STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLE			ETED		
155424		B. WIN			11/03/	/2011	
NAME OF E	PROVIDER OR SUPPLIE	R	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					25TH ST		
HICKOR	Y CREEK AT COL	JMBUS		COLUM	/IBUS, IN 47203		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0000							
] 	l   This visit was fo	or a Recertification and	F00	00	This Plan of Correction constit	ues	
		Survey. This visit	1 00	00	the written allegation of		
		restigation of Complaints			compliance for the deficiencie		
	IN00098813 and	• •			cited. Hower, submission of the Plan of Correction is not an	ne	
	11.00070015 und	# 11.VVV// 10V.			admission that a deficiency ex	ist	
	Complaint INOO	099165 - Substantiated.			or that one is cited correctly.		
	_	ficiencies related to the			Plan of Correction is submitted	d to	
	allegations are cited at F223, F224, F225,				meet the requirements	ol	
	F226.	110d at 1 223, 1 224, 1 223,			established by state and feder law.Hickory Creek at Columbu		
	1220.				desires this Plan of Correction		
	Complaint INO	098813 - Unsubstantiated			be considered the facility's		
	due to lack of ev				allegation of Compliance.		
	due to lack of ex	ridence.			Compliance is effective December 8, 2011.		
	Survey dates: C	October 31, November 1,			Boochiber o, 2011.		
	2, and 3, 2011	retobel 31, two vember 1,					
	2, and 3, 2011						
	Facility number	000284					
	Provider numbe						
	AIM number: 1						
		00290090					
	   Survey Team:   I	anie Faulkner, RN-TC					
	1	heryl Fielden, RN					
		enny Marlatt, RN					
		ll Ross, RN					
		iana Sidell, RN					
		1/2/2011)					
		11212011					
	Census bed type						
	SNF/NF: 35	•					
	Total: 35						
	10141. 33						
	Census payor ty	ne·					
	Consus puyor ty	P*·					

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

TITLE

(X6) DATE

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETED			
155424		B. WING		11/03/2011	
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R	5480 E	25TH ST	
	Y CREEK AT COL			/IBUS, IN 47203	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Medicaid: 34				
	Other: 1				
	Total: 35				
	Sample: 10				
	Supplemental sa	ample: 3			
	These deficienc	ies reflect state findings			
	cited in accorda	nce with 410 IAC 16.2.			
	Quality review	11/14/11 by Suzanne			
	Williams, RN				

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED
155424		B. WING		11/03/2011
NAME OF I	PROVIDER OR SUPPLIER	STREET .	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SUPPLIER	5480 E	25TH ST	
HICKOR	Y CREEK AT COLUMBUS	COLUN	//BUS, IN 47203	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	BROWINEBIC DLANLOF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0223	The resident has the right to be free from			
SS=D	verbal, sexual, physical, and mental abuse,			
	corporal punishment, and involuntary			
	seclusion.			
	The facility must not use verbal, mental,			
	sexual, or physical abuse, corporal			
	punishment, or involuntary seclusion.			
	Based on record review and interviews,	F0223	F223	12/03/2011
	the facility failed to prevent mental and		T	
	verbal abuse to residents. This affected 3		The facility disagrees with the survey findings regarding this	
	of 10 residents reviewed for abuse in the		alleged deficiency and	-
	sample of 10 (Residents #D, #E, #I).		respectfully requests the	
	sample of to (residents #2, #2, #1).		face-to-face Informal Dispute	
	Findings include:		Resolution process.	
	Thidings include.			
	On 11/1/2011 at 5:20 D.M. daning		It is the standard and policy of	
	On 11/1/2011 at 5:30 P.M., during		this facility that the resident hat the right to be free from verba	
	confidential interview, Employee #J		sexual, physical and mental	',
	stated, "[Resident#E's name] witnessed		abuse, corporal punishment, a	and
	the Administrator yelling and screaming		involuntary seclusion. It is the	
	at one of her department heads, and		standard of this facility to not	
	[Resident's name] started crying and went		allow verbal, mental, sexual, o	or
	to the nurses' station and asked, 'Is that		physical abuse, corporal punishment, or involuntary	
	woman going to start yelling at me next?""		seclusion.	
	Confidential interview with Resident #D,		The survey document indicate	es
	on 11/2/11 at 2:55 P.M., indicated, "the		that 3 of 10 residents were	
	Administrator is snippy, rude and mean. I		affected by the facility's allege	
	reported her to Hickory Creek. The		inability to prevent mental and verbal abuse. The facility	
	Administrator is rude to everyone."		disagrees with the surveyor(s)	)
	7 rammistrator is rude to everyone.		interpretation that a discussion	
	On 11/2/2011 at 10:45 A.M. danier		between the Administrator and	
	On 11/3/2011 at 10:45 A.M., during		Employee #K constitutes verb	al
	confidential interview, Employee #K		or mental abuse towards a	
	stated, "Two weeks ago, [Administrator's		resident. While it is true that	20,0
	name] yelled at me over menus posted on		Resident #E did go to the Nur Station and voice concern with	
			Station and voice concern with	'

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING 00		COMPLETED			
155424		A. BUILDING 11/03/2011			11/03/2011		
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
					25TH ST		
HICKOR	Y CREEK AT COLU	IMBUS		COLUN	IBUS, IN 47203		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ON
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	the wall. I had the	ne breakfast menu in the			the conversation the		
	dinner snot and t	he dinner menu in the			Administrator was having with		
	_				Employee #K, per Hickory		
		'm dyslexic, but I don't			Creek's interview with the		
	know if she know				Director of Nursing Services,		
	"Administrator y	relled, 'Look at this. It's			(DON) on November 4, 2011,		
	not right. Can't	you get it right.'" The			DON indicates she immediate	′ I	
	employee indica	ted this happened two			consoled Resident #E telling h	er	
		he employee stated the			that the Administrator would	ion	
	*	relled at me in the hall			never speak to her in this fash and asked resident if she wou		
	1				like to go to her room to talk		
		m #1, and [Resident #E's			about this further. Resident #E		
		ying and went back to her			acknowledged that she wanted		
	room questioning	g was she going to yell at			discuss further with the DON.		
	her too." Emplo	yee #K stated, "I should			Resident #E has a diagnosis		
	have called my c	orporate manager, but I			which includes Alzheimer's an	d	
	didn't."				according to the DON, residen	t	
	didii t.				had moved on to a new		
	G 61 4:1:4	· · · · · · · · · · · · · · · · · · ·			conversation within a minute o	r	
		rview with Employee #L,			so and never brought up the		
		11/3/2011, indicated			incident again. While it was		
	they were presen	t and heard Resident #E			unfortunate that Resident #E		
	crying and askin	g, " is that woman going			overheard a conversation between the Administrator and	,	
	to start yelling at	me next?"			Employee #K, the verbal		
					exchange which happened		
	During on interv	iew with Resident #A on			between these two employees	did	
					not include "verbal abuse" ora		
		0 P.M., resident stated,			gestured language that willfull		
		noisy around here,			included disparaging and		
	depending on who is working, whether it			derogatory terms to the residents		nts	
	is loud or not. The Administrator is loud				or "mental abuse" including, b	ıt	
	sometimes."				not limited to, humiliation,		
	Sometimes.				harassment, threats of		
	On 11/1/2011 of	2:20 D.M. interview			punishment or deprivation as		
		2:30 P.M., interview			defined in the federal/state		
		, the resident stated, "I			regulations and guidance to	-	
	heard yelling in	the hall a couple of weeks			surveyors and nothing contain	<b>∃</b> 0	
	ago. Not sure wh	no it was, but I'm pretty			within this survey report		
	sure it was staff."				substantiates this activity.		

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		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. building 00		00	COMPLETED		
155424		B. WIN			11/03/	2011	
2712		L			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				25TH ST		
	Y CREEK AT COLU				IBUS, IN 47203		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
IAU	On 11/3/2011 at interview with the regarding the alles she stated, "That never yelled at (consequence of the stated, "That never yelled at (consequence of the stated, "That never yelled at (consequence of the stated of the sta	3:25 P.M., during the Administrator regation of verbal abuse, didn't happen, I have department head) or the hall or elsewhere. That the interview on 11/3/2011 the facility Regional regarding the abuse the Administrator, she the her way to the facility, suspend Administrator regation was completed. The properties of the Administrator after the with the Administrator.		IAU	Resident #D contacted Hickory Creek Healthcare Foundation's corporate office on Friday, October 28, 2011. Her report to Hickory Creek was that the administrator was snippy and rude to the Nurses. Hickory Creek's Director of Operations who is the Administrator's director of Operations who is the Administrator was verbally, non-verbally to the resident #D state the Administrator was verbally, non-verbally or mentally abuse to her or other residents; nor of she give any examples that with meet the definition of verbal of mental abuse. Thus, the Administrator's alleged interactions with her staff, per interview does not meet the in of "verbal abuse" oral or gestul language that willfully included disparaging and derogatory te to the residents or "mental abuse including, but not limited to, humiliation, harassment, three of punishment or deprivation adefined in the federal/state regulations and guidance to surveyors and nothing contain within this survey report substantiates this alleged activity. The resident's interpretation is completely subjective and no examples of the Administrator's alleged rudeness to her staff were given the office of the staff were given the staff were given the office of the staff were given the staff were given the office of the staff were given th	to  sect ent  t no he ive did ould r  tent ured d rms use" ats	DATE
					Tadeness to her stall were give	C11.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETE			COMPLETED	
155424		B. WIN		<del></del>	11/03/2011	
			D. ((1)		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				25TH ST	
HICKOR'	Y CREEK AT COLU	IMBUS			IBUS, IN 47203	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	During the exit c	onference on 11/3/2011			Surveyor interview of Resident	! #A
	~	Administrator stated,			and the response does not me	
		ne] had not posted like I			the intent of "verbal abuse" ora	
		appened several times,			gestured language that willfully	′
		nall, I was frustrated,			included disparaging and derogatory terms to the reside	nte
	. ^				or "mental abuse" including, bu	•
		oice, that's what I recall,			not limited to, humiliation,	···
		rell, don't know who was			harassment, threats of	
	around."				punishment or deprivation as	
					defined in the federal/state	
	Review of Hicko	ry Creek Healthcare			regulations and guidance to	,
	Foundation, Inc.				surveyors and nothing contain	ed
	Accident/Inciden	nt/Reportable/State			within this survey report substantiates this alleged activ	rits (
	Officials- Indiana	a, Provided 10/31/2011 at			Substantiales this alleged activ	ny.
		dministrator as their			Surveyor interview of Resident	: # <i>I</i>
	1	d procedure with Issue			and the response does not me	•
		last revision date 10/11,			the intent of "verbal abuse" ora	nl or
		*			gestured language that willfully	/
	•	use - Physical, Sexual,			included disparaging and	
		ental (known and/or			derogatory terms to the resider or "mental abuse" including, bu	
		al Abuse- the use of			not limited to, humiliation,	
		ring distance regardless			harassment, threats of	
	of their age, abili	ty to			punishment or deprivation as	
	comprehendEx	xamples of verbal abuse			defined in the federal/state	
	include, but are r	not limited to: threats of			regulations and guidance to	
	harm, saying thir				surveyors and nothing contain	ed
	' ' '	ntal Abuse - includes,			within this survey report	.,
	but is not limited	· · · · · · · · · · · · · · · · · · ·			substantiates this alleged activ	rity.
	harassment"	w, nummanon,			The surveyor interview on pag	es
	narassineit				3&4 of the survey document as	•
					occurring on 11-3-11 at 3:25 P	•
		relates to complaint			did not occur as written. Two	
	IN00099165.				surveyors asked the	
					Administrator why her demean	or
	3.1-27(a)(1)				had changed and if she was	
	3.1-27(b)				aware there was an allegation	of
					verbal abuse against her. The	
	I		- 1		Administrator was not	1

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 11/03/2011
	ROVIDER OR SUPPLIE		5480 E	ADDRESS, CITY, STATE, ZIP CODE 25TH ST MBUS, IN 47203	•
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE COMPLETION  DATE
				interviewed, given any detain the allegation and wasn't as about details of any incident. She was denied the ability to respond in a meaningful mathat might have assisted the surveyors' understanding of alleged incident. There was attempt by the surveyors to validate any of the information with the Administrator that of from the resident interviews. Thus, the facility is seeking Informal Dispute of the survey document, the title Regional Operations Manager is inact as the correct title is Director Operations, (DO). The DO also misquoted. During the telephone conversation with Surveyor — TC, on 11-3-11 as:28 P.M. the DO asked the Surveyor the why she (DO) not informed of the abuse allegation when she was in facility on 11-2-11. The Surveyor's response was the was at the time. The DO dies state had she been informed 11-2-11 of an abuse allegation DO returned to the facility to participate in the Exit Confeheld on 11-3-11 at 5:04 P.M.  The facility believes that bas upon the above provided	sked ts. o onner e the s no on con came . ey  I curate or of was of the at e d or on con con con con con con con con con

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155424	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY  COMPLETED  11/03/2011
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP 5480 E 25TH ST COLUMBUS, IN 47203	CODE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE TAG DEFICIENCY)	SHOULD BE COMPLETION
	documentation that me "verbal" nor "mental" a defined by federal / st regulation occurred air respectfully requests entire survey citation from the record.  What corrective action done by the facility?  All employees will be re-in-serviced on the facility and mental abuse, co punishment, and invoseclusion and misapp resident property and employees of this facilito use or allow verball sexual, or physical ab corporal punishment, involuntary seclusion December 3, 2011.  Employees will be reduring these rein-servithis is the resident's his that employees must courteous and conscibusiness matters need discussed in private ir non-resident care are staff should refrain fro loudly, or making excein resident care areas.  How will the facility ideresidents having the pe affected by the sar	facility lude but not ent's right to il, physical rporal luntary ropriation of that ility are not mental, ruse, or by  ninded rices that ome and be entious, that d to be n an office or a and that om speaking essive noise i. entify other cotential to

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETED 11/03/2011		
R				
IMBUS				
		T	(X5)	
NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
		and what corrective action will taken?		
		All residents have the potential be affected, but particularly the residents with dementia, who a confused, unable to freely communicate, have behavioral symptoms and totally dependent residents.  What measures will be put intoplace to ensure this practice denot recur?  During re-in-services, staff will 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 reporting is also considered abuse / neglect.  During routine Guardian Angel Rounds Department Managers will inquire with their assigned residents regarding the overall atmosphere of the nursing hor and whether the resident has a concerns. Any identified concerns will be transferred to the Resident/Family Concern Formand the facility will follow its investigative protocol and grievance procedures.	ose are al ent	
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:  155424  R  STREET  5480 E  COLUM  STATEMENT OF DEFICIENCIES  NCY MUST BE PERCEDED BY FULL  A. BUILDING B. WING  STREET  5480 E  COLUM	IDENTIFICATION NUMBER: 155424  R  UMBUS  STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203  STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)  R  A BUILDING 5TREET ADDRESS, CITY, STATE, ZIP CODE 6A80 E 25TH ST COLUMBUS, IN 47203  STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)  A Manual What corrective action will taken?  All residents have the potentia be affected, but particularly the residents with dementia, who confused, unable to freely communicate, have behaviora symptoms and totally dependence residents.  What measures will be put interplace to ensure this practice of not recur?  During re-in-services, staff will 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 will the facility's abuse protocols a not reporting is also considered abuse / neglect.  During routine Guardian Ange Rounds Department Manager will inquire with their assigned residents regarding the overal atmosphere of the nursing how and whether the resident has concerns. Any identified conce will be transferred to the Resident/Family Concern Forn and the facility will follow its investigative protocol and	

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		IDENTIFICATION NUMBER:  155424	A. BUILDING B. WING	00 	COMPLETED  11/03/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
HICKORY	Y CREEK AT COLU	IMBUS		25TH ST //BUS, IN 47203	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORY OR	LOC IDENTIF TING INFORMATION)	IAU	How will the corrective action is monitored to ensure the deficie practice does not recur and when QA will be put into place?  The Resident/Family Concern forms will be brought to the monthly QA Committee for revand further recommendations. This reporting will continue monthly for the next 90 days at then at least one time per qual thereafter. In addition, the Director of Operations will revithe Resident/Family Concern forms monthly for at least 90 dand will conduct random interviews with Residents and Employees to ascertain compliance.	riew  nd rter ew

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DAME DING	00	COMPLETED	
I 155424		A. BUILDING	<del></del>	11/03/2011	
			B. WING		1
NAME OF F	PROVIDER OR SUPPLIEF	<b> </b>		ET ADDRESS, CITY, STATE, ZIP CODE	
				E 25TH ST	
HICKOR'	Y CREEK AT COLU	JMBUS	COL	JMBUS, IN 47203	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0224		develop and implement			<del> </del>
SS=D	,	nd procedures that prohibit			
00-D		plect, and abuse of			
		appropriation of resident			
	property.	appropriation or regident			
'	i	review, observation and	F0224	F224	12/03/2011
	interview, the fa	cility failed to ensure			
		sappropriation of		The facility disagrees with the	
		ty. This affected 2 of 5		survey findings regarding this	=
				alleged deficiency and	
		ed for misappropriation		respectfully requests the	
	of property in a	sample of 10 and		face-to-face Informal Dispute	-
	supplemental sar	mple of 3. (Residents #A,		Resolution process.	
	#H)			It is the standard and policy o	f
	,			this facility to develop and	'
	Findings include			implement written policies and	d
	Findings include	··		procedures that prohibit	
				mistreatment, neglect, and ab	ouse
		o interview with residents		of residents and misappropria	ition
	at 1:30 P.M. on	11/1/2011, the following		of resident property.	
	residents indicat	ed they had items			
	missing:	J		Resident #G asked to attend	
		a wedding band missing.		group resident meeting, but w	
		_		not identified on the Resident	
		icated the wedding ring		as a resident to be interviewe	
	had not been rep	laced or found at this		This resident's most recent N	NDS,
	time.			a copy which is included demonstrates a score of 10 o	n
				her BIMS assessment. A sco	•
	During an interv	iew with the Social		of 10 indicates cognitive	110
	_	or on 11/1/2011 at 2:30		impairment. The facility was	
				unaware that Resident #G ha	d
	' ' '	any allegations of		voiced a concern of missing in	
		n of funds or property and		because this was not reported	
	the process of in	vestigation, the Social		anyone at the facility before to	
	Services Directo	r replied, "any staff		surveyors reported it to facility	
	member can heli	o residents fill out		management via the 2567. It	was
	1	ninistrator gets all		when the survey document w	
		· ·		received and reviewed by the	
	~	ivestigation and then I get		Administrator that this concer	n
them for follow-up and have to give them		1	was brought to the facility's		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  O	COMPLETED
155424 B. WING	11/03/2011
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER  5480 E 25TH ST	
HICKORY CREEK AT COLUMBUS  COLUMBUS, IN 47203	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY  TAG DEFICIENCY  TAG DEFICIENCY	IATE COM ESTIGIT
TAG REGULATOR OR ESC IDENTIFIED IN ORDER TO THE	DATE
back to Administrator to go in the attention. After investigation determine the resident's ider	
grievance log book." "I do not keep any  the Administrator interviewed	
copies in my office, and these are not  Resident #G who alleged that	
documented anywhere other than wedding band and watch we	
grievance forms." missing. The resident's room	
searched and the resident's	
Interview with Resident #H on 11/2/2011 watch was located in her bed	
cabinet where it is always ke	•
at 10:25 A.M., indicated about two thus in fact it was not missing	
months ago he had a ring missing and he  Resident #G's daughter was	
reported it to the Social Services Director,  and has received no feedback. He  missing wedding band and the	
and has received no feedback. He resident's daughter indicated	
indicated he would like some resolve to her mother has never had he	
the issue. wedding band at the nursing	
home, that the wedding band	
Interview with the Social Services the daughter's home for	
Director on 11/2/2011 at 10:42 A M	
reported to the ISDIT, although	
indicated, "I don't recall him saying incident meets the Reportable anything to me about it recently or before Unusual Occurrences Policy	
that the resident is confused	
but I would have filled out a grievance watch was located in the bed	
form and give it to the Administrator." "I cabinet where it is always ke	pt
would remember it if it was in the last and per interview of the resid	dent's
couple of weeks." daughter, her mother's weda	ling
The Social Services Director provided a band has never been at the	
hlank "Dacidant / Family Company Fame"	
miopiacomoni, exploitation, e	
per request. wrongful, temporary or permit use of the ring without the	aneni
un side with a second, the about	there
on 11/2/2011 at 10.50 A.W., the	
Administrator was observed to enter	
Resident #H's room and asked about his  Based upon the above provided in the second provide	
missing ring, she began searching his <u>documentation it is clear that</u>	
room, and informed him they would be <u>violation of the facility's abuse</u>	<u>se</u>
searching his room for the ring.  protocol including that of misopper printing of regident	
During interview with Resident #H on misappropriation of resident property as defined by federal	i

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		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	4 DI II	I DDIC	00	COMPL	ETED
		155424		LDING		11/03/	2011
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
	V 0DEE!( AT 00! !	W 40110			25TH ST		
HICKOR	Y CREEK AT COL	DMBOS		COLUN	MBUS, IN 47203		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	12	DATE
	11/3/2011. he in	dicated that a grievance			state regulation did not occur,	and	
		eted on 11/2/2011, and he			respectfully requests that this	i	
	_	e facility is looking into			section of the survey citation b	<u>e</u>	
		e facility is fooking into			deleted from the record.		
	this issue.						
					Resident #B reported two		
	During a confide	ential interview with			turquoise Hanes tee shirts		
	Employee #L, o	n 11/2/2011 at 11:48			missing on August 17, 2011. A	ıπer	
		yee stated, "If I get a			a search of other residents'		
	_	sident, family, or staff, I			closets and the laundry the tee shirts were not found so the	7	
		•			facility purchased two new tee		
		e nurse and then I fill out			shirts for the resident on Augu		
a grievance form to be turned in to the				26, 2011. The Administrator ha			
	Administrator."	"If it is a big problem, I			been advised by the Director of		
	notify the DON	and the Administrator			Operations that all reports of		
	1 *	I fill out a grievance form			missing resident belongings		
	for any missing	•			require the implementation of		
	101 any missing	items.			Hickory Creek's Resident		
					Mistreatment, Neglect, Abuse	&	
		dated 9/27/11, Resident A,			Misappropriation of Property		
	indicated family	states wallet was in			Administrative Policy and		
	bedside table dra	awer, room has been			Procedure. In fact, the		
	searched, and w	vallet has not been found,			Administrator followed the		
	· ·	d no one was aware of the			applicable policy and the		
		There were no staff			resident's grievance/concern v		
	_				rectified. The State and Federal regulations do not require that		
		ified with dates or times			nursing facility be held strictly	а	
	of their investig	ation.			liable when a resident's tee sh	irts	
	On 11/2/2011 at	4:30 P.M., any other			are missing, only that the facility		
	investigations of	f concerns/missing items			have a grievance/concern	,	
	were requested t	to review from the			procedure to address any		
	•	The Administrator			unfortunate incidents. In this		
		P.M. on 11/2/2011 and			case, the facility has such a		
					policy, the policy was		
	stated, "I don't h	ave any (investigations)."			implemented and followed and		
					the resident's concern alleviate	ed.	
	Hickory Creek I	Healthcare Foundation,					
	Inc. Topic Griev	vances, provided by the			Resident #F's family member	,	
		n 11/2/2011 at 1:35 P.M.,			reported a missing black walle		
	1 Manimisuator O	11 1 1 1 2 1 2 0 1 1 ut 1 . J J 1 . 1 v 1 . ,			with roses on it which contained	ea l	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO		(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155424	B. WIN	G		11/03/	2011
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		5480 E	25TH ST		
HICKOR'	Y CREEK AT COLU	JMBUS			IBUS, IN 47203		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		DATE
	indicating curren	at policy and procedure			\$32.00 to the Administrator on		
		002 with Revision date			September 27, 2011. The fami	ily	
					member indicated that wallet w	vas	
		All complaint/concerns			in Resident #F's drawer on the	,	
	will be thorough				left hand side, but he had not		
	Resolution or sta	tus of follow-up will be			seen it for two months. Accord	- 1	
	relayed to reside	nts and/or families within			to the Administrator, no report		
	48 hours"				a missing sweater was made a	at	
					this time. Resident #F has a		
	This fodomal to a	rolates to complaint			diagnosis of dementia and was		
		relates to complaint			unable to provide any feedbac	ĸ	
	IN00099165.				regarding the wallet. The administrator contacted Reside	ont	
					#F's family member on Novem		
	3.1-28(a)				23 and the family member	ibei	
					indicates sweater was missing	a	
					long time ago. Due to the time	<u> </u>	
					frames involved and Resident	F's	
					diagnosis the wallet, money or		
					sweater have not been located		
					The facility made the decision	to	
					reimburse the \$32.00 and this		
					was given to Resident #F's fan	nily	
					on November 9, 2011. The		
					facility agrees that this incident	t	
					meets the state / federal		
					regulations regarding possible		
					misappropriation of resident		
					property and the incident shou		
					have been reported to the ISD	H	
					per the Reportable Unusual		
					Occurrences Policy.		
					The facility contends that the fi	iret	
					time they were made aware of		
					Resident #H's concern that his		
					ring was missing was when the		
					surveyor(s) indicated that		
					Resident #H had brought it to		
					their attention on 11-2-2011 at		
					10:25 A.M. Upon being told of	the	
					resident concern, the		

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	OF CORRECTION	IDENTIFICATION NUMBER:  155424	A. BUII B. WIN	DING	00 	COMPL 11/03/	ETED
	ROVIDER OR SUPPLIER			5480 E	ADDRESS, CITY, STATE, ZIP CODE 25TH ST 1BUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					Administrator approached Resident #H and his wife, who share a room, on 11/2/2011 at approximately 10:50 A.M. Resident #H indicated his ring was missing and it had been for while. When queried if Resident #H had told anyone the responsas "I don't recall". Resident #H was going through his jewelry few weeks ago and the ring wain a white jewelry bag. Resident #H swife indicated she thinks Resident #H threw the white be away before he took the ring on Resident #H agreed that was to case. With permission, Resident #H agreed that was to case. With permission, Resident #I sjewelry box and dresser drawers were searched and the ring was not found. Resident #I indicates that all of his other jewelry is accounted for. The jewelry box belonging to these residents is very large and contains a tremendous amount jewelry. The facility is working with the residents to inventory jewelry box as a majority of the items are not listed on the facil Inventory Sheet. The facility had Guardian Angel program in placensisting of frequent visits by Department Managers to their assigned residents. No one recalls Resident #H indicating that he had a missing ring until was brought to the Administration attention by the surveyor(s). The incident, upon being brought for the ISDH, in accordance with the IsDH.	or a nt nse H's H as nt ag ut. the the the tese lity as a acce lit	

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	OF CORRECTION	IDENTIFICATION NUMBER:  155424	A. BUILDING B. WING	00 	COMPLETED 11/03/2011
	ROVIDER OR SUPPLIER		5480 E	ADDRESS, CITY, STATE, ZIP CODE 25TH ST MBUS, IN 47203	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
				facility policy, although the facility policy, although the facility believe the incident meets the Reportable Unusual Occurrences Policy in that per interview or Resident #H and I wife, it does not appear that the was a deliberate misplacement exploitation, or wrongful, temporary or permanent use of the ring without the resident's consent. Both Resident H and Mrs. Resident H are capable historians.  The facility believes that based upon the above provided documentation that a violation the facility's abuse protocol including that of misappropriate of resident property as defined federal / state regulation did not occur, and respectfully requese that this section of the survey citation be deleted from the record.  Resident #A through surveyor interview on 11-2-11 at 2:00 P alleges that the Administrator disposed of her clothes and he dogs (stuffed animals, bingo prizes). On Thursday, October 13, 2011, Hickory Creek at Columbus received a very large shipment including all new electric hi-low beds, wardrobes and bedside cabinets for each resident room, which cost approximately \$58,000.00. Multiple staff members from Hickory Creek at Columbus as well as the Maintenance Men	nis ere tt,  f  d  of ion I by ot ts  (s)M.  er ee

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Event ID: J1HE11

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	OF CORRECTION	IDENTIFICATION NUMBER:  155424	A. BUILDING B. WING	00	COMPLETED  11/03/2011
	NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS		5480 E	ADDRESS, CITY, STATE, ZIP CODE 25TH ST MBUS, IN 47203	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				from at least eight other Hickor Creek nursing homes and approximately eight of Hickory Creek's home office staff all wat Hickory Creek at Columbus perform the tasks of unloading the semi-truck, unpacking the furniture items, putting the bed together, removing the old furniture and replacing it with a new. After the conclusion of the furniture move-in, just before a supper meal, Resident #A voic that she had some items miss. The Administrator followed-up with her and attempted to locate the items in her room without success. The Administrator whome of the individuals who ear in the day during the furniture conversion assisted with puttings into the new wardrobe at told the resident she did not resident indicated were missing. The Administrator apologized Resident #A and assured her the search for the missing item would continue, but if the item could not be located, they would continue, but if the item could not be located, they would the resident would the missing item would continue, but if the item could not be located, they would at thorough search of the dumpster and found the missing items. Per interview with the Maintenance Supervisor by Hickory Creek's Vice Presider Operations, Director of Clinical Services on Friday, November 4, 2011 he indicated that he opened and searched	rere s to g ds the ne the ced cing. o to that ns s s uld ober nn ng

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PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER:  155424	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED 11/03/2011
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS		5480 E	ADDRESS, CITY, STATE, ZIP CODE 25TH ST MBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				several garbage bags like the used day-in and day-out at the facility and inside one of those bags he found a small plastic that he described as "like a Wal-Mart bag that said Senio Shopping on it and then a gift type bag with items in it as we along with other trash type material. All these items below to Resident #A. The Administ was scheduled off the followinday – Friday, October 14, 20% but was contacted by the Dire of Nursing Services early in the A.M. and advised that Reside #A was still upset regarding the missing items even though the had been located. The Administrator came in to the facility to speak with Resident to apologize that the items we accidentally thrown away Apparently these items had be placed in a garbage bag, but not clear by whom. This incident was not reported to the ISDH because the facility followed the ISDH Reportable Unusual Occurrences Policy Page 4 of 5 under (13) which indicates – "Misappropriation resident property is defined a deliberate misplacement, exploitation, or wrongful, temporary or permanent use resident's belongings or mone without the resident's consen The report must be submitted within 24 hours after the preliminary investigation has determined that resident propersident	e e e bag  r e e e e e e e e e e e e e e e e e e

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	OF CORRECTION	IDENTIFICATION NUMBER: 155424	A. BUILDING B. WING	00	COMPLETED 11/03/2011
	ROVIDER OR SUPPLIER		5480 E	ADDRESS, CITY, STATE, ZIP CODE 25TH ST MBUS, IN 47203	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				or funds have been misappropriated. It is unfortunated that Resident #A's belongings co-mingled with trash type item and placed in the dumpster. However, just because the resident believes that the Administrator threw her items away there is no evidence to suggest that the Administrator "deliberately" misplaced Resid #A's belongings. In fact, the Administrator made an extraordinary effort in initially searching for the items upon discovery that they were missiand even came back to the fact on the morning of a day she wischeduled off to console Resid #A and apologize that she had accidentally disposed of the ite during the renovation of the resident's living quarters.  Based upon the above provided documentation a violation of the facility's abuse protocol included that of misappropriation of resident property as defined by federal / state regulation did no occur, and respectfully request that this section of the survey citation be deleted from the record.  What corrective action will be done by the facility?  All employees will be re-in-serviced on the facility Abuse Protocol to include but	got ins  dent dent dent dent dent dent dent den

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	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER:  155424	A. BUILDING	00	COMP	ESURVEY LETED 3/2011
	ROVIDER OR SUPPLIE	R	5480 E	ADDRESS, CITY, STATE, ZIP CO 25TH ST MBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
				be limited to the resider be free from verbal, sex physical and mental abu corporal punishment, ar involuntary seclusion ar misappropriation of resi property and that emplothis facility are not to all participate in any verbal sexual, or physical abus corporal punishment, or involuntary seclusion by December 3, 2011.  How will the facility iden residents having the porbe affected by the same and what corrective actitaken?  All residents have the perbe affected, but particul residents, with dementia confused, unable to free communicate, with behasymptoms and totally deresidents.  What measures will be place to ensure this pranot recur?  During re-in-services, the reminded that any al verbal, sexual, physical mental abuse, corporal punishment, and involus seclusion, including misappropriation of resi property must be report immediately in accordant the facility's abuse proteins.	eual, use, and and dent eyees of ow or I, mental, se, atify other tential to e practice ion will be  otential to arly those a, who are ely avioral ependent  put into ctice does  ne staff will legation of and  ntary dent's ed nce with	

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STREET ADDRESS, CITY, STATE, ZIP  5480 E 25TH ST  COLUMBUS, IN 47203  ID  PREFIX TAG  PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  not reporting is also c abuse / neglect.  During routine Guardi Rounds Department M	ORRECTION (X5) SHOULD BE E APPROPRIATE COMPLETION DATE
PREFIX TAG  PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  not reporting is also c abuse / neglect.  During routine Guardi	SRECTION SHOULD BE COMPLETION DATE
abuse / neglect.  During routine Guardi	considered
will inquire with their a residents regarding the atmosphere of the nure and whether the residencerns. Any identification will be transferred to the Resident/Family Concard the facility will foll investigative protocol grievance procedures.  How will the corrective monitored to ensure the practice does not recure QA will be put into plate. The Resident/Family forms will be brought monthly QA Committee and further recommer. This reporting will commonthly for the next 9 then at least one time thereafter. In addition Director of Operations the Resident/Family Commonthly for at least one time therework. In addition Director of Operations the Resident/Family Commonthly for at least one time therework.	Managers assigned ne overall ursing home dent has any ied concerns the cern Form low its and s.  e action be the deficient ur and what ace?  Concern to the ee for review ndations. ntinue do days and e per quarter to, the s will review Concern east 90 days om ents and
	will be transferred to Resident/Family Conand the facility will fol investigative protocol grievance procedures  How will the corrective monitored to ensure the practice does not receda will be put into plate. The Resident/Family forms will be brought monthly QA Committe and further recomme. This reporting will commonthly for the next state at least one time thereafter. In addition Director of Operations the Resident/Family stand will conduct rand interviews with Resident/Res

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Facility ID: 000284

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DDIG	00	COMPLETED
		155424	A. BUILDING		11/03/2011
		100.12.	B. WING		11/00/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
TOTAL OF T	KO VIDEK OK BOI I EIEK		5480 E	E 25TH ST	
HICKORY	CREEK AT COLU	IMBUS	COLU	MBUS, IN 47203	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225	The facility must n	ot employ individuals who	ĺ		
SS=E	have been found of				
33-L	•	treating residents by a			
		ve had a finding entered			
		•			
		se aide registry concerning			
		istreatment of residents or			
		of their property; and report			
		nas of actions by a court of			
	•	ployee, which would			
		for service as a nurse aide			
		iff to the State nurse aide			
	registry or licensin	g authorities.			
		nsure that all alleged			
		g mistreatment, neglect, or			
	•	njuries of unknown source			
		ion of resident property are			
		ely to the administrator of			
	the facility and to				
	accordance with S				
	established proced	dures (including to the			
	State survey and o	certification agency).			
		ave evidence that all			
	alleged violations				
	investigated, and i	must prevent further			
	potential abuse wh	nile the investigation is in			
	progress.				
		nvestigations must be			
	reported to the ad				
	•	entative and to other			
		ance with State law			
		tate survey and certification			
	agency) within 5 w	orking days of the incident,			
	and if the alleged	violation is verified			
	appropriate correct	tive action must be taken.			
Ì	Based on record	review, observation and	F0225	F225	12/03/2011
		cility failed to ensure			
		-		The facility disagrees with the	_
	_	use and misappropriation		survey findings regarding this	='   ■
	of resident prope	rty were immediately		alleged deficiency and	
		-			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIVILIDING	00	COMPLETED
		155424	A. BUILDING B. WING		11/03/2011
		<u> </u>	_	EET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		0 E 25TH ST	
HICKOR	Y CREEK AT COLU	IMBLIS		LUMBUS, IN 47203	
	1			100000000000000000000000000000000000000	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	,	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	_	roughly investigated, and		respectfully requests the face-to-face Informal Disput	
	-	residents from further		Resolution process.	_
	_	This affected 5 residents		<u></u>	
	from the sample	of 10 and supplemental		It is the standard and policy	of
	sample of 3 revi	ewed for abuse and		this facility to:	
	misappropriation	n of property (#A, D, E,		Net employed all the start	hava
	H, I) and had the	e potential to affect all of		Not employ individuals who been found guilty of abusing	
	the residents in t	he facility.		neglecting, or mistreating	,
		, and the second		residents, have had findings	
	Findings include	••		entered into the State nurse	aide
	i mamgs merade	·•		registry concerning the above	
	Confidential interview with Resident			including misappropriation o	
				resident property; and repor	-
	· ·	at 2:55 P.M., indicated,		knowledge it may have of ac by a court of law against an	alions
		for is snippy, rude and		employee regarding the abo	ve
	-	d her to Hickory Creek.		actions.	
	The Administrat	or is rude to everyone."			
				Assure all alleged violations	
	Confidential inte	erview with Employee #L,		involving mistreatment, negl	
	at 12:20 P.M. on	11/3/2011, indicated		or abuse, including injuries of unknown source and	
	they were preser	nt and heard Resident #E		misappropriation of resident	
	crying and askin	g, " is that woman going		property are reported immed	
	to start yelling a	t me next?"		to the administrator and to o	
				officials in accordance with	State
	During an interv	iew with Resident #A on		law through established procedures including to the	State
	_	0 P.M., resident stated,		survey and certification ager	
		noisy around here,		carroy and continuation age.	
		no is working, whether it		Assure all alleged violations	are
		The Administrator is loud		thoroughly investigated, and	
	sometimes."	ne / Idillillisuator is loud		prevent further potential abu	se
	Sometimes.			while the investigation is in progress.	
	011/1/2011	2.20 D.M. : 4		progresso.	
		2:30 P.M., interview		The results of all investigation	ons
		, the resident stated, "I		will be reported to the	
		the hall a couple of weeks		administrator or his designa	
	ago. Not sure wh	no it was, but I'm pretty		representatives and to other	

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	OF CORRECTION  OF CORRECTION  155424	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED 11/03/2011
	PROVIDER OR SUPPLIER  Y 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 PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5) DBE COMPLETION DATE
	sure it was staff."  On 11/3/2011 at 10:45 A.M., during confidential interview, Employee #K stated, "Two weeks ago, [Administrator's name] yelled at me over menus posted on the wall. I had the breakfast menu in the dinner spot and the dinner menu in the breakfast spot. I'm dyslexic, but I don't know if she knows that or not."  "Administrator yelled, 'Look at this. It's not right. Can't you get it right."' The employee indicated this happened two days in a row. The employee stated the Administrator "yelled at me in the hall across from Room #1, and [Resident #E's name] started crying and went back to her room questioning was she going to yell at her too." Employee #K stated, "I should have called my corporate manager, but I didn't."  During telephone interview on 11/3/2011 at 3:28 P.M. with the facility Regional Operations Manager regarding the abuse allegation against Administrator, she stated she was on her way to the facility, and intended to suspend Administrator until their investigation was completed. The Regional Operations Manager indicated she was just made aware of the allegation by the Administrator. She stated she was in the facility yesterday and had interviewed a resident who had	officials in accordance with law within 5 working days incident, and if the alleged violation is verified approp corrective action will be tal Resident #D contacted Hite Creek Healthcare Foundar corporate office on Friday, October 28, 2011. Her rep Hickory Creek was that the administrator was snippy a rude to the Nurses. Hickory Creek's Director of Operat who is the Administrator's interviewed Resident #D of November 2, 2011 and was of Resident D's concerns. time during the meeting with DO did Resident #D state Administrator was verbally mentally abusive to her or other residents; nor did shany examples that would refer the definition of verbal or residents. Resident #D's subconcern does not rise to the of "verbal abuse" oral or glanguage that willfully includisparaging and derogator to the residents or "mental including, but not limited to humiliation, harassment, the of punishment or deprivation defined in the federal/state regulations and guidance is surveyors and nothing conwithin this survey report substantiates this alleged.  Based upon the above producumentation that a violation.	of the riate cen.  skory cion's cort to control of the centrol of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155424	B. WIN			11/03/2011
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	L			25TH ST	
HICKOR'	Y CREEK AT COLU	JMBUS			1BUS, IN 47203	
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID	<u> </u>	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	called the compl	iance complaint line on			the facility's abuse protocol	
	_	11, and the resident			including that of misappropriat	<u>ion</u>
		nistrator was snippy.			of resident property as defined	
	stated the Admin	iistiatoi was silippy.			federal / state regulation did no	·
	Daine dhe e ite				occur and respectfully request	<u>s</u>
	_	conference on 11/3/2011			that this section of the survey citation be deleted from the	
	•	Administrator stated,			record.	
		ne] had not posted like I			<u>1000741</u>	
	had asked him, h	appened several times,			Surveyor interview of Resident	t #A
	spoke to him in l	nall, I was frustrated,			and the response does not sat	•
	didn't raise my v	oice, that's what I recall,			the definition or meet the inten	<b>I</b>
	at no time did I y	vell, don't know who was			requirement of "verbal abuse"	<b>I</b>
	around."	,			or gestured language that willf	ully
		5:05 P.M., the facility			included disparaging and derogatory terms to the reside.	nts
		ions Manager stated, "If			or "mental abuse" including, but	
		_			not limited to, humiliation,	"
		of the complaint, I think			harassment, threats of	
	this is a stretch."				punishment or deprivation as	
					defined in the federal/state	
	2. During the gr	oup interview with			regulations and guidance to	
	residents at 1:30	P.M. on 11/1/2011, the			surveyors and nothing contain	ed
	following residen	nts indicated they had			within this survey report	eith e
	items missing:				substantiates this alleged activ	nty.
		a wedding band missing.			Based upon the above provide	ed
		licated the wedding ring			documentation a violation of th	<b> </b>
		laced or found at this			facility's abuse protocol includi	
	1	iacca or round at tills			that of misappropriation of	
	time.				resident property as defined by	
					federal / state regulation did od	
	_	iew with the Social			and respectfully requests that section of the survey citation b	
		r on 11/1/2011 at 2:30			deleted from the record.	<u>-</u>
	1 -	any allegations of			asisted from the record.	
	misappropriation	of funds or property and			Surveyor interview of Resident	t #I
	the process of in	vestigation, the Social			and the response does satisfy	
	Services Directo	r replied, "any staff			definition or meet the intent	
		residents fill out			requirement of "verbal abuse"	
	_	ninistrator gets all			or gestured language that willf	uiiy
	231100111 unu 1 lui				included disparaging and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155424	A. BUII B. WIN			11/03/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER					
HICKOD	V CDEEK AT COLL	IMPLIE			25TH ST	
HICKOR	Y CREEK AT COLU	JIVIBUS		COLUIV	1BUS, IN 47203	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	grievances for in	vestigation and then I get			derogatory terms to the reside	
	them for follow-	up and have to give them			or "mental abuse" including, bu	ut
		trator to go in the			not limited to, humiliation,	
		ok." "I do not keep any			harassment, threats of	
	-	* *			punishment or deprivation as	
		ice, and these are not			defined in the federal/state	
	documented any				regulations and guidance to surveyors and nothing contain	ed
	grievance forms.	"			within this survey report	
					substantiates this alleged activ	uitv.
	Interview with R	esident #H on 11/2/2011				
	at 10:25 A M ir	ndicated about two			Based upon the above provide	ed
	•	ad a ring missing and he			documentation a violation of th	ne_
	_	-			facility's abuse protocol includi	i <u>ng</u>
		Social Services Director,			that of misappropriation of	
		no feedback. He			resident property as defined by	
	indicated he wou	lld like some resolve to			federal / state regulation did no	
	the issue.				occur and respectfully request	<u>s</u>
					that this section of the survey	
	Interview with th	ne Social Services			citation be deleted from the	
					<u>record.</u>	
		/2011 at 10:43 A.M.,			Sometime around mid-Octobe	r
	1 -	ent #H's missing ring,			2011 the Administrator had a	'
	indicated, "I don	't recall him saying			discussion with the Dietary	
	anything to me a	bout it recently or before,			Services Manager regarding th	ne l
	but I would have	filled out a grievance			resident menu board. This	
		to the Administrator." "I			discussion took place in front o	of
	_	it if it was in the last			the menu board which is in a	
					hallway across from room #1.	
	couple of weeks.				The Dietary Services Manager	•
		ces Director provided a			had on more than one occasio	
	blank "Resident	/ Family Concern Form"			positioned the daily menus on	the
	per request.				menu board incorrectly. The	hia
					Administrator had addressed to	•
	On 11/2/2011 at	10:50 A M the			on more than one occasion. C	ווע
		as observed to enter			the day in question when the Administrator asked the Dietar	v
					Services Manager why he cou	
		om and asked about his			not "hang this correctly" the	
	1	began searching his			Dietary Services Manager	
	room, and inforn	ned him they would be			questioned the Administrator's	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLET	ΓED
		155424				11/03/20	011
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
LUOKODY	V 00551/ AT 0011	IMPLIO			25TH ST		
HICKOR	Y CREEK AT COLU	JMB02		COLUN	IBUS, IN 47203		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	searching his roo	om for the ring.			direction. Although both		
	During interview	w with Resident #H on			employees admit there was so		
		dicated that a grievance			disagreement and frustration,	at	
		eted on 11/2/2011, and he			no time was the discussion		
	•	-			directed toward any resident.		
	1 1 1 1	facility is looking into			no time was the Administrator		
	this issue.				"screaming and yelling".		
					On page 11 of the survey		
	During a confide	ential interview with			document, the title Regional		
	_	n 11/2/2011 at 11:48			Operations Manager is inaccu	rate	
		yee stated, "If I get a			as the correct title is Director of		
		sident, family, or staff, I			Operations, (DO) and the DO	has	
		• • • • • • • • • • • • • • • • • • • •			been misquoted. During the		
		e nurse and then I fill out			telephone conversation with th	ne	
	a grievance form	n to be turned in to the			Surveyor – TC, on 11-3-11 at		
	Administrator."	"If it is a big problem, I			3:28 P.M. the DO asked why s	she	
	notify the DON	and the Administrator			(DO) was not informed of the		
	immediately " "I	fill out a grievance form			abuse allegation when she wa	s in	
	for any missing i				the facility on 11-2-11. The		
		items.			Surveyor's response was they were not aware of who the DC		
		1 . 10/27/11 : 1: . 1			was at that time. The DO state		
	_	lated 9/27/11, indicated			that had she been informed or		
		llet was in bedside table			11-2-11 the Administrator wou		
	drawer, room ha	s been searched, and			have been placed on suspens	ion.	
	wallet has not be	een found, staff			The DO did return to the facilit		
	interviewed no o	one was aware of the			participate in the Exit Conferer		
		." There were no staff			held on 11-3-11 at 5:04 P.M.	The	
		ified with dates or times			quote made by the "Regional		
					Operation Manager" is taken o		
	of their investiga				of context and does not reflect		
		4:30 P.M., any other			nature of the discussion that to		
	investigations of	concerns/missing items			place during the exit conference As the survey team would not		
	were requested to	o review from the			share any information regardir		
	Administrator.	Γhe Administrator			the nature of the abuse	' <del>9</del>	
	returned at 4:35	P.M. on 11/2/2011 and			allegations, the Administrator		
		ave any (investigations)."			shared the incident that occur	red	
	siaicu, Tuontin	ave any (mivesingations).			between she and the Dietary		
					Services Manager in October.		
	Confidential Inte	erview with Employee #J			The Administrator stated this v	vas	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		OO OO	COMP	E SURVEY LETED
		155424	B. WING			11/03	3/2011
	PROVIDER OR SUPPLIER		5	5480 E 2	DDRESS, CITY, STATE, ZIP CODE 5TH ST BUS, IN 47203	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
	on 11/1/2011 at a had talked with the regarding resident but she wouldn't residents called the Compliance line corporate called heads and that per to the Administration call to help the indicated she called heads and that per to the Administration call to help the indicated she called heads and the per devised to send at the ISDH. She state corporate office, would help the resident property Administration property Administration property and possible property and possible property and property	be a described by the Administrator and someone from and ator. I didn't know who are residents." She led the Ombudsman and Services, and was a complaint anonymously ted, "No, I did not call because I didn't think it asidents."  Fory Creek Healthcare Resident Mistreatment, and Misappropriation of a strative Policy & aided by the Administrator at 12:01 P.M., with Issue and last Revision Date: Residents will be free and neglect, abuse, a of resident funds and a setigation: All reported and ast ged violations involving a glect, abuse are to be			the only incident she could After listening to this discuss the Director of Operations of state to the survey team that this is the extent of the conditional little this is the extent of the conditional little this is a stretch."  Resident #G asked to atter group resident meeting, but not identified on the Resident as a resident to be interview. This resident's most recent a copy of which is provided demonstrates a score of 10 her BIMS assessment. As of 10 indicates cognitive impairment. The facility was unaware that Resident #G voiced a concern of missing because this was not report anyone at the time of the substitute of the survey document was received and reviewed by the survey document was received and reviewed by the Administrator that this conditional the facility's attention. After investigation determine the resident's identification and the resident #G who stated the wedding band and watch was located in her becabinet where it is always the Resident #G's daughter was contacted regarding the remissing wedding band and resident's daughter indicate her mother has never had it wedding band at the nursing home, that the wedding band at the nursing home, that the wedding band and the that the we	esion, did at "If aplaint, and the t was ent List wed. MDS, toore as thad g items tted to urvey when the tern at to entity, ed at her tere m was sedside tept. s s ported ed that aner g	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155424		A. BUILDING B. WING	00 	COMPLETED  11/03/2011	
	PROVIDER OR SUPPLIER		5480 E	ADDRESS, CITY, STATE, ZIP CODE E 25TH ST MBUS, IN 47203	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	allegation will ca Operations for th Corporate Comp immediately"	ne person reporting the all the Director of the facility and/or the liance Call Line relates to complaint		the daughter's home for safekeeping. This incident, up discovery by the facility upon receipt of the survey document was reported to the ISDH, although the facility does not believe the incident meets the Reportable Unusual Occurrent Policy in that the resident is confused, the watch was locat in the bedside cabinet where it always kept and per interview the residen'ts daughter, her mother's wedding band has not been at the facility. There was deliberate misplacement, exploitation, or wrongful, temporary or permanent use of the ring without the resident's consent. In fact, there was not incident; no items were and not had been missing.  Based upon the above provided documentation that a violation the facility's abuse protocol including that of misappropriate of resident property as defined federal / state regulation did not occur and respectfully request that this section of the survey citation be deleted from the record.  Resident #B reported two turquoise Hanes tee shirts missing on August 17, 2011. As a search of other residents' closets and the laundry the tee shirts were not found so the facility purchased two new tee shirts for the resident on August 15, 15, 15, 15, 15, 15, 15, 15, 15, 15,	ces ed t is of ever no of ever sion d by ot es

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	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER: 155424	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED  11/03/2011
	ROVIDER OR SUPPLIER		5480 E	ADDRESS, CITY, STATE, ZIP CODE 25TH ST MBUS, IN 47203	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION DATE DATE
				26, 2011. The Administrate been advised by the Direct Operations that all reports resident missing belonging require the implementation Hickory Creek's Resident Mistreatment, Neglect, Abu Misappropriation of Proper Administrative Policy and Procedure. In this particula instance, the Administrator followed the facility's policy procedure dealing with misitems, the resident was mawhole and the facility did noviolate State or Federal guidelines dealing with misitems.  The facility contends that the time management was maware of Resident #H's contact that ring was missing when the surveyor(s) indicated that Resident #H had broughtheir attention on 11-2-201 10:25 A.M. Upon being told resident concern, the Administrator approached Resident #H and his wife, was have a room on 11-2-201 approximately 10:50 A.M. Resident #H indicated his in was missing and it had been while. When queried if Resident was going through his jewe few weeks ago and the ring in a white jewelry bag. Resim a white jewelry bag. Resim a white jewelry bag. Resim a white indicated she thin	tor of of of use & ty ar

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	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	00	(X3) DATE SURVEY  COMPLETED
		155424	A. BUILDING B. WING		11/03/2011
	ROVIDER OR SUPPLIER		5480 E	FADDRESS, CITY, STATE, ZIP CODE E 25TH ST MBUS, IN 47203	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				Resident #H threw the white away before he took the ring Resident #H agreed with that version of the events. With permission, Resident #H's jet box and dresser drawers wer searched and the ring was not found. Resident #H indicates all of his other jewelry is accounted for. The jewelry be belonging to these residents very large and contains a tremendous amount of jewelre. The facility is working with the residents to inventory the jew box as a majority of these item are not listed on the facility. Inventory Sheet. The facility is found in a magerial program in processisting of frequent visits be department Managers to the assigned residents. No one recalls Resident #H indicating that he had a missing ring un was brought to the Administration by the surveyor(s). Incident, upon being brought by the surveyor(s) was reported to the ISDH, although the fact does not believe the incident meets the Reportable Unusual Occurrences Policy in that perinterview or Resident #H and wife, it does not appear that the was a deliberate misplaceme exploitation, or wrongful, temporary or permanent use the ring without the resident's consent. Both Resident H and Mrs. Resident H are capable historians. The nursing facility cannot be held responsible for	out.  welry e out that that  ox is y. e elry ms nas a lace y ir g til it ators This forth ed ility al r his here nt, of

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AND PLAN OF CORRECTION		A. BUILDING  B. WING		COMPLETED 11/03/2011
NAME OF PROVIDER OR SU		STREET ADDRESS, 5480 E 25TH S' COLUMBUS, IN		
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PERCEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH	PROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE -REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		Resided disposs and will to the inhandled facility.  Based document the facility of resident includity of resident federal occur, that the citation record.  Resided reported with rown \$32.00 Septements in Resident felt has seen it to the inhandled facility of the inhandled faci	ent H inadvertently sing of his own belongin hen the matter was broad facility's attention, it was ed in accordance with a policy and procedure.  I upon the above providual nentation that a violation cility's abuse protocoling that of misappropriadent property as defined and respectfully requestis section of the survey to be deleted from the	egs, ught s s  led of of of otton of ot

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Event ID: J1HE11

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN (	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
	155424	B. WING		11/03/2011
NAME OF D	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TVI IVIE OF F	AO FIDER OR BUITEILE	5480 E	25TH ST	
HICKORY	CREEK AT COLUMBUS	COLUN	MBUS, IN 47203	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	DDOMEDDIA DI LIVER CONSTRU	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
			decision to reimburse the \$32	2.00
			and this was given to Reside	nt
			#F's family on November 9,	
			2011. The facility agrees tha	t this
			incident meets the state / fed	eral
			regulations regarding possibl	e
			misappropriation of resident	
			property and the incident sho	
			have been reported to the ISI	DH
			per the Reportable Unusual	
			Occurrences Policy.	
			Resident #A through surveyo	r(s)
			interview on 11-2-11 at 2:00 i	
			alleges that the Administrator	
			disposed of her clothes and h	ner
			dogs (stuffed animals, bingo	
			prizes). On Thursday, Octobe	er
			13, 2011, Hickory Creek at	
			Columbus received a very lar	ge
			shipment including all new electric hi-low beds, wardrobe	20
			and bedside cabinets for eac	
			resident room, which cost	
			approximately \$58,000.00.	
			Multiple staff members from	
			Hickory Creek at Columbus a	ıs
			well as the Maintenance Men	,
			from at least eight other Hick	ory
			Creek nursing homes and	
			approximately eight of Hickor	у
			Creek's home office staff all v	
			at Hickory Creek at Columbu	
			perform the tasks of unloadin	=
			the semi-truck, unpacking the	l l
			furniture items, putting the be together, removing the old	rus
			furniture and replacing it with	the
			new. After the conclusion of t	l l
			furniture move-in, just before	
			supper meal, Resident #A vo	
			that she had some items mis-	

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	N OF CORRECTION	IDENTIFICATION NUMBER: 155424	A. BUILDING B. WING	00	COMPLETED 11/03/2011		
NAME OF	F PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP CODE			
ніскої	RY CREEK AT COLU	JMBUS	5480 E 25TH ST COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				The Administrator followed-up with her and attempted to local the items in her room without success. The Administrator was one of the individuals who earn in the day during the furniture conversion assisted with puttire things into the new wardrobe is told the resident she did not reseeing any of the items the resident indicated were missing. The Administrator apologized Resident #A and assured her is the search for the missing item would continue, but if the items could not be located, they wou be replaced. On Friday, Octobe 14, 2011the Maintenance Maria thorough search of the dumpster and found the missing items. Per interview with the Maintenance Supervisor by Hickory Creek's Vice President Operations, Director of Clinical Services on Friday, November 4, 2011 he indicated that he opened and searched several garbage bags like those used day-in and day-out at the facility and inside one of those bags he found a small plastic of that he described as "like a Wal-Mart bag that said Senior Shopping on it and then a gift type bag with items in it as we other trash type material. All these items belonged to Resident Hall the tems the tems belonged to Resident Hall the tems the tems belonged to Resident Hall the tems	te  as lier  ag but bout bout botall  g. to that as s uld er a did ag  tt of  d  se s bag  ll as lent		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DING	00	COMPLETED	
		155424	A. BUILDING		11/03/2011	
			B. WING	EFT ADDRESS OF A STATE OF GODE		
NAME OF P	ROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP CODE		
				0 E 25TH ST		
HICKORY	Y CREEK AT COL	UMBUS	COL	_UMBUS, IN 47203		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DATE	
	*			Nursing Services early in the and advised that Resident #A was still upset regarding the missing items even though the had been located. The Administrator came in to the facility to speak with Resident and again apologized that he items had been accidentally thrown away. Apparently the items had been placed in a garbage bag, but it is unclear whom. This incident was not reported to the ISDH because facility followed the ISDH Reportable Unusual Occurred Policy — Page 4 of 5 under (1 which indicates — "Misappropriation of resident property is defined as deliber misplacement, exploitation, of wrongful, temporary or permause of a resident's belonging money without the resident's consent. The report must be submitted within 24 hours aft the preliminary investigation of funds have been misappropriated. It is unfortunt that Resident #A's belonging co-mingled with trash type items.	A.M.  tey  t #A  r  se  by  the  nces 3)  ate  r  anent s or  er  has  perty  nate s got	
				and placed in the dumpster. However, just because the		
				resident believes that the		
				Administrator threw her items		
				away, there is no evidence to		
				suggest that the Administrate		
				"deliberately" misplaced Resi	aent	
				#A's belongings. In fact, the		
				Administrator made an		
				extraordinary effort in initially		

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	OF CORRECTION	IDENTIFICATION NUMBER:  155424	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 11/03/2011
	ROVIDER OR SUPPLIE		5480 E	ADDRESS, CITY, STATE, ZIP CODE  25TH ST  MBUS, IN 47203	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				searching for the items upon discovery that they were miss and even came back to the far on the morning of a day she was cheduled off to console Results. Ha and apologize that she has accidentally disposed of the induring the renovation of the resident's living quarters.  Based upon the above proving documentation that a violation the facility's abuse protocol including that of misappropriate of resident property as define federal / state regulation did recur and respectfully request that this section of the survey citation be deleted from the record.  What corrective action will be done by the facility?  All employees will be re-in-serviced on the facility Abuse Protocol to include but be limited to the resident's rig be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion and misappropriation of resident property and that employees this facility are not to engage allow verbal, mental, sexual, physical abuse, corporal punishment, or involuntary seclusion by December 3, 20 Employees will be reminded during these re-in-services the	acility was ident id tems  led n of not not tts -  not ht to  of in or or  111.

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 11/03/2011		
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
				this is the resident's home an that employees should be courteous and conscientious, business matters need to be discussed in private in an offin non-resident care area and the staff should refrain from speal loudly, or making excessive min resident care areas.  The Director of Operations will the Administrator's immediate supervisor will do one-on-one documented re-training regarklickory Creek's Abuse Protochlickory Creek's Resident Mistreatment, Neglect, Abuse Misappropriation of Property Administrative Policy and Procedure, the federal regula and interpretive guidelines at §483.13 et al, (F tags 223, 22 225 & 226), and the Indiana Spepartment of Health — Divisi of Long Term Care Policy and Procedure regarding Reporta Unusual Occurrences. In add the Director of Operations will review with the Administrator importance of not conducting nursing home business which might result in disagreement subordinates in a direct reside care area.  How will the facility identify of residents having the potential be affected by the same pracand what corrective action will taken?  All residents have the potential	that  ce or nat king noise  ho is e ding col, e tions  4, State ion d ble ition, I the n with ent  her to tice II be		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	OO OO	(X3) DATE SURVEY  COMPLETED		
		155424	A. BUILDING B. WING			3/2011
	ROVIDER OR SUPPLIE		STREET . 5480 E	ADDRESS, CITY, STATE, ZIP C 25TH ST MBUS, IN 47203	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
			be affected, but partice residents with dement confused, unable to frecommunicate, with be symptoms and totally residents.  What measures will be place to ensure this presidents.	ia, who are eely havioral dependent e put into		
				not recur?  During re-in-services, reminded that any alle verbal, sexual, physica mental abuse, corpora punishment, and invol seclusion, including misappropriation of reproperty must be repoimmediately in accordate facility's abuse pronot reporting is also coabuse / neglect.	gation of al and al untary sident's rted ance with otocols and	
				During routine Guardia Rounds Department M will inquire with their a residents regarding the atmosphere of the nur and whether the reside concerns. Any identifie will be transferred to the Resident/Family Concerns and the facility will followinvestigative protocol and grievance procedures.	Managers ssigned e overall sing home ent has any ed concerns ne ern Form ow its and	
				How will the corrective monitored to ensure the practice does not recure QA will be put into plant	ne deficient or and what	

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		IDENTIFICATION NUMBER:  155424	A. BUILDING  B. WING		COMPLETED 11/03/2011		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
HICKORY	CREEK AT COLU	IMBUS	5480 E 25TH ST COLUMBUS, IN 47203				
(X4) ID		FATEMENT OF DEFICIENCIES	ID		(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
				The Resident/Family Concern forms will be brought to the monthly QA Committee for revand further recommendations. This reporting will continue monthly for the next 90 days athen at least one time per qual thereafter. In addition, the Director of Operations will revithe Resident/Family Concern forms monthly for at least 90 dand will conduct random interviews with Residents and Employees to ascertain compliance. Thereafter, the Director of Operations will conduct at least a quarterly review. The Director of Operations will also review the documentation regarding Reportable Incidents for thoroughness and compliance with applicable facility policy a federal / state regulations for tinext 90 days, with quarterly reviews to follow thereafter.	nd rter ew lays		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED				
THIS TEAM	or conduction	155424	A. BUILD	ING		11/03/2	
		1.00.2	B. WING	STDEET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			25TH ST		
HICKOR	Y CREEK AT COLI				BUS, IN 47203		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·			REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=E	written policies ar mistreatment, neg residents and mis property.  Based on record interview, the fa	develop and implement and procedures that prohibit glect, and abuse of exappropriation of resident areview, observation and acility failed to follow ention policy and	F022	6	F226  The facility disagrees with the survey findings regarding this	-	12/03/2011
	procedure by fai	iling to ensure allegations			alleged deficiency and		
	-	sappropriation of resident			respectfully requests the		
		nmediately reported and			face-to-face Informal Dispute		
	thoroughly investigated, and failed to protect residents from further potential				Resolution process.		
					It is the standard of this facility	, to	
	•	ected 5 residents from the			have developed and implemen		
	sample of 10 and	d supplemental sample of			written policies and procedure	s	
	3 reviewed for a				that prohibit mistreatment,		
	misappropriation	n of property (#A, D, E,			neglect, and abuse of resident and misappropriation of reside		
		e potential to affect all of			property.		
	the residents in t	-				1/	
					Resident #D contacted Hickory Creek Healthcare Foundation?		
	Findings include	2:			corporate office on Friday,		
					October 28, 2011. Her report t	60	
		interview with Resident			Hickory Creek was that the		
		at 2:55 P.M., indicated,			administrator was snippy and rude to the Nurses. Hickory		
		tor is snippy, rude and			Creek's Director of Operations	,	
	mean. I reported	d her to Hickory Creek.			who is the Administrator's dire		
	The Administrat	tor is rude to everyone."			supervisor interviewed Reside		
					#D on November 2, 2011 and		
	Confidential inte	erview with Employee #L,			was basically told the same information by the resident. A	t no	
	at 12:20 P.M. or	11/3/2011, indicated			time during the meeting with the		
	they were presen	nt and heard Resident #E			DO did Resident #D state the		
	crying and askin	ng, " is that woman going			Administrator was verbally,		
	to start yelling a	t me next?"			non-verbally or mentally abusi to her or other residents; nor o		
					she give any examples that we		
	During an interv	view with Resident #A on			meet the definition of verbal or		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ED	
		155424	A. BUII B. WIN			11/03/20	11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	R			25TH ST		
HICKOD	Y CREEK AT COLU	IMPLIS			1BUS, IN 47203		
			1		1000, 111 47 200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		0 P.M., resident stated,			mental abuse. Thus the		
	"It can get very r	noisy around here,			Administrator's alleged interactions with her staff, per		
	depending on wh	no is working, whether it			interview does not meet the in	tent	
	is loud or not. T	he Administrator is loud			of "verbal abuse" oral or gestu		
	sometimes."				language that willfully included		
					disparaging and derogatory te		
	On 11/1/2011 at	2:30 P.M., interview			to the residents or "mental abu	ıse"	
		, the resident stated, "I			including, but not limited to,		
	· ·	· · · · · · · · · · · · · · · · · · ·			humiliation, harassment, threa		
		the hall a couple of weeks			of punishment or deprivation a defined in the federal/state	s	
	ago. Not sure who it was, but I'm pretty				regulations and guidance to		
	sure it was staff.	"			surveyors and nothing contain	ed	
					within this survey report		
	On 11/3/2011 at	10:45 A.M., during			substantiates this alleged		
	confidential inter	rview, Employee #K			activity. The Resident's		
		eks ago, [Administrator's			interpretation is completely		
		me over menus posted on			subjective and no examples of	f	
		he breakfast menu in the			the Administrator's alleged		
					rudeness to her staff were give	en.	
	•	the dinner menu in the			The facility believes that based	, l	
	•	'm dyslexic, but I don't			upon the above provided		
	know if she know				documentation that a violation	of	
	"Administrator y	velled, 'Look at this. It's			the facility's abuse protocol		
	not right. Can't	you get it right.'" The			including that of misappropriat	ion_	
	employee indica	ted this happened two			of resident property as defined		
		The employee stated the			federal / state regulation has n	<u>ot</u>	
		velled at me in the hall			occurred and respectfully	_	
	_	m #1, and [Resident #E's			requests that this section of the		
		· •			survey citation be deleted from the record.	<u>'</u>	
	· ·	ying and went back to her			uio iecoia.		
	,	g was she going to yell at			Surveyor interview of Resident	t #A	
		yee #K stated, "I should			and the response does not sat		
	have called my c	corporate manager, but I			the definition or meet the inten	-	
	didn't."				requirement of "verbal abuse"		
					or gestured language that willf	ully	
	During telephone	e interview on 11/3/2011			included disparaging and	,	
		h the facility Regional			derogatory terms to the reside		
		i die idenity Regional			or "mental abuse" including, bเ	JT	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155424	A. BUII B. WIN			11/03/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L.				
LUOKOD	V ODEEK AT OOL	IMPLIO			25TH ST	
HICKOR	HICKORY CREEK AT COLUMBUS			COLUM	1BUS, IN 47203	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL				COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Operations Mana	ager regarding the abuse			not limited to, humiliation,	
	allegation agains	t Administrator, she			harassment, threats of	
	"	n her way to the facility,			punishment or deprivation as	
		suspend Administrator			defined in the federal/state	
		•			regulations and guidance to surveyors and nothing contain	ad
		igation was completed.			within this survey report	
	_	perations Manager			substantiates this alleged activ	uitv
		s just made aware of the				
	allegation by the	Administrator. She			Based upon the above provide	e <u>d</u>
	stated she was in the facility yesterday and had interviewed a resident who had				documentation a violation of th	
					facility's abuse protocol includi	ing_
	called the compliance complaint line on				that of misappropriation of	
	Friday, 10/27/2011, and the resident				resident property as defined by	
	_				federal / state regulation did no	•
	stated the Admir	nistrator was snippy.			occur and respectfully request	<u>s</u>
					that this section of the survey	
	During the exit c	conference on 11/3/2011			citation be deleted from the	
	at 5:04 P.M., the	Administrator stated,			record.	
	"[Employee nan	ne] had not posted like I			Surveyor interview of Resident	<sub>t #1</sub>
		appened several times,			and the response does not sat	
		nall, I was frustrated,			the definition or meet the inten	-
	_				requirement of "verbal abuse"	oral
	· ·	oice, that's what I recall,			or gestured language that willf	iully
		vell, don't know who was			included disparaging and	
	around."				derogatory terms to the reside	
	On 11/3/2011 at	5:05 P.M., the facility			or "mental abuse" including, bu	ut
	Regional Operat	ions Manager stated, "If			not limited to, humiliation,	
		of the complaint, I think			harassment, threats of	
	this is a stretch."				punishment or deprivation as defined in the federal/state	
	ting is a stretch.				regulations and guidance to	
	2 D	in4i tat			surveyors and nothing contain	ed
		oup interview with			within this survey report	
		P.M. on 11/1/2011, the			substantiates this alleged activ	vity.
	following resider	nts indicated they had				
	items missing:				Based upon the above provide	<u>ed</u>
	Resident #H had	a wedding band missing.			documentation that a violation	<u>of</u>
		cated the wedding ring			the facility's abuse protocol	
		laced or found at this			including that of misappropriat	
	nau not been rep	iactu oi iounu at tilis			of resident property as defined	l by

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155424	B. WIN			11/03/2011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				25TH ST	
HICKODY	V CDEEK AT COLL	IMPLIE				
HICKOK	Y CREEK AT COLU	JIVIBUS		COLUM	1BUS, IN 47203	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	time.				federal / state regulation did no	<u>ot</u>
					occurred and respectfully	
	During on interes	ion with the Social			requests that this section of the	<u>e</u>
	-	iew with the Social			survey citation be deleted from	<u>1</u>
		r on 11/1/2011 at 2:30			the record.	
	P.M., regarding a	any allegations of				
	misappropriation	of funds or property and			Sometime around mid-Octobe	
	the process of in	vestigation, the Social			2011 when the Administrator h	nad
		r replied, "any staff			a discussion with the Dietary	
		•			Services Manager regarding th	ne
	_	residents fill out			resident menu board. This	
		ninistrator gets all			discussion took place in front of	OT
	grievances for in	vestigation and then I get			the menu board which is in a	
	them for follow-	up and have to give them			hallway across from room #1. The Dietary Services Manager	
		trator to go in the			had on more than one occasio	
		•			positioned the daily menus on	
		ok." "I do not keep any			menu board incorrectly. The	lile
	copies in my offi	ice, and these are not			Administrator had addressed t	his
	documented any	where other than			on more than one occasion.	
	grievance forms.	"			the day in question when the	~~
					Administrator asked the Dietar	v
	Intomicor with D	esident #H on 11/2/2011			Services Manager why he cou	-
					not "hang this correctly" the	
	•	ndicated about two			Dietary Services Manager	
	months ago he ha	ad a ring missing and he			questioned the Administrator's	
	reported it to the	Social Services Director,			direction. Although both	
	-	no feedback. He			employees admit there was so	me
		ald like some resolve to			disagreement and frustration, a	
		ing like sollie resolve to			no time was the discussion	
	the issue.				directed toward any resident.	At
					no time was the Administrator	
	Interview with the	ne Social Services			"screaming and yelling".	
	Director on 11/2	/2011 at 10:43 A.M.,				
		ent #H's missing ring,			On page 11 of the survey	
		't recall him saying			document, the title Regional	
	· ·	, ,			Operations Manager is inaccul	
		bout it recently or before,			as the correct title is Director of	
	but I would have	filled out a grievance			Operations, (DO) and the DO	lias
	form and give it	to the Administrator." "I			been misquoted. During the telephone conversation with th	
	_	it if it was in the last			Surveyor – TC, on 11-3-/11 at	
					Surveyor – TC, On TT-3-/TT at	

			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155424	B. WING		11/03/2011	
HICKOR'	PROVIDER OR SUPPLIER	JMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	couple of weeks The Social Servi blank "Resident per request.  On 11/2/2011 at Administrator w Resident #H's ro missing ring, she room, and inform searching his roo During interview 11/3/2011, he in form was comple is happy that the this issue.  During a confide Employee #L, or A.M., the emplo concern from res notify the charge a grievance form Administrator." notify the DON	ces Director provided a / Family Concern Form"  10:50 A.M., the as observed to enter om and asked about his be began searching his ned him they would be om for the ring. with Resident #H on dicated that a grievance eted on 11/2/2011, and he facility is looking into  ential interview with n 11/2/2011 at 11:48 yee stated, "If I get a sident, family, or staff, I e nurse and then I fill out n to be turned in to the "If it is a big problem, I and the Administrator fill out a grievance form		3:28 P.M. the DO asked the Surveyor why she (DO) was not informed of the abuse allegation when she was in the facility on 11-2-11. The Surveyors' response was they were not aware of who the DO was at the time. The DO stated that had been informed on 11-2-11 the Administrator would have been placed on suspension. The Dodid return to the facility to participate in the Exit Conference held on 11-3-11 at 5:04 P.M. quote made by the "Regional Operations Manager" is taken of context and does not reflect nature of the discussion that to place during the exit conference As the survey team would not share any information regarding the nature of the abuse allegation, the Administrator shared the incident that had occurred between she and Dietary Services Manager in October. The Administrator stated this was the only incides she could recall. After listening this discussion, the Director of Operations did state to the surteam that "if this is the extent of the complaint, I think this is a stretch.	ot on	
	family states was drawer, room ha wallet has not be interviewed no o	lated 9/27/11, indicated llet was in bedside table s been searched, and een found, staff one was aware of the " There were no staff		Resident #G asked to attend to group resident meeting, but we not identified on the Resident to as a resident to be interviewed. This resident's most recent MI a copy is provided, demonstra a score of 10 on her BIMS	as List f. DS,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED	
		155424	B. WIN			11/03/2011	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	25TH ST		
HICKUB.	Y CREEK AT COLI	IMRUS			1BUS, IN 47203		
					1200, 114 17200		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETIO	ON
TAG		R LSC IDENTIFYING INFORMATION)		TAG		DATE	
		ified with dates or times			assessment. A score of 10 indicates cognitive impairment		
	of their investiga				The facility was unaware that		
	On 11/2/2011 at	4:30 P.M., any other			Resident #G had voiced a		
	investigations of	f concerns/missing items			concern of missing items beca	use	
	were requested t	to review from the			this was not reported to anyon		
	•	The Administrator			the time of the survey by the		
		P.M. on 11/2/2011 and			surveyor(s). It was when the		
		ave any (investigations)."			survey document was received	d	
	stated, 1 don't n	ave any (mvestigations).			and reviewed by the  Administrator that this concern		
	Confidential Interview with Employee #J on 11/1/2011 at 5:30 P.M., indicated she				was brought to the facility's	'	
					attention. After investigation to	,	
					determine the resident's identi		
	had talked with	the Administrator			the Administrator interviewed	,	
	regarding reside	nts with money missing,			Resident #G who stated that h	er	
	but she wouldn't	listen. "One of the			wedding band and watch were		
	residents called	the Corporate			missing. The resident's room v	vas	
		and someone from			searched and the resident's		
	-	one of the department			watch was located in her beds		
	•	erson immediately went			cabinet where it is always kep Resident #G's daughter was		
	_	rator. I didn't know who			contacted regarding the report	red	
					missing wedding band and		
	•	e residents." She			resident's daughter indicated t	hat	
		lled the Ombudsman and			her mother has never had her		
	Adult Protective	e Services, and was			wedding band at the nursing		
	advised to send	a complaint anonymously			home, that the wedding band i	s at	
	to ISDH. She sta	ated, "No, I did not call			the daughter's home for		
	corporate office.	, because I didn't think it			safekeeping. This incident, updiscovery by the facility upon	on	
	would help the r				receipt of the survey documen	<i>t</i>	
					was reported to the ISJH,		
	Review of "Hick	kory Creek Healthcare			although the facility does not		
		. Resident Mistreatment,			believe the incident meets the		
					Reportable Unusual Occurren	ces	
		& Misappropriation of			Policy in that the resident is	,	
	Property Administrative Policy &				confused, the watch was locat		
	-	rided by the Administrator			in the bedside cabinet where in always kept and per interview		
	on 10/31/2011 a	t 12:01 P.M., with Issue			the residents daughter, her	o,	
	Date 12/1999, an	nd last Revision Date:			mother's wedding band has ne	ever	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155424	ı			11/03/2011
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE	
		MARLIO			25TH ST	
HICKOR	Y CREEK AT COLU	IMBUS		COLUN	IBUS, IN 47203	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	9/10, indicated "	Residents will be free			been at the facility. There was	no
	from mistreatme	nt, neglect, abuse,			deliberate misplacement,	
		of resident funds and			exploitation, or wrongful,	
		estigation: All reported			temporary or permanent use o	f
					the ring without the resident's	
	`	ged violations involving			consent. In fact, there is no	N/0"
	mistreatment, ne	glect, abuseare to be			incident; no items were and ne have been missing.	ever
	reported to the A	dministrator			nave been missing.	
	immediately, inv	restigated and reported			Based upon the above provide	ed
	per state and federal lawIf the report of				documentation that a violation	
	alleged abuse involves the facility				the facility's abuse protocol	
					including that of misappropriat	ion_
	Administrator, the person reporting the				of resident property as defined	<u>l by</u>
		all the Director of			federal / state regulation did no	<u>ot</u>
	Operations for the	ne facility and/or the			occur and respectfully request	<u>s</u>
	Corporate Comp	liance Call Line			that this section of the survey	
	immediately"				citation be deleted from the	
					<u>record.</u>	
	This federal tag	relates to complaint			Resident #B reported two	
	IN00099165.	r			turquoise Hanes tee shirts	
	11100077105.				missing on August 17, 2011. A	lfter
	2 1 29(a)				a search of other residents'	
	3.1-28(a)				closets and the laundry the tee	,
	3.1-28(c)				shirts were not found so the	
	3.1-28(d)				facility purchased two new tee	i i
	3.1-28(e)				shirts for the resident on Augu	
					26, 2011. The Administrator ha	i i
					been advised by the Director of	)T
					Operations that all reports of	
					resident missing belongings require the implementation of	
					Hickory Creek's Resident	
					Mistreatment, Neglect, Abuse	&
					Misappropriation of Property	
					Administrative Policy and	
					Procedure. In this particular	
					instance, the Administrator	
					followed the facility's policy an	d
					procedure dealing with missing	9
					items, the resident was made	

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	T OF DEFICIENCIES  DF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED 11/03/2011		
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE  5480 E 25TH ST  COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				whole and the facility did not violate State or Federal guidelines dealing with missil items.	ng		
				The facility contends that the time management was made aware of Resident #H's conce that his ring was missing was when the surveyor(s) indicate that Resident #H had brough their attention on 11-2-2011 a 10:25 A.M. Upon being told oresident concern, the Administrator approached Resident #H and his wife, who share a room, on 11-2-2011 approximately 10:50 A.M. Resident #H indicated his ring was missing and it had been while. When queried if Resident #H had told anyone the responsas "I don't recall". Resident #I was going through his jewelry few weeks ago and the ring win a white jewelry bag. Resident #H threw the white away before he took the ring Resident #H agreed with this version of events. With permission, Resident #H's je box and dresser drawers were searched and the ring was not found. Resident #H indicates all of his other jewelry is accounted for. The jewelry be belonging to these residents very large and contains a tremendous amount of jewelr The facility is working with the search was more than the resident with the search was a tremendous amount of jewelr The facility is working with the search was more than the resident was the search was a tremendous amount of jewelr The facility is working with the search was more than the search was a tremendous amount of jewelr The facility is working with the search was a s	ern  and at it to at at of the  o at g for a ent onse #H's #H v a vas ent s bag out.  welry re ot that		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155424		A. BUILDING B. WING	00	COMPLETED 11/03/2011			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  5480 E 25TH ST				
HICKORY	Y CREEK AT COLU	IMBUS		/BUS, IN 47203			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				residents to inventory the jewe box as a majority of these item are not listed on the facility Inventory Sheet. The facility he Guardian Angel program in placonsisting of frequent visits by Department Managers to their assigned residents. No one recalls Resident #H indicating that he had a missing ring untiwas brought to the Administratention by the surveyor(s). Tincident, upon being brought for the ISDH, although the facility does not believe the incident meets the Reportable Unusual Occurrences Policy in that per interview or Resident #H and wife, it does not appear that the was a deliberate misplacement exploitation, or wrongful, temporary or permanent use of the ring without the resident's consent. Both Resident H and Mrs. Resident H are capable historians. The nursing facility cannot be held responsible for Resident H inadvertently disposing of his own belonging and when the matter was brout to the facility's attention, it was handled in accordance with facility policy and procedure.  Based upon the above provided documentation that a violation the facility's abuse protocol including that of misappropriated of resident property as defined federal / state regulation did no occur and respectfully requestions.	as a acce  if it tors ihis corth ced bity  I  this pere cot,  of  d  of  of  of  of  of  of  of  of		

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	OF CORRECTION	IDENTIFICATION NUMBER:  155424	(X2) MULTIPLE CO	00 	COMPLETED  11/03/2011	
	PROVIDER OR SUPPLIE Y CREEK AT COL	R	B. WING TI703/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  5480 E 25TH ST  COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION	
				that this section of the surve citation be deleted from the record.	<u>v</u>	
				Resident #F's family member reported a missing black wawith roses on it which contain \$32.00 to the Administrator of September 27, 2011. The famember indicated that walled in Resident #F's drawer on the left hand side, but he had not seen it for two months. Account to the Administrator, no report a missing sweater was made this time. Resident #F has a diagnosis of dementia and when the wallet is time. Resident #F has a diagnosis of dementia and when the wallet is time. The Administrator contacted Resident #F's family member on Nove 23 and family member on Nove 23 and family member indicated the sweater was missing a lettime ago. Due to the time frainvolved and Resident #F'dementia diagnosis, the wall money or sweater have not allocated. The facility made the decision to reimburse the \$3 and this was given to Resident #F's family on November 9, 2011. The facility agrees the incident meets the state / fed regulations regarding possib misappropriation of resident property and the incident she have been reported to the IS per the Reportable Unusual Occurrences Policy.	llet ned on mily t was he it rding ort of e at eas eation ident ember ated ong mes let, been ne 12.00 ent at this deral le ould SDH	
				Resident #A through surveyor interview on 11/2/11 at 2:00		

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	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER: 155424	A. BUILDING B. WING	00	COMP	E SURVEY PLETED 3/2011
	ROVIDER OR SUPPLIE		5480 E	ADDRESS, CITY, STATE, ZIP CC E 25TH ST MBUS, IN 47203	)DE	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE PPROPRIATE	(X5) COMPLETION DATE
				alleges that the Administ disposed of her clothes dogs (stuffed animals, but prizes) On Thursday, 13, 2011, Hickory Creek Columbus received a veshipment including all numbers of the clear of the clear of the compensation of	and her bingo October k at ery large ew rdrobes or each ost OO. from hbus as e Men r Hickory and Hickory aff all were umbus to loading ang the the beds old it with the perfore the #A voiced is missing. Wed-up to locate without rator was rho earlier ratiture h putting drobe but the missing. Or each to earlier ratiture the putting drobe but the missing.	

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	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00 	COMPLETED		
		155424	B. WING		11/03/2011		
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  5480 E 25TH ST  COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				would continue, but if the item could not be located, they would be replaced. On Friday, Octobe 14, 2011 the Maintenance Madid a thorough search of the dumpster and found the missivitems. Per interview with the Maintenance Supervisor by Hickory Creek's Vice Presider Operations, Director of Operations and Director of Clinical Services on Friday, November 4, 2011 he indicated that he opened and searched several garbage bags like those used day-in and day-out at the facility and inside one of those bags he found a small plastice that he described as "like a Wal-Mart bag that said Senior Shopping on it and then a gift type bag with items in it along with other trash type material. These items belonged to Resident 4A. The Administrator was scheduled off the following day Friday, October 14, 2011, but contacted by the Director of Nursing Services early in the Administrator came in to the facility to speak with Resident 4A was still upset regarding the missing items even though the had been found. The Administrator came in to the facility to speak with Resident and again apologized that her items were accidentally thrown away. Apparently these items had been placed in a garbage bag, but it is unclear by whom This incident was not reported the ISDH because the facility	ald per n ng nt of  ad se e e e bag .  All dent y – was A.M.		

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	OF CORRECTION	IDENTIFICATION NUMBER:  155424	A. BUII B. WIN	LDING	00	COMPLETED 11/03/2011		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  5480 E 25TH ST					
HICKORY	CREEK AT COLU	MBUS			251H 51 1BUS, IN 47203			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
					followed the ISDH Reportable Unusual Occurrences Policy — Page 4 of 5 under (13) which indicates — "Misappropriation of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or mone without the resident's consent. The report must be submitted within 24 hours after the preliminary investigation has determined that resident prope or funds have been misappropriated. It is unfortund that Resident #A's belongings co-mingled with trash type item and placed in the dumpster. However, just because the resident believes that the Administrator threw her items away there is no evidence to suggest that the Administrator "deliberately" misplaced Resid #A's belongings. In fact, the Administrator made an extraordinary effort in initially searching for the items upon discovery that they were missi and even came back to the fac on the morning. of a day she w scheduled off to console Resid #A and apologize that she had accidentally disposed of the ite during the renovation of the resident's living quarters.  Based upon the above provide documentation that a violation the facility's abuse protocol including that of misappropriat	of a  y  erty  ate got ns  dent  dent  dent  dent  dent  dent  dent  dent  dent		

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	T OF DEFICIENCIES  DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 11/03/2011		
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
				of resident property as define federal / state regulation did noccur and respectfully request that this section of the survey citation be deleted from the record.  What corrective action will be done by the facility?  All employees will be re-in-serviced on the facility Abuse Protocol to include but be limited to the resident's rig be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion and misappropriation of resident property and that employees this facility are not to allow or participate in any verbal, men sexual, or physical abuse, corporal punishment, or involuntary seclusion by December 3, 2011.  Employees will be reminded during these re-in-services the this is the resident's home and that employees should be courteous and conscientious, business matters need to be discussed in private in an offinon-resident care area and the staff should refrain from speal loudly, or making excessive min resident care areas.  The Director of Operations with the Administrator's immediate supervisor will do one-on-one	of stal,  at d that ce or nat king noise tho is		

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	OF CORRECTION	IDENTIFICATION NUMBER:  155424	A. BUILDING  B. WING	00	COMPLETED 11/03/2011		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
HICKORY	Y CREEK AT COLU	IMBUS	5480 E 25TH ST COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
				documented re-training regard Hickory Creek's Abuse Protocol Hickory Creek's Resident Mistreatment, Neglect, Abuse Misappropriation of Property Administrative Policy and Procedure, the federal regulati and interpretive guidelines at §483.13 et al, (F tags 223, 224 225 & 226), and the Indiana St Department of Health – Division of Long Term Care Policy and Procedure regarding Reportab Unusual Occurrences. In addit the Director of Operations will review with the Administrator regarding the importance of not conducting nursing home business which might result in disagreement with subordinate in a direct resident care area.  How will the facility identify othersidents having the potential to be affected by the same practice and what corrective action will taken?  All residents have the potential be affected, but particularly the residents with dementia, who a confused, unable to freely communicate, have behavioral symptoms and totally dependence residents.  What measures will be put intoplace to ensure this practice denot recur?  During re-in-services, staff will reminded that any allegation of the process of the same practice denot recur?	ling ol, & dons dons dons dons dons dons dons dons		

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	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	COMPLETED
		155424	B. WING		<del>-</del> 11/03/2011
	ROVIDER OR SUPPLIE		5480 E	ADDRESS, CITY, STATE, ZIP C 25TH ST MBUS, IN 47203	CODE
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
				verbal, sexual, physical mental abuse, corporal punishment, and involus seclusion, including misappropriation of resproperty must be reported the facility's abuse pronot reporting is also consuse / neglect.  During routine Guardia Rounds Department Mill inquire with their as residents regarding the atmosphere of the nursuand whether the resident concerns. Any identifies will be transferred to the Resident/Family Concerns and the facility will follow investigative protocol and the facility will follow investigation and the facility in accordance protocol and the facility in accordance	al and al untary  sident's red ance with a tocols and onsidered  an Angel anagers ssigned a overall sing home ent has any ed concerns he ern Form ow its and  action be he deficient r and what ce?  Concern o the e for review dations. The ern and t

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	(X2) MULTIPLE CO  A. BUILDING  B. WING	00		SURVEY LETED 5/2011	
	PROVIDER OR SUPPLIE Y CREEK AT COL		STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	TION ILD BE ROPRIATE	(X5) COMPLETION DATE	
				Employees to ascertain compliance. Thereafter, to Director of Operations with conduct at least a quarter review. The Director of Operations will also review documentation regarding Reportable Incidents for thoroughness and complimite the applicable facility postederal / state regulations next 90 days, with quarter reviews to follow thereafted.	II rly w the iance licy and s for the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLE			ETED	
		155424	B. WIN			11/03/	2011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				25TH ST		
HICKODY	V CDEEK AT COLL	IMPLIS			1BUS, IN 47203		
HICKOK	Y CREEK AT COLU	JIVIBUS		COLUIV	1BO3, IN 47203		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)		DATE	
F0279	A facility must use	the results of the					
SS=D		velop, review and revise					
	the resident's com	prehensive plan of care.					
		evelop a comprehensive					
	•	resident that includes					
	-	tives and timetables to					
	meet a resident's medical, nursing, and mental and psychosocial needs that are						
	identified in the comprehensive assessment.  The care plan must describe the services						
that are to be furnished to attain or maintain							
	the resident's highest practicable physical, mental, and psychosocial well-being as						
		83.25; and any services					
		se be required under					
	-	ot provided due to the					
		e of rights under §483.10,					
	§483.10(b)(4).	to refuse treatment under					
l		review and interview, the	E03	70	F279 Comprehensive Care Pla	ans I	11/07/2011
		·	F0279			21.10	11/0//2011
	_	develop a care plan for a			It is the standard of this facility	to	
	resident receiving	g an antiplatelet			develop a care plan that include		
	medication.				measurable objectives to meet		
	This deficient pra	actice affected 1 of 10			the resident's medical, nursing		
	_	ed for care plans in a			mental and psychosocial need	S,	
	sample of 10. (R	-			including medications that are		
	sample of for (1)	tesiaent ii 20)			ordered by the physician.		
	Findings in dealeds	_			What corrective action will be		
	Findings include	•			done by the facility?		
					done by the identy!		
	Resident # 20's c	linical record was			- Resident #20 Plavix was care		
	reviewed on 11-1	1-11 at 9:35 a.m. His			planned on 11/1/11.		
	diagnoses includ	ed, but were not limited					
	_	r extremity paraplegia			How will the facility identify oth		
	-	ry of gastrointestinal			residents having the potential		
	u 5 //				be affected by the same practi		
	(stomach) bleedi	ng and ancilla.			and what corrective action will	<u>be</u>	
					taken?		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NING	00	COMPL	ETED
		155424	B. WING	AING		11/03/	2011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			25TH ST		
HICKOR	Y CREEK AT COL	JMBUS			BUS, IN 47203		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Review of Resider recapitulation of dated October 2 receive Plavix 7 mouth once dail care plans indicated plan related to the medication, the monitoring of the In interview with 11:47 a.m., she is	dent # 20's most recent rders (physician orders), 011, indicated he was to 5 mg (milligrams) by y. Review of his current ated a lack of any care ne use of this antiplatelet potential side affects or		TAG	An audit was completed on 11/7/11 on all residents who receive an antiplatelet medicine to ensure he or she had a curricare plan in place. All resident have a current care plan to address antiplatelet medicine use.  However, if the DON or design finds that a resident receiving antiplatelet medication does not have a care plan in place, she bring that issue to the next scheduled interdisciplinary morning management meeting for review and development of appropriate care plan with interventions recommended by the IDT team. Once that care plan has been developed and in place, the DON will review to facility policy regarding the development of pertinent care plans for residents on antiplate medication with the staff involving the medication with the staff involving the medication of Nursing or designee. The results of this review dat least 5 times a we by the Director of Nursing or designee. The results of this review will be shared with the Interdisplinary Team during the morning interdisciplinary	ee eent t's nee ot will san y is he elet ved.	
					management meeting that also occurs at least 5 times a week Any identified issues will be		

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AND PLAN OF COR	RECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	COMI	E SURVEY PLETED
		155424	B. WING		11/0	3/2011
NAME OF PROVIDE			5480 E	ADDRESS, CITY, STATE, ZIP ( 25TH ST MBUS, IN 47203	CODE	
l '	EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
				addressed as indicate question #2. The MDS write a care plan for o medication, including interventions that are the interdisciplinary ted discussion at the morn meeting. The care plated on that resider that time. The interditeam will continue to replans during the week meeting and as physic changes are received.  How will the corrective monitored to ensure the practice does not recure QA will be put into plated. The Director of Nursing designee will monitor orders for residents and days a week New meorders, including those antiplatelet drugs, will discussed with the interdisciplinary team above. The DON will results of her reviews monthly QA Committee and further recommer This reporting will connext 60 days and the Committee members to stop the requirement reporting results to the Committee members to stop the requirement reported. However, even the QA Committee no wants to review this is DON/designee's review to medicate the province of the pr	sc will then ordered any a result of earn ning in will be nt's chart at isciplinary monitor care dy care plan cian order.  be action be he deficient ar and what ice?  as indicated bring the to the ee for review notations. It is the control of the	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  00	COM	e survey pleted 3/2011	
NAME OF P	PROVIDER OR SUPPLIEF	·	STREET	ADDRESS, CITY, STATE, ZII	P CODE		
HICKOR	Y CREEK AT COLU	JMBUS	5480 E 25TH ST COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE )	(X5) COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	orders for residents a processes outline processes outline processes outline processes outline on an ongo	and the eviously will	DATE	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155424	(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  (X3) DATE SURVEY COMPLETED 11/03/2011				
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 PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F0441 SS=F	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with					
	a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.  (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.					
	Based on observation, record review and interview, the facility failed to ensure appropriate handwashing was conducted by facility staff during the environmental	F0441	F441 Infection Control It is the standard of this facility that an infection control program is in place to provide for safe, sanit and comfortable environment	ary		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NU		IDENTIFICATION NUMBER:	A DINI DINIC 00		COMPLETED		
155424		155424	A. BUILDING		11/03/2011		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R		E 25TH ST			
HICKUB.	Y CREEK AT COLI	IMRUS		MBUS, IN 47203			
			COLONIBOS, IN 47203				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE		
		during a dressing change.		prevent the development and transmission of disease and			
	_	ractice affected 1 of 1		infection, including appropriat	e		
	resident observe	d during a dressing		handwashing during			
	change (#20) an	d had the potential to		administration of			
	affect all 35 resi	dents of the facility.		treatments. What corrective			
		•		action will be done by the faci			
	Findings include	à·		The facility would like on reco			
	i mamgo meraak			that the Administrator did not			
	The environmen	tal observation was		her ungloved hand over the to seat" on 11/1/11. When aske			
				the surveyor what an area wa			
		-1-11 between 1:40 p.m.		the toilet seat the Administrate			
	and 2:10 p.m. with the Administrator and			touched the area with her poil	nter		
	the Maintenance	e Supervisor.		finger on left hand. The			
				administrator was inserviced			
	1. During the ol	oservation of Bathroom		11/16/11 regarding the facility	'		
	#4 on 11-1-11 at	t 1:48 p.m., the		hand washing policy and procedure. The administrator			
	Administrator w	as observed to run her		completed a handwashing ski			
	ungloved hand o	over the toilet seat while		checklist 11/16/11. LPN #1 v			
	-	n area on the seat was a		inserviced on 11/16/11 regard	ling		
	_	s not observed to wash		the facility hand washing police	cy		
		eaving Bathroom #4 and		and procedure. LPN #1			
		•		completed a handwashing ski			
	-	Rooms 1, 3, 5, 7,		the facility identify other resident			
		d Bathroom #1. While in		having the potential to be affe			
		the Administrator was		by the same practice and wha			
		ectivate the call lights at		corrective action will be			
	the bedsides of t	the residents in those		taken? No residents have bee			
	rooms with ungl	oved hands. Upon		affected by this practice. In the			
	entering Bathroo	om #1 at 2:04 p.m., the		future if any staff, including th Administrator and LPN #1, is	e		
	_	vas observed to remove a		noticed to not wash their hand	ds at		
		of unknown waste from		appropriate times, they will be			
		at the use of gloves. She		provided with re-education			
		return to Bathroom #1		concerning the facility's policy			
				procedure for handwashing a			
	_	g her hands after removing		that time. The staff involved in			
		iste material. She was		inappropriate practice will also	o be		
	then observed to	enter Room 9 without		asked to perform a return			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155424		A. BUILDING 00 COMPLETED 11/03/2011				
	PROVIDER OR SUPPLIER Y 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 PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	washing her hands. Bathrooms #1, #2 and #4 are restrooms utilized by all residents in the facility for bathing and toileting needs.  In interview with the Administrator on 11-1-11 at 3:22 p.m., she indicated she did not wash her hands during the environmental observation conducted earlier the same afternoon. She indicated, "I'm guilty. I should have washed my hands after both things [touching the toilet seat and picking up the trash bag.]"	demonstration which will be documented on the handwast skills checklist until 100% compliance has been achieved. What measures will put into place to ensure this practice does not recur? All swere inserviced on hand wast on 11/16/11. Handwashing schecklists will be completed of staff by 12/6/11. Licensed stawill be inserviced on approprise handwashing during treatment administration as of by 12/9/11. The Director of Nursi will then conduct monthly handwashing skills observations wo various staff members, include the Administrator and LPN #1 a total of five staffmembers a month. Once staff members have been observed, the Director of Nursing will conduct quarted handwashing skills observation on random staff, departments and shifts for no less than 6 employees. Every nurse will observed for handwashing dutreatment administration by 12/9/11. Any identified issue will be addressed as indicated question #2. How will correct action be monitored to ensure deficient practice does not rect and what QA will be put into place? The DON will bring the results of the handwashing & treatment administration observations to the QA Committee for review and recommendation at the month meeting until all staff has been deficient until all sta	taff ning kills n iff ate t ng d d ith ing for ctor rly ins pe ring s d in etive the eur			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155424		A. BUILDING B. WING  COMPLETED 11/03/2011				
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	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	reviewed 11-1-1 diagnoses includ to, bilateral lowe (paralysis), diabe malnutrition, and (deep/extensive)  A dressing change conducted with I 10:45 a.m. for 2 and putting on claremoved the old on the left lower apply the new dragloves or washin Later in the dress #1 washed and donoticed a needed She was observed up the item. She rewash her hands sterile package of with her dressing	decubitus (bed sore).  ge observation was LPN #1 on 11-2-11 at of 3 wounds for Resident gan by washing her hands ean gloves. She dressing from the wound leg and proceeded to essing without changing g her hands.  Sing change process, LPN ried her hands. She then item laying on the floor. d to bend down and pick was not observed to s prior to opening a f gauze as she continued		observed. When the DON star her quarterly random handwashing observations, she will report those results quarte to the QA Committee – this will continue on an ongoing basis. Date of Compliance:	e rly	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL			
155424		A. BUII B. WIN	LDING G		11/03/	2011		
NAME OF T	DROLUDED OF GUMPY TO		S. 1111		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	NAME OF PROVIDER OR SUPPLIER			5480 E	25TH ST			
	HICKORY CREEK AT COLUMBUS			COLUMBUS, IN 47203				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TE	COMPLETION DATE	
1710		to remove her gloves		1710			DITTE	
		n the trash bag. She then						
	_	nove the trash bag from						
	_	th ungloved hands and tie						
		picked up the soiled linen						
		ands and placed the						
	_	trash bag and again tied it						
	up.							
	_							
	In interview with	n LPN #1 on 11-2-11 at						
	5:18 p.m. she inc	dicated, "I can't think of						
	anything I could	have done different with						
	hand washing or	glove use. I bet I						
	changed gloves a	at least 15 times."						
	A policy entitled	l,						
	_	Alcohol-Based Hand						
		ision date of 7-10, was						
	-	Administrator on 11-2-11						
		is policy indicated,						
		e absolute indications for						
		quency of handwashing						
		However, in the absence						
	1	ncy, personnel should						
		ir hands (even when						
		:After gloves are						
		situations during which						
		nination of hands is likely						
	_	illy those involving						
	contact with muc							
	I `	nd vaginal surfaces),						
	1	fluids, secretions, or						
	-	ems contaminated with						
	these substances	; After touching						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
155424		B. WING 11/03/2011					
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE			
HICKOR'	Y CREEK AT COL	UMBUS	5480 E 25TH ST COLUMBUS, IN 47203				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	T	(X5)		
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	inanimate sourc	es that are likely to be					
	contaminated w						
	epidemiological	-					
	_	(including urinary					
	-	nents and containers used					
		easure urine); When					
		ated to avoid transfer of					
	_	to other residents and					
		And when indicated nd procedures on the same					
		ent cross-contamination of					
	_	ites;Before and after					
		ntact; After touching a					
	resident or hand	_					
	belongings;"	88					
	, , , , , , , , , , , , , , , , , , ,						
	3.1-18(1)						

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