident #B, "this type of behavior will not be tolerated in this type of setting [referring to the Meet-and-Greet]." The DON indicated the conversation, after about 5 or 10 minutes, got heated. The DON indicated she knew the Administrator was upset and not backing down, so she told the Administrator to stop. The DON indicated the Administrator turned away and was crying hysterically and had "lost it." The DON further indicated the Administrator's voice and tone warranted being reported and her tone was probably not becoming of an Administrator.</p> <p>During an interview on 8/3/16 at 3:32 p.m., the Administrator indicated she was leading the Meet-and-Greet that occurs twice monthly. The Administrator indicated Resident #B had multiple complaints and was wanting other residents to support [him/her]. The Administrator indicated Resident #B was mad and she was concerned that Resident #B and Resident #C were going to get into it. The Administrator indicated she tried to end the meeting, however, Resident #B kept on and was loud, angry and accusatory. The Administrator indicated she thought Resident #B's behavior care plan was to tell [him/her] when [his/her] behavior was unacceptable so she asked Resident #B to</p>		<p>the Meet-and-Greet, thusly asking the Director of Nursing to participate in the meeting. Admittedly by the Administrator, Director of Nursing and Resident #B, the conversation escalated and both resident #B and the Administrator raised their voices during the meeting. Resident #C was interviewed by the surveyor indicating "the door was shut and I could still hear them in the dining room" and "further indicated it seemed like they were arguing and it was getting out of hand". It is doubtful as witnessed by the Director of Nursing that the noise level of the conversation reached that whereby Resident #C actually heard the conversation. Rather, Resident #C was positioned so that she could see through the window to the Administrator's office. Review of Resident #C's behavior plan # 2 indicates that the resident "has the potential to make false statements and exaggerate circumstances" and care plan indicates that the resident is care planned for embellishing and making up issues that do not exist. Resident #B often times indicates she is "afraid she will be asked to leave" and when so indicates is always reassured regardless of the circumstance that this is her home and she certainly would not be asked to leave. Care Plan states "I sometimes have delusional</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170			
(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>come to her office. The Administrator indicated she went and asked the DON to come to her office. The Administrator indicated she told Resident #B [his/her] behavior was not ok, and the Meet-and-Greet was not the time or place for the discussion Resident #B wanted to have. The Administrator indicated the conversation went back and forth and it did not go good. The Administrator indicated she had a "freak out moment" and thought this isn't how this was suppose to happen. The Administrator indicated she heard the DON say stop. The Administrator indicated she was tearful, torn up and questioned herself regarding her tone of voice, at which point, she turned away and tried to analyze her emotions. The Administrator further indicated she thought she was following Resident #B's plan of care, and stated, "I was wrong, I messed up. I knew immediately things could have been handled differently."</p> <p>On 8/3/16 at 10:35 a.m., the Administrator provided a current copy of the document titled, "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property", dated February, 2015. It included, but was not limited to, the following: "...Standard...Residents will be free from mistreatment...abuse...verbal...Definitions</p>		<p>thinking, I believe things are true thatare contrary to the reality. I do have a mental illness, depression andbipolar. I get nervous at times about bringing my concerns/issues to staffbecause I feel that they may get mad and make me leave the facility even thoughno one has ever said that to me." SS Progress Note dated 3-31-16 Resident B did expresssome delusional thinking where she feels the nursing home is going to dissolveand she will be out on the streets, reassured resident that this was not thecase but she continues to be fixated on this. While the meeting ended up escalating, both theAdministrator and Resident #B apologized to each other before Resident #B leftthe meeting. Upon conclusion of the meeting, the Administrator knew thatthe meeting and what had occurred did not go well and immediately notified herimmediate supervisor, (Director of Operations), with the Director of Nursingpresent and self reported the event. The Administrator was suspended pending investigation onJuly 7, 2016. Director of Operations arrived at facility late afternoon onJuly 7, 2016 to submit initial report to ISDH, (reportable event) and begininvestigation. Investigation continued through 7-11-16. Director of Operations met with Administrator on 7-7-16 and7-11-16 and while the investigation did not support the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170		
(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>...Abuse...intimidation...This presumes that instances of abuse of all residents...cause physical harm, or pain or mental anguish...Verbal Abuse...oral...or gestured language..."</p> <p>This Federal tag relates to Complaint IN00204617</p> <p>3.1-28(a)</p>		<p>fact that theAdministrator's verbal exchange and raising of her voice was willful in nature,it was construed as failure to maintain acceptable standards of conduct and respect for others. TheAdministrator received formal counseling from the Director of Operations on7-11-16. Conditions required from counseling included: the Administratorparticipate in short term counseling to deal with stress and/or angermanagement which was initiated on 7-13-16. And utilize techniques learned inLean Six Sigma Training to problem solve issues instead of reactingimmediately. The Director of Operationswill continue to monitor the ADM stress level. The DON has been asked to keepthe DO informed of any concerns. Although the Administrator and Resident havenot had any prior issues like this situation, it has been recommended that theSSD or DON be present for any private meetings between these two parties. Follow-up report submitted to the ISDH on 7-11-16.Hickory Creek at Scottsburg will continue to follow current Policies & Procedures in place which are designed to prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1. How will corrective action be accomplished for those residents found to have</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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>beenaffected by the alleged deficient practice? Resident #B was immediately followed up with by the Director of Nursing to assure the resident did not sustain any harm. Resident #B voiced to the Director of Nursing that she was afraid she might have to leave the nursing home and she was reassured by the Director of Nursing and the Administrator that she would not. SS Progress Note dated 3-31-16 Judy did express some delusional thinking where she feels the nursing home is going to dissolve and she will be out on the streets, reassured resident that this was not the case but she continues to be fixated on this. The Director of Operations also reassured the resident during an interview on 7-7-16 that she would not have to leave the facility. Additional follow-up by Social Services and other staff members have noted no real significant change in Resident #B's demeanor, etc. The Administrator and Resident cordially interact daily as prior to 7-7-16. 7-11-16, 7-12-16 and 7-15-16 Progress notes all indicate that resident is continuing at her baseline mood and behavior, Shows no signs or symptoms of distress, No concerns. Administrator and Resident cordially interact daily/weekly as prior to 7-7-16. All residents attend Meet N Greet as per their normal since 7-7-16.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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>There have been two (2) Meet-and-Greets since July 7. While Resident #B has not participated, Resident #B usually only participates in the Meet-and-Greet every other month and the resident has been and will be invited to participate in the future should she desire.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents have the potential to be affected but it is highly unlikely given that this was an isolated incident involving only one resident. This Administrator has had near ten (10) year spotless service to this nursing home and the residents it serves. The Director of Operations, Director of Nursing and Social Services Director will continue to monitor all residents for signs and symptoms of any distress.</p> <p>3. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Hickory Creek believes the Administrator should have been able to control the situation in a better manner. As a result proper disciplinary action has been taken. In addition, the Administrator has been asked to participate in short term counseling to deal with stress and/or anger management. The DO will continue to monitor the ADM stress level. The DON has</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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>been asked to keep the DO informed of any concerns. Although the Administrator and Resident have not had any prior issues like this situation, it has been recommended that the SSD or DON be present for any private meetings between these two parties. 4. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? What quality assurance program will be put into place? The Director of Operations, Director of Nursing and Social Services Director will continue to monitor all residents for signs and symptoms of any distress. The DO will continue to monitor the ADM stress level. The DON has been asked to keep the DO informed of any concerns. Although the Administrator and Resident have not had any prior issues like this situation, it has been recommended that the SSD or DON be present for any private meetings between these two parties. The Administrator, DON, SSD or designee will complete weekly interviews for all current residents with a BIMS score of 13 and above, indicating cognitively intact. Interviews will be documented using the "Resident Interview Worksheet". All concerns/complaints will be documented per facility Policy and Procedure on the "Resident Concern form" for identification purposes and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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
F 0280 SS=D Bldg. 00	<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</p>		<p>investigated for resolution. Documentation of facility response and resolution of the concerns will also be documented on the concern form. Resident weekly interviews will be completed for 12 consecutive weeks. After that time period the IDT will interview residents during the Guardian Angel Rounds about the appropriate comfort, respect and communication between staff and residents. The results will be reviewed at the monthly QA meeting for the next 60 days. After the 60 days the QA Committee may decide to stop the requirement for reporting results if 100% compliance has been achieved. By what date will the systemic changes be completed? 8-19-16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170			
(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>representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure a residents plan of care was modified to reflect the use of a sit to stand lift for transfers for 1 of 3 residents reviewed for care plans. (Resident #C)</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 8/2/16 at 3:10 p.m. Diagnoses included, but were not limited to, osteoarthritis of the left knee, immobility syndrome, and chronic pain. The quarterly MDS (Minimum Data Set) assessment indicated Resident #C was an extensive, two person assist with transfers. Resident #C had a BIMS (Brief Interview of Mental Status) score of 15, which signified intact cognition. The MDS also indicated Resident #C was an extensive, two person assist with toileting and frequently incontinent of bladder.</p> <p>The care plan for Resident #C included, but was not limited to, the following: "...Focus...I am unable to transfer myself related to immobility syndrome...Date Initiated: 11/30/2015...Goal...I will transfer to and from the bed to the w/c</p>	F 0280	<p>It is the standard of this facility for the resident to have the right to participate, 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. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? The care plan for resident #C has been reviewed and updated to reflect the use of the Sit-Stand Lift for transfers. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? The care plans for all current residents have been reviewed and updated as needed to ensure the current transfer ability for each resident is reflected in the care plan. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur? Upon admission, quarterly and with change of status the care plan will be reviewed and updated as needed to ensure the current status is reflected. The DON or designee will monitor and record 5 days weekly, any noted changes in resident's transfer ability utilizing form "QA Audit Form: IDT Review</p>	08/19/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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>[wheel chair] and back throughout the day with limited assist from staff...Date Initiated: 11/30/2015...Revision on: 05/05/2016...Interventions/Tasks...Assist me with sitting on the side of the bed and allow me time to get me balance...Date Initiated: 11/30/2015...Cue me to hold onto the arm rests of the w/c and slowly lower myself to the w/c...Date Initiated: 11/30/2015...Have me put my hands on the arm rests of w/c or the positioning bar of the bed and have me pivot to the place I'm going to...Date Initiated: 11/30/2015...Using a gait belt assist me in standing up...Date Initiated: 11/30/2015..."</p> <p>During an interview on 8/3//16 at 9:15 a.m., Resident #C indicated he/she has a bad left knee and cannot stand. Resident #C also indicated he/she and has to be transferred to the toilet with the sit to stand lift.</p> <p>On 8/3/16 at 1:30 p.m., CNA (Certified Nursing Assistant) #5 was observed to take the stand to sit lift into bathroom #3 while CNA #6 was observed to propel Resident #C in his/her wheel chair into bathroom #3.</p> <p>During an interview on 8/3/16 at 3:20 p.m., the MDS Coordinator indicated Resident #C had been using the sit to</p>		<p>for Resident Status Changes". How will the corrective action (s) be monitored to ensure the deficient practice will not recur? What quality assurance program will be put into place? The DON or designee will monitor the changes in resident's transfer ability along with the care plan to ensure the care plan is reflective of the current status at least 5 days a week. During the weekly Standards of Care meeting the IDT will also review for any changes in transfer ability. If changes are noted, the documentation will be completed under the "Physical Functioning-ADL Decline: Review any resident with decline in the past 7 days" section of the Standards of Care Form and the care plan will be updated to reflect these changes. The results of any changes will be brought to the monthly QA Committee 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. By what date will the systemic changes be completed? 8-19-16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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
F 0312 SS=D Bldg. 00	<p>stand lift for about a month and a half.</p> <p>Resident #C's care plan lacked documentation of the sit to stand lift to be used for transfers.</p> <p>3.1.35(b)(1)(d)(2)(B)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to ensure toileting needs were met for 2 of 3 residents reviewed for activities of daily living. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B was reviewed on 8/2/16 at 2:20 p.m. Diagnoses included, but were not limited to, rheumatoid arthritis, restless leg syndrome and chronic obstructive pulmonary disease. The annual MDS (Minimum Data Set) assessment, dated 6/21/16, indicated Resident #B had a BIMS (Brief Interview of Mental Status) score of 13, which signified intact cognition. The MDS also indicated</p>	F 0312	<p>F312 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? The Administrator, DON or SSD have met with resident # B and #C during the week of 8/15/16 - 8/19/16 regarding concerns of prolonged call light waiting periods. Designee will document all meetings and identify any areas of concern and follow-up accordingly. All information from the meetings will be documented on the "Resident Interview Worksheet" and all concerns/complaints will be documented per facility Policy</p>	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170		
(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 #B was occasionally incontinent of bowel.</p> <p>The care plan for Resident #B included, but was not limited to, the following: "...Focus...At times, when my RA [Rheumatoid Arthritis] is acting, I require assistance to use the toilet. I am able to tell staff when I need to use the bathroom and can manage my pericare [sic]...Date initiated: 05/20/2014...Revision on: 11/30/2015...Goal...I will remain continent of bowel and bladder daily with staff assist PRN [as needed] through next review...Date Initiated: 05/20/2014...Revision on: 07/18/2016...Interventions/Tasks...Answer call light promptly and assist me to the bathroom as needed..."</p> <p>On 8/3/16 at 9:00 a.m., during an interview with Resident #B, he/she indicated he/she has had to wait long periods of time, sometimes 45 minutes to an hour, for the call light to be answered. Resident #B indicated he/she can take his/herself to the bathroom with assistance, but when he/she has diarrhea, he/she cannot wait and has had accidents waiting for someone to come and help him/her.</p> <p>2. The clinical record for Resident #C was reviewed on 8/2/16 at 1:15 p.m.</p>		<p>and Procedure on the "Resident Concern Form". How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? All residents have the potential to be affected by this practice. The Administrator, DON or designee completed an initial interview during the week of 8/15/16 - 8/19/16 of all residents with a BIMS score of 13 and above, indicating cognitively intact. "There were no other concerns voiced about the time taken for staff to respond to call lights." Initial interviews will be documented on the "Resident Interview Worksheet". The Administrator, DON, or designee having identified any other areas of concern and will follow-up accordingly with corresponding departments using the "Resident Concern Form" as per facility policy. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur? The Administrator, DON or designee will complete weekly interviews for all current residents with a BIMS score of 13 and above, indicating cognitively intact. Interviews will be documented using the "Resident Interview Worksheet". All concerns / complaints will be documented per facility Policy and Procedure on the "Resident Concern Form" for identification</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
---	---

(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>Diagnoses included, but were not limited to, muscle weakness and unilateral primary osteoarthritis of the left knee. The quarterly MDS (Minimum Data Set) assessment, dated 7/19/16, indicated Resident #C had a BIMS score of 15, which signified intact cognition. The MDS also indicated Resident #C was an extensive, two person assist with toileting and frequently incontinent of bladder.</p> <p>The care plan for Resident #C included, but was not limited to, the following: "...Focus...I am frequently incontinent of...bladder...Date Initiated: 03/15/2016...Goal...I will have no complications...daily...Intervention/Tasks ...Assist me with my toileting needs...Date Initiated: 03/15/2016...."</p> <p>During an interview on 8/3/16 at 9:15 a.m., Resident #C indicated he/she has had to go to the bathroom and wait an hour, more than once, for his/her call light to be answered. Resident #C indicated, by then, it's too late and has already wet his/herself. Resident #C also indicated he/she is unable to stand and has to use the lift (sit to stand) to go to the bathroom. Resident #C indicated there was only one lift and it only fits in bathroom #2 and #3. Resident #C indicated he/she has also had accidents waiting for the lift. Resident #C indicated</p>		<p>purposes and investigated for resolution. Documentation of facility response and resolution of the concerns will also be documented on the concern form. Resident weekly interviews will be completed for 12 consecutive weeks. After that time period the IDT will interview residents during the Guardian Angel Rounds about the timeliness of call lights being answered this will be done 5 times a week. All information gathered during the interviews will be brought to the morning IDT management meeting which occurs at least 5 days a week for further review and recommendations from the team. How will the corrective action (s) be monitored to ensure the deficient practice will not recur? What quality assurance program will be put into place? The results of the Administrator's / DON's / designee's and IDT interviews will be brought to the QA Committee monthly for further review for the next 90 days. After the 90 day period, the QA Committee may decide to stop the requirement for reporting results if 100% compliance has been achieved; however, the monitoring by the Administrator, DON, designee and IDT will continue as indicated on an ongoing basis as indicated in question # 3. By what date will the systemic changes be completed?8-19-16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2016
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170		
(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>he/she was on a diuretic and had to change the administration time to nights because he/she has to go to the bathroom more frequently and cannot hold it if he/she has to wait.</p> <p>During an interview on 8/3/16 at 2:30 p.m., the DON (Director of Nursing) indicated the facility had just one sit to stand lift for six people, which requires 2 people for transfers per their policy for lift transfers. The DON also indicated, if the lift was in use, residents who require the use of the lift, have to wait until it was available.</p> <p>3.1-38(a)(2)(C)</p>				