STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155424	A. BUILDING 00 B. WING	11/03/2011

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

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00098813 and IN00099165. Complaint IN00099165 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F224, F225, F226. Complaint IN00098813 - Unsubstantiated due to lack of evidence. Survey dates: October 31, November 1, 2, and 3, 2011 Facility number: 000284 Provider number: 155424 AIM number: 100290690 Survey Team: Janie Faulkner, RN-TC Cheryl Fielden, RN Penny Marlatt, RN Jill Ross, RN Diana Sidell, RN (11/2/2011) Census bed type: SNF/NF: 35 Total: 35 Census payor type:	F0000	This Plan of Correction constitues the written allegation of compliance for the deficiencies cited. Hower, submission of the Plan of Correction is not an admission that a deficiency exist or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.Hickory Creek at Columbus desires this Plan of Correction to be considered the facility's allegation of Compliance. Compliance is effective December 8, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicaid: 34 Other: 1 Total: 35 Sample: 10 Supplemental sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 11/14/11 by Suzanne Williams, RN			

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F0223 SS=D	The resident has the right to be free from 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, the facility failed to prevent mental and verbal abuse to residents. This affected 3 of 10 residents reviewed for abuse in the sample of 10 (Residents #D, #E, #I). Findings include: On 11/1/2011 at 5:30 P.M., during confidential interview, Employee #J stated, "[Resident#E's name] witnessed the Administrator yelling and screaming at one of her department heads, and [Resident's name] started crying and went to the nurses' station and asked, 'Is that woman going to start yelling at me next?'" Confidential interview with Resident #D, on 11/2/11 at 2:55 P.M., indicated, "the Administrator is snippy, rude and mean. I reported her to Hickory Creek. The Administrator is rude to everyone." 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	F0223	F223 *The facility disagrees with the survey findings regarding this alleged deficiency and respectfully requests the face-to-face Informal Dispute Resolution process.* It is the standard and policy of this facility that the resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. It is the standard of this facility to not allow verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. *The survey document indicates that 3 of 10 residents were affected by the facility's alleged inability to prevent mental and verbal abuse. The facility disagrees with the surveyor(s) interpretation that a discussion between the Administrator and Employee #K constitutes verbal or mental abuse towards a resident. While it is true that Resident #E did go to the Nurse's Station and voice concern with*	12/03/2011

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	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." Confidential interview with Employee #L, at 12:20 P.M. on 11/3/2011, indicated they were present and heard Resident #E crying and asking, " is that woman going to start yelling at me next?" During an interview with Resident #A on 11/2/2011 at 2:00 P.M., resident stated, "It can get very noisy around here, depending on who is working, whether it is loud or not. The Administrator is loud sometimes." On 11/1/2011 at 2:30 P.M., interview with Resident #I, the resident stated, "I heard yelling in the hall a couple of weeks ago. Not sure who it was, but I'm pretty sure it was staff."		*the conversation the Administrator was having with Employee #K, per Hickory Creek's interview with the Director of Nursing Services, (DON) on November 4, 2011, the DON indicates she immediately consoled Resident #E telling her that the Administrator would never speak to her in this fashion and asked resident if she would like to go to her room to talk about this further. Resident #E acknowledged that she wanted to discuss further with the DON. Resident #E has a diagnosis which includes Alzheimer's and according to the DON, resident had moved on to a new conversation within a minute or so and never brought up the incident again. While it was unfortunate that Resident #E overheard a conversation between the Administrator and Employee #K, the verbal exchange which happened between these two employees did not include "verbal abuse" oral or gestured language that willfully included disparaging and derogatory terms to the residents or "mental abuse" including, but not limited to, humiliation, harassment, threats of punishment or deprivation as defined in the federal/state regulations and guidance to surveyors and nothing contained within this survey report substantiates this activity.*	

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	On 11/3/2011 at 3:25 P.M., during interview with the Administrator regarding the allegation of verbal abuse, she stated, "That didn't happen, I have never yelled at (department head) or anyone else in the hall or elsewhere. That is just not true." 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 made aware of the allegation by the Administrator after the above interview with the Administrator. She stated she was in the facility yesterday and had interviewed a resident who had called the compliance complaint line on Friday, 10/27/2011, and the resident stated the Administrator was snippy. She stated, "I talked with resident quite a bit, asked her to define snippy. Resident could not define snippy." "I talked with the resident at least 30 minutes and at no point did she say [Administrator's name] yelled, just that she was talking to staff in a way that was not nice."		*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 direct supervisor interviewed Resident #D on November 1, 2011 and was basically told the same information by the resident. At no time during the meeting with the DO did Resident #D state the Administrator was verbally, non-verbally or mentally abusive to her or other residents; nor did she give any examples that would meet the definition of verbal or mental abuse. Thus, the Administrator's alleged interactions with her staff, per interview does not meet the intent of "verbal abuse" oral or gestured language that willfully included disparaging and derogatory terms to the residents or "mental abuse" including, but not limited to, humiliation, harassment, threats of punishment or deprivation as defined in the federal/state regulations and guidance to surveyors and nothing contained 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.*	

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	During the exit conference on 11/3/2011 at 5:04 P.M., the Administrator stated, "[Employee name] had not posted like I had asked him, happened several times, spoke to him in hall, I was frustrated, didn't raise my voice, that's what I recall, at no time did I yell, don't know who was around." Review of Hickory Creek Healthcare Foundation, Inc. Accident/Incident/Reportable/State Officials- Indiana, Provided 10/31/2011 at 12:01 P.M. by Administrator as their current policy and procedure with Issue Date of 3/02 and last revision date 10/11, indicated, "...Abuse - Physical, Sexual, Verbal and/or Mental (known and/or alleged) C. Verbal Abuse- the use of oral....within hearing distance regardless of their age, ability to comprehend....Examples of verbal abuse include, but are not limited to: threats of harm, saying things to frighten a resident....D. Mental Abuse - includes, but is not limited to, humiliation, harassment...." This federal tag relates to complaint IN00099165. 3.1-27(a)(1) 3.1-27(b)		*Surveyor interview of Resident #A and the response does not meet the intent of "verbal abuse" oral or gestured language that willfully included disparaging and derogatory terms to the residents or "mental abuse" including, but not limited to, humiliation, harassment, threats of punishment or deprivation as defined in the federal/state regulations and guidance to surveyors and nothing contained within this survey report substantiates this alleged activity.* *Surveyor interview of Resident #I and the response does not meet the intent of "verbal abuse" oral or gestured language that willfully included disparaging and derogatory terms to the residents or "mental abuse" including, but not limited to, humiliation, harassment, threats of punishment or deprivation as defined in the federal/state regulations and guidance to surveyors and nothing contained within this survey report substantiates this alleged activity.* *The surveyor interview on pages 3&4 of the survey document as occurring on 11-3-11 at 3:25 P.M. did not occur as written. Two surveyors asked the Administrator why her demeanor had changed and if she was aware there was an allegation of verbal abuse against her. The Administrator was not*	

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			interviewed, given any details of the allegation and wasn't asked about details of any incidents. She was denied the ability to respond in a meaningful manner that might have assisted the surveyors' understanding of the alleged incident. There was no attempt by the surveyors to validate any of the information with the Administrator that came from the resident interviews. Thus, the facility is seeking Informal Dispute of the survey allegations. *On page 4 of the survey document, the title Regional Operations Manager is inaccurate as the correct title is Director of Operations, (DO). The DO was also misquoted. During the telephone conversation with the Surveyor – TC, on 11-3-11 at 3:28 P.M. the DO asked the Surveyor the why she (DO) was not informed of the abuse allegation when she was in the facility on 11-2-11. The Surveyor's response was they were not aware of who the DO was at the time. The DO did state had she been informed on 11-2-11 of an abuse allegation the Administrator would have been placed on suspension. The DO returned to the facility to participate in the Exit Conference held on 11-3-11 at 5:04 P.M.* *<u>The facility believes that based upon the above provided</u>*	

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			documentation that neither "verbal" nor "mental" abuse as defined by federal / state regulation occurred and respectfully requests that this entire 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 not be limited to the resident's right to be from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion and misappropriation of resident property and that employees of this facility are not to use or allow verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion by December 3, 2011. Employees will be reminded during these rein-services that this is the resident's home and that employees must be courteous and conscientious, that business matters need to be discussed in private in an office or non-resident care area and that staff should refrain from speaking loudly, or making excessive noise in resident care areas. How will the facility identify other residents having the potential to be affected by the same practice	

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			and what corrective action will be taken? All residents have the potential to be affected, but particularly those residents with dementia, who are confused, unable to freely communicate, have behavioral symptoms and totally dependent residents. What measures will be put into place to ensure this practice does not recur? During re-in-services, staff will be reminded that any allegation of verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion, including misappropriation of resident's property must be reported immediately in accordance with the facility's abuse protocols and not reporting is also considered abuse / neglect. During routine Guardian Angel Rounds Department Managers will inquire with their assigned residents regarding the overall atmosphere of the nursing home and whether the resident has any concerns. Any identified concerns will be transferred to the Resident/Family Concern Form and the facility will follow its investigative protocol and grievance procedures.	

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			How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Resident/Family Concern forms will be brought to the monthly QA Committee for review and further recommendations. This reporting will continue monthly for the next 90 days and then at least one time per quarter thereafter. In addition, the Director of Operations will review the Resident/Family Concern forms monthly for at least 90 days and will conduct random interviews with Residents and Employees to ascertain compliance.	

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F0224 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			
	Based on record review, observation and interview, the facility failed to ensure there was not misappropriation of residents' property. This affected 2 of 5 residents reviewed for misappropriation of property in a sample of 10 and supplemental sample of 3. (Residents #A, #H) Findings include: During the group interview with residents at 1:30 P.M. on 11/1/2011, the following residents indicated they had items missing: Resident #H had a wedding band missing. The resident indicated the wedding ring had not been replaced or found at this time. During an interview with the Social Services Director on 11/1/2011 at 2:30 P.M., regarding any allegations of misappropriation of funds or property and the process of investigation, the Social Services Director replied, "any staff member can help residents fill out concern and Administrator gets all grievances for investigation and then I get them for follow-up and have to give them	F0224	F224 *The facility disagrees with the survey findings regarding this alleged deficiency and respectfully requests the face-to-face Informal Dispute Resolution process.* It is the standard and policy of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. *Resident #G asked to attend the group resident meeting, but was not identified on the Resident List as a resident to be interviewed. This resident's most recent MDS, a copy which is included demonstrates a score of 10 on her BIMS assessment. A score of 10 indicates cognitive impairment. The facility was unaware that Resident #G had voiced a concern of missing items because this was not reported to anyone at the facility before the surveyors reported it to facility management via the 2567. It was when the survey document was received and reviewed by the Administrator that this concern was brought to the facility's*	12/03/2011

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	back to Administrator to go in the grievance log book." "I do not keep any copies in my office, and these are not documented anywhere other than grievance forms." Interview with Resident #H on 11/2/2011 at 10:25 A.M., indicated about two months ago he had a ring missing and he reported it to the Social Services Director, and has received no feedback. He indicated he would like some resolve to the issue. Interview with the Social Services Director on 11/2/2011 at 10:43 A.M., regarding Resident #H's missing ring, indicated, "I don't recall him saying anything to me about it recently or before, but I would have filled out a grievance form and give it to the Administrator." "I would remember it if it was in the last couple of weeks." The Social Services Director provided a blank "Resident / Family Concern Form" per request. On 11/2/2011 at 10:50 A.M., the Administrator was observed to enter Resident #H's room and asked about his missing ring, she began searching his room, and informed him they would be searching his room for the ring. During interview with Resident #H on		*attention. After investigation to determine the resident's identity, the Administrator interviewed Resident #G who alleged that her wedding band and watch were missing. The resident's room was searched and the resident's watch was located in her bedside cabinet where it is always kept, thus in fact it was not missing. Resident #G's daughter was contacted regarding the reported missing wedding band and the resident's daughter indicated that her mother has never had her wedding band at the nursing home, that the wedding band is at the daughter's home for safekeeping. This incident, was reported to the ISDH, although the facility does not believe the incident meets the Reportable Unusual Occurrences Policy in that the resident is confused, the watch was located in the bedside cabinet where it is always kept and per interview of the resident's daughter, her mother's wedding band has never been at the facility. There was no deliberate misplacement, exploitation, or wrongful, temporary or permanent use of the ring without the resident's consent. In short, there was no incident.* *Based upon the above provided documentation it is clear that violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal /*	

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	11/3/2011, he indicated that a grievance form was completed on 11/2/2011, and he is happy that the facility is looking into this issue. During a confidential interview with Employee #L, on 11/2/2011 at 11:48 A.M., the employee stated, "If I get a concern from resident, family, or staff, I notify the charge nurse and then I fill out a grievance form to be turned in to the Administrator." "If it is a big problem, I notify the DON and the Administrator immediately." "I fill out a grievance form for any missing items." Grievance Log dated 9/27/11, Resident A, indicated family states wallet was in bedside table drawer, room has been searched, and wallet has not been found, staff interviewed no one was aware of the wallet or money." There were no staff interviews identified with dates or times of their investigation. On 11/2/2011 at 4:30 P.M., any other investigations of concerns/missing items were requested to review from the Administrator. The Administrator returned at 4:35 P.M. on 11/2/2011 and stated, "I don't have any (investigations)." Hickory Creek Healthcare Foundation, Inc. Topic Grievances, provided by the Administrator on 11/2/2011 at 1:35 P.M.,		*state regulation did not occur, and respectfully requests 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. After 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 26, 2011. The Administrator has been advised by the Director of Operations that all reports of missing resident belongings require the implementation of Hickory Creek's Resident Mistreatment, Neglect, Abuse & Misappropriation of Property Administrative Policy and Procedure. In fact, the Administrator followed the applicable policy and the resident's grievance/concern was rectified. The State and Federal regulations do not require that a nursing facility be held strictly liable when a resident's tee shirts are missing, only that the facility have a grievance/concern procedure to address any unfortunate incidents. In this case, the facility has such a policy, the policy was implemented and followed and the resident's concern alleviated.* *Resident #F's family member reported a missing black wallet with roses on it which contained*	

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	155424	A. BUILDING 00 B. WING	11/03/2011

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	indicating current policy and procedure issued July 15, 2002 with Revision date 01/04. Policy: "All complaint/concerns will be thoroughly investigated. Resolution or status of follow-up will be relayed to residents and/or families within 48 hours...." This federal tag relates to complaint IN00099165. 3.1-28(a)		*$32.00 to the Administrator on September 27, 2011. The family member indicated that wallet was in Resident #F's drawer on the left hand side, but he had not seen it for two months. According to the Administrator, no report of a missing sweater was made at this time. Resident #F has a diagnosis of dementia and was unable to provide any feedback regarding the wallet. The administrator contacted Resident #F's family member on November 23 and the family member indicates sweater was missing a long time ago. Due to the time 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 family on November 9, 2011. The facility agrees that this incident meets the state / federal regulations regarding possible misappropriation of resident property and the incident should have been reported to the ISDH per the Reportable Unusual Occurrences Policy.* *The facility contends that the first 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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	155424	A. BUILDING 00 B. WING	11/03/2011

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			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 a while. When queried if Resident #H had told anyone the response was "I don't recall". Resident #H's wife indicated that Resident #H was going through his jewelry a few weeks ago and the ring was in a white jewelry bag. Resident #H's wife indicated she thinks Resident #H threw the white bag away before he took the ring out. Resident #H agreed that was the case. With permission, Resident #H's jewelry box and dresser drawers were searched and the ring was not found. Resident #H 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 of jewelry. The facility is working with the residents to inventory the jewelry box as a majority of these items are not listed on the facility Inventory Sheet. The facility has a Guardian Angel program in place consisting of frequent visits by Department Managers to their assigned residents. No one recalls Resident #H indicating that he had a missing ring until it was brought to the Administrators attention by the surveyor(s). This incident, upon being brought forth by the surveyor(s) was reported to the ISDH, in accordance with	

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			facility policy, although the facility does not believe the incident meets the Reportable Unusual Occurrences Policy in that per interview or Resident #H and his wife, it does not appear that there 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 of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did not occur, and respectfully requests that this section of the survey citation be deleted from the record.* *Resident #A through surveyor(s) interview on 11-2-11 at 2:00 P.M. alleges that the Administrator disposed of her clothes and her 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*	

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			from at least eight other Hickory Creek nursing homes and approximately eight of Hickory Creek's home office staff all were at Hickory Creek at Columbus to perform the tasks of unloading the semi-truck, unpacking the furniture items, putting the beds together, removing the old furniture and replacing it with the new. After the conclusion of the furniture move-in, just before the supper meal, Resident #A voiced that she had some items missing. The Administrator followed-up with her and attempted to locate the items in her room without success. The Administrator was one of the individuals who earlier in the day during the furniture conversion assisted with putting things into the new wardrobe but told the resident she did not recall seeing any of the items the resident indicated were missing. The Administrator apologized to Resident #A and assured her that the search for the missing items would continue, but if the items could not be located, they would be replaced. On Friday, October 14, 2011 the Maintenance Man did a thorough search of the dumpster and found the missing items. Per interview with the Maintenance Supervisor by Hickory Creek's Vice President of Operations, Director of Operations and Director of Clinical Services on Friday, November 4, 2011 he indicated that he opened and searched	

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			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 bag 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 well, along with other trash type material. All these items belonged to Resident #A. The Administrator was scheduled off the following day – Friday, October 14, 2011, but was contacted by the Director of Nursing Services early in the A.M. and advised that Resident #A was still upset regarding the missing items even though they had been located. The Administrator came in to the facility to speak with Resident #A to apologize that the items were accidentally thrown away.. Apparently these items had been placed in a garbage bag, but it is 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 of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The report must be submitted within 24 hours after the preliminary investigation has determined that resident property	

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			or funds have been misappropriated. It is unfortunate that Resident #A's belongings got co-mingled with trash type items 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 Resident #A's belongings. In fact, the Administrator made an extraordinary effort in initially searching for the items upon discovery that they were missing and even came back to the facility on the morning of a day she was scheduled off to console Resident #A and apologize that she had accidentally disposed of the items during the renovation of the resident's living quarters. *Based upon the above provided documentation a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did not occur, and respectfully requests 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 not	

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			be limited to the resident's right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion and misappropriation of resident property and that employees of this facility are not to allow or participate in any verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion by December 3, 2011. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to be affected, but particularly those residents, with dementia, who are confused, unable to freely communicate, with behavioral symptoms and totally dependent residents. What measures will be put into place to ensure this practice does not recur? During re-in-services, the staff will be reminded that any allegation of verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion, including misappropriation of resident's property must be reported immediately in accordance with the facility's abuse protocols and	

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			not 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 home and whether the resident has any concerns. Any identified concerns will be transferred to the Resident/Family Concern Form and the facility will follow its investigative protocol and grievance procedures. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Resident/Family Concern forms will be brought to the monthly QA Committee for review and further recommendations. This reporting will continue monthly for the next 90 days and then at least one time per quarter thereafter. In addition, the Director of Operations will review the Resident/Family Concern forms monthly for at least 90 days and will conduct random interviews with Residents and Employees to ascertain compliance.	

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F0225 SS=E	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review, observation and interview, the facility failed to ensure allegations of abuse and misappropriation of resident property were immediately	F0225	F225 *The facility disagrees with the survey findings regarding this alleged deficiency and*	12/03/2011

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	reported and thoroughly investigated, and failed to protect residents from further potential abuse. This affected 5 residents from the sample of 10 and supplemental sample of 3 reviewed for abuse and misappropriation of property (#A, D, E, H, I) and had the potential to affect all of the residents in the facility. Findings include: 1. Confidential interview with Resident #D, on 11/2/11 at 2:55 P.M., indicated, "the Administrator is snippy, rude and mean. I reported her to Hickory Creek. The Administrator is rude to everyone." Confidential interview with Employee #L, at 12:20 P.M. on 11/3/2011, indicated they were present and heard Resident #E crying and asking, " is that woman going to start yelling at me next?" During an interview with Resident #A on 11/2/2011 at 2:00 P.M., resident stated, "It can get very noisy around here, depending on who is working, whether it is loud or not. The Administrator is loud sometimes." On 11/1/2011 at 2:30 P.M., interview with Resident #I, the resident stated, "I heard yelling in the hall a couple of weeks ago. Not sure who it was, but I'm pretty		*respectfully requests the face-to-face Informal Dispute Resolution process.* It is the standard and policy of this facility to: Not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents, have had findings entered into the State nurse aide registry concerning the above and including misappropriation of resident property; and report any knowledge it may have of actions by a court of law against an employee regarding the above actions. Assure all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator and to other officials in accordance with State law through established procedures including to the State survey and certification agency. Assure all alleged violations are thoroughly investigated, and will prevent further potential abuse while the investigation is in progress. The results of all investigations will be reported to the administrator or his designated representatives and to other	

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	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 State law within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action will be taken. *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 interviewed Resident #D on November 2, 2011 and was told of Resident D's concerns. At no time during the meeting with the DO did Resident #D state the Administrator was verbally or mentally abusive to her or any other residents; nor did she give any examples that would meet the definition of verbal or mental abuse. Resident #D's subjective concern does not rise to the level of "verbal abuse" oral or gestured language that willfully included disparaging and derogatory terms to the residents or "mental abuse" including, but not limited to, humiliation, harassment, threats of punishment or deprivation as defined in the federal/state regulations and guidance to surveyors and nothing contained within this survey report substantiates this alleged activity.* *Based upon the above provided documentation that a violation of*	

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	called the compliance complaint line on Friday, 10/27/2011, and the resident stated the Administrator was snippy. During the exit conference on 11/3/2011 at 5:04 P.M., the Administrator stated, "[Employee name] had not posted like I had asked him, happened several times, spoke to him in hall, I was frustrated, didn't raise my voice, that's what I recall, at no time did I yell, don't know who was around." On 11/3/2011 at 5:05 P.M., the facility Regional Operations Manager stated, "If this is the extent of the complaint, I think this is a stretch." 2. During the group interview with residents at 1:30 P.M. on 11/1/2011, the following residents indicated they had items missing: Resident #H had a wedding band missing. The residents indicated the wedding ring had not been replaced or found at this time. During an interview with the Social Services Director on 11/1/2011 at 2:30 P.M., regarding any allegations of misappropriation of funds or property and the process of investigation, the Social Services Director replied, "any staff member can help residents fill out concern and Administrator gets all		*the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did not occur and respectfully requests that this section of the survey citation be deleted from the record.* *Surveyor interview of Resident #A and the response does not satisfy the definition or meet the intent requirement of "verbal abuse" oral or gestured language that willfully included disparaging and derogatory terms to the residents or "mental abuse" including, but not limited to, humiliation, harassment, threats of punishment or deprivation as defined in the federal/state regulations and guidance to surveyors and nothing contained within this survey report substantiates this alleged activity.* *Based upon the above provided documentation a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did occur and respectfully requests that this section of the survey citation be deleted from the record.* *Surveyor interview of Resident #I and the response does satisfy the definition or meet the intent requirement of "verbal abuse" oral or gestured language that willfully included disparaging and*	

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	grievances for investigation and then I get them for follow-up and have to give them back to Administrator to go in the grievance log book." "I do not keep any copies in my office, and these are not documented anywhere other than grievance forms." Interview with Resident #H on 11/2/2011 at 10:25 A.M., indicated about two months ago he had a ring missing and he reported it to the Social Services Director, and has received no feedback. He indicated he would like some resolve to the issue. Interview with the Social Services Director on 11/2/2011 at 10:43 A.M., regarding Resident #H's missing ring, indicated, "I don't recall him saying anything to me about it recently or before, but I would have filled out a grievance form and give it to the Administrator." "I would remember it if it was in the last couple of weeks." The Social Services Director provided a blank "Resident / Family Concern Form" per request. On 11/2/2011 at 10:50 A.M., the Administrator was observed to enter Resident #H's room and asked about his missing ring, she began searching his room, and informed him they would be		*derogatory terms to the residents or "mental abuse" including, but not limited to, humiliation, harassment, threats of punishment or deprivation as defined in the federal/state regulations and guidance to surveyors and nothing contained within this survey report substantiates this alleged activity.* *Based upon the above provided documentation a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did not occur and respectfully requests that this section of the survey citation be deleted from the record.* *Sometime around mid-October 2011 the Administrator had a discussion with the Dietary Services Manager regarding the resident menu board. This discussion took place in front of the menu board which is in a hallway across from room #1. The Dietary Services Manager had on more than one occasion positioned the daily menus on the menu board incorrectly. The Administrator had addressed this on more than one occasion. On the day in question when the Administrator asked the Dietary Services Manager why he could not "hang this correctly" the Dietary Services Manager questioned the Administrator's*	

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	searching his room for the ring. During interview with Resident #H on 11/3/2011, he indicated that a grievance form was completed on 11/2/2011, and he is happy that the facility is looking into this issue. During a confidential interview with Employee #L, on 11/2/2011 at 11:48 A.M., the employee stated, "If I get a concern from resident, family, or staff, I notify the charge nurse and then I fill out a grievance form to be turned in to the Administrator." "If it is a big problem, I notify the DON and the Administrator immediately." "I fill out a grievance form for any missing items." Grievance Log dated 9/27/11, indicated family states wallet was in bedside table drawer, room has been searched, and wallet has not been found, staff interviewed no one was aware of the wallet or money." There were no staff interviews identified with dates or times of their investigation. On 11/2/2011 at 4:30 P.M., any other investigations of concerns/missing items were requested to review from the Administrator. The Administrator returned at 4:35 P.M. on 11/2/2011 and stated, "I don't have any (investigations)." Confidential Interview with Employee #J		*direction. Although both employees admit there was some disagreement and frustration, at no time was the discussion directed toward any resident. At no time was the Administrator "screaming and yelling".* *On page 11 of the survey document, the title Regional Operations Manager is inaccurate as the correct title is Director of Operations, (DO) and the DO has been misquoted. During the telephone conversation with the Surveyor – TC, on 11-3-11 at 3:28 P.M. the DO asked why she (DO) was not informed of the abuse allegation when she was in the facility on 11-2-11. The Surveyor's response was they were not aware of who the DO was at that time. The DO stated that had she been informed on 11-2-11 the Administrator would have been placed on suspension. The DO did return to the facility to participate in the Exit Conference held on 11-3-11 at 5:04 P.M. The quote made by the "Regional Operation Manager" is taken out of context and does not reflect the nature of the discussion that took place during the exit conference. As the survey team would not share any information regarding the nature of the abuse allegations, the Administrator shared the incident that occurred between she and the Dietary Services Manager in October. The Administrator stated this was*	

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	155424	A. BUILDING 00 B. WING	11/03/2011

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	on 11/1/2011 at 5:30 P.M., indicated she had talked with the Administrator regarding residents with money missing, but she wouldn't listen. "One of the residents called the Corporate Compliance line and someone from corporate called one of the department heads and that person immediately went to the Administrator. I didn't know who to call to help the residents." She indicated she called the Ombudsman and Adult Protective Services, and was advised to send a complaint anonymously to ISDH. She stated, "No, I did not call corporate office, because I didn't think it would help the residents." Review of "Hickory Creek Healthcare Foundation, Inc. Resident Mistreatment, Neglect, Abuse & Misappropriation of Property Administrative Policy & Procedure" provided by the Administrator on 10/31/2011 at 12:01 P.M., with Issue Date 12/1999, and last Revision Date: 9/10, indicated "Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property....J. Investigation: All reported incidents of alleged violations involving mistreatment, neglect, abuse....are to be reported to the Administrator immediately, investigated and reported per state and federal law....If the report of alleged abuse involves the facility		*the only incident she could recall. After listening to this discussion, the Director of Operations did state to the survey team that "If this is the extent of the complaint, I think this is a stretch".* *Resident #G asked to attend the group resident meeting, but was not identified on the Resident List as a resident to be interviewed. This resident's most recent MDS, a copy of which is provided, demonstrates a score of 10 on her BIMS assessment. A score of 10 indicates cognitive impairment. The facility was unaware that Resident #G had voiced a concern of missing items because this was not reported to anyone at the time of the survey by the surveyor(s). It was when the survey document was received and reviewed by the Administrator that this concern was brought to the facility's attention. After investigation to determine the resident's identity, the Administrator interviewed Resident #G who stated that her wedding band and watch were missing. The resident's room was searched and the resident's watch was located in her bedside cabinet where it is always kept. Resident #G's daughter was contacted regarding the reported missing wedding band and resident's daughter indicated that her mother has never had her wedding band at the nursing home, that the wedding band is at*	

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	Administrator, the person reporting the allegation will call the Director of Operations for the facility and/or the Corporate Compliance Call Line immediately...." This federal tag relates to complaint IN00099165. 3.1-28(c) 3.1-28(d) 3.1-28(e)		*the daughter's home for safekeeping. This incident, upon 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 Occurrences Policy in that the resident is confused, the watch was located in the bedside cabinet where it is always kept and per interview of the residen'ts daughter, her mother's wedding band has never been at the facility. There was no deliberate misplacement, exploitation, or wrongful, temporary or permanent use of the ring without the resident's consent. In fact, there was no incident; no items were and never had been missing.* *Based upon the above provided documentation that a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did not occur and respectfully requests 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. After 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*	

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			26, 2011. The Administrator has been advised by the Director of 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 and procedure dealing with missing items, the resident was made whole and the facility did not violate State or Federal guidelines dealing with missing items. *The facility contends that the first time management was 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 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 a while. When queried if Resident #H had told anyone the response was "I don't recall". Resident #H's wife indicated that Resident #H was going through his jewelry a few weeks ago and the ring was in a white jewelry bag. Resident #H's wife indicated she thinks*	

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			Resident #H threw the white bag away before he took the ring out. Resident #H agreed with that version of the events. With permission, Resident #H's jewelry box and dresser drawers were searched and the ring was not found. Resident #H 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 of jewelry. The facility is working with the residents to inventory the jewelry box as a majority of these items are not listed on the facility Inventory Sheet. The facility has a Guardian Angel program in place consisting of frequent visits by Department Managers to their assigned residents. No one recalls Resident #H indicating that he had a missing ring until it was brought to the Administrators attention by the surveyor(s). This incident, upon being brought forth by the surveyor(s) was reported to the ISDH, although the facility does not believe the incident meets the Reportable Unusual Occurrences Policy in that per interview or Resident #H and his wife, it does not appear that there 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	

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			Resident H inadvertently disposing of his own belongings, and when the matter was brought to the facility's attention, it was handled in accordance with facility policy and procedure. *Based upon the above provided documentation that a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did not occur, and respectfully requests that this section of the survey citation be deleted from the record.* *Resident #F's family member reported a missing black wallet with roses on it which contained $32.00 to the Administrator on September 27, 2011. The family member indicated that wallet was in Resident #F's drawer on the left hand side, but he had not seen it for two months. According to the Administrator, no report of a missing sweater was made at this time. Resident #F has a diagnosis of dementia and was unable to provide any information regarding the wallet. The administrator contacted Resident #F's family member on November 23 and family member indicated the sweater was missing a long time ago. Due to the time frames involved and Resident F's dementia diagnosis the wallet, money or sweater have not been located. The facility made the*	

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			decision to reimburse the $32.00 and this was given to Resident #F's family on November 9, 2011. The facility agrees that this incident meets the state / federal regulations regarding possible misappropriation of resident property and the incident should have been reported to the ISDH per the Reportable Unusual Occurrences Policy. *Resident #A through surveyor(s) interview on 11-2-11 at 2:00 P.M. alleges that the Administrator disposed of her clothes and her 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 from at least eight other Hickory Creek nursing homes and approximately eight of Hickory Creek's home office staff all were at Hickory Creek at Columbus to perform the tasks of unloading the semi-truck, unpacking the furniture items, putting the beds together, removing the old furniture and replacing it with the new. After the conclusion of the furniture move-in, just before the supper meal, Resident #A voiced that she had some items missing.*	

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			The Administrator followed-up with her and attempted to locate the items in her room without success. The Administrator was one of the individuals who earlier in the day during the furniture conversion assisted with putting things into the new wardrobe but told the resident she did not recall seeing any of the items the resident indicated were missing. The Administrator apologized to Resident #A and assured her that the search for the missing items would continue, but if the items could not be located, they would be replaced. On Friday, October 14, 2011the Maintenance Man did a thorough search of the dumpster and found the missing items. Per interview with the Maintenance Supervisor by Hickory Creek's Vice President of 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 plastic bag 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 well as other trash type material. All these items belonged to Resident #A. The Administrator was scheduled off the following day – Friday, October 14, 2011, but was contacted by the Director of	

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			Nursing Services early in the A.M. and advised that Resident #A was still upset regarding the missing items even though they had been located. The Administrator came in to the facility to speak with Resident #A and again apologized that her items had been accidentally thrown away. Apparently these items had been placed in a garbage bag, but it is unclear 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 of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The report must be submitted within 24 hours after the preliminary investigation has determined that resident property or funds have been misappropriated. It is unfortunate that Resident #A's belongings got co-mingled with trash type items 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 Resident #A's belongings. In fact, the Administrator made an extraordinary effort in initially	

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			searching for the items upon discovery that they were missing and even came back to the facility on the morning of a day she was scheduled off to console Resident #A and apologize that she had accidentally disposed of the items during the renovation of the resident's living quarters. *Based upon the above provided documentation that a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did not occur and respectfully requests 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 not be limited to the resident's right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion and misappropriation of resident property and that employees of this facility are not to engage in or allow verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion by December 3, 2011. Employees will be reminded during these re-in-services that	

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			this is the resident's home and that employees should be courteous and conscientious, that business matters need to be discussed in private in an office or non-resident care area and that staff should refrain from speaking loudly, or making excessive noise in resident care areas. The Director of Operations who is the Administrator's immediate supervisor will do one-on-one documented re-training regarding Hickory Creek's Abuse Protocol, Hickory Creek's Resident Mistreatment, Neglect, Abuse & Misappropriation of Property Administrative Policy and Procedure, the federal regulations and interpretive guidelines at §483.13 et al, (F tags 223, 224, 225 & 226), and the Indiana State Department of Health – Division of Long Term Care Policy and Procedure regarding Reportable Unusual Occurrences. In addition, the Director of Operations will review with the Administrator the importance of not conducting nursing home business which might result in disagreement with subordinates in a direct resident care area. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to	

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			be affected, but particularly those residents with dementia, who are confused, unable to freely communicate, with behavioral symptoms and totally dependent residents. What measures will be put into place to ensure this practice does not recur? During re-in-services, staff will be reminded that any allegation of verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion, including misappropriation of resident's property must be reported immediately in accordance with the facility's abuse protocols and not reporting is also considered abuse / neglect. During routine Guardian Angel Rounds Department Managers will inquire with their assigned residents regarding the overall atmosphere of the nursing home and whether the resident has any concerns. Any identified concerns will be transferred to the Resident/Family Concern Form and the facility will follow its investigative protocol and grievance procedures. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?	

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			The Resident/Family Concern forms will be brought to the monthly QA Committee for review and further recommendations. This reporting will continue monthly for the next 90 days and then at least one time per quarter thereafter. In addition, the Director of Operations will review the Resident/Family Concern forms monthly for at least 90 days and 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 and federal / state regulations for the next 90 days, with quarterly reviews to follow thereafter.	

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F0226 SS=E	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			
	Based on record review, observation and interview, the facility failed to follow their abuse prevention policy and procedure by failing to ensure allegations of abuse and misappropriation of resident property were immediately reported and thoroughly investigated, and failed to protect residents from further potential abuse. This affected 5 residents from the sample of 10 and supplemental sample of 3 reviewed for abuse and misappropriation of property (#A, D, E, H, I) and had the potential to affect all of the residents in the facility. Findings include: 1. Confidential interview with Resident #D, on 11/2/11 at 2:55 P.M., indicated, "the Administrator is snippy, rude and mean. I reported her to Hickory Creek. The Administrator is rude to everyone." Confidential interview with Employee #L, at 12:20 P.M. on 11/3/2011, indicated they were present and heard Resident #E crying and asking, " is that woman going to start yelling at me next?" During an interview with Resident #A on	F0226	F226 *The facility disagrees with the survey findings regarding this alleged deficiency and respectfully requests the face-to-face Informal Dispute Resolution process.* It is the standard of this facility to have developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. *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 direct supervisor interviewed Resident #D on November 2, 2011 and was basically told the same information by the resident. At no time during the meeting with the DO did Resident #D state the Administrator was verbally, non-verbally or mentally abusive to her or other residents; nor did she give any examples that would meet the definition of verbal or*	12/03/2011

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	11/2/2011 at 2:00 P.M., resident stated, "It can get very noisy around here, depending on who is working, whether it is loud or not. The Administrator is loud sometimes." On 11/1/2011 at 2:30 P.M., interview with Resident #I, the resident stated, "I heard yelling in the hall a couple of weeks ago. Not sure who it was, but I'm pretty 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		*mental abuse. Thus the Administrator's alleged interactions with her staff, per interview does not meet the intent of "verbal abuse" oral or gestured language that willfully included disparaging and derogatory terms to the residents or "mental abuse" including, but not limited to, humiliation, harassment, threats of punishment or deprivation as defined in the federal/state regulations and guidance to surveyors and nothing contained 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 facility believes that based upon the above provided documentation that a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation has not occurred and respectfully requests that this section of the survey citation be deleted from the record.* *Surveyor interview of Resident #A and the response does not satisfy the definition or meet the intent requirement of "verbal abuse" oral or gestured language that willfully included disparaging and derogatory terms to the residents or "mental abuse" including, but*	

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	155424	A. BUILDING 00 B. WING	11/03/2011

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	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 called the compliance complaint line on Friday, 10/27/2011, and the resident stated the Administrator was snippy. During the exit conference on 11/3/2011 at 5:04 P.M., the Administrator stated, "[Employee name] had not posted like I had asked him, happened several times, spoke to him in hall, I was frustrated, didn't raise my voice, that's what I recall, at no time did I yell, don't know who was around." On 11/3/2011 at 5:05 P.M., the facility Regional Operations Manager stated, "If this is the extent of the complaint, I think this is a stretch." 2. During the group interview with residents at 1:30 P.M. on 11/1/2011, the following residents indicated they had items missing: Resident #H had a wedding band missing. The resident indicated the wedding ring had not been replaced or found at this		*not limited to, humiliation, harassment, threats of punishment or deprivation as defined in the federal/state regulations and guidance to surveyors and nothing contained within this survey report substantiates this alleged activity.* *Based upon the above provided documentation a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did not occur and respectfully requests that this section of the survey citation be deleted from the record.* *Surveyor interview of Resident #I and the response does not satisfy the definition or meet the intent requirement of "verbal abuse" oral or gestured language that willfully included disparaging and derogatory terms to the residents or "mental abuse" including, but not limited to, humiliation, harassment, threats of punishment or deprivation as defined in the federal/state regulations and guidance to surveyors and nothing contained within this survey report substantiates this alleged activity.* *Based upon the above provided documentation that a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by*	

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	time. During an interview with the Social Services Director on 11/1/2011 at 2:30 P.M., regarding any allegations of misappropriation of funds or property and the process of investigation, the Social Services Director replied, "any staff member can help residents fill out concern and Administrator gets all grievances for investigation and then I get them for follow-up and have to give them back to Administrator to go in the grievance log book." "I do not keep any copies in my office, and these are not documented anywhere other than grievance forms." Interview with Resident #H on 11/2/2011 at 10:25 A.M., indicated about two months ago he had a ring missing and he reported it to the Social Services Director, and has received no feedback. He indicated he would like some resolve to the issue. Interview with the Social Services Director on 11/2/2011 at 10:43 A.M., regarding Resident #H's missing ring, indicated, "I don't recall him saying anything to me about it recently or before, but I would have filled out a grievance form and give it to the Administrator." "I would remember it if it was in the last		*federal / state regulation did not occurred and respectfully requests that this section of the survey citation be deleted from the record.* *Sometime around mid-October 2011 when the Administrator had a discussion with the Dietary Services Manager regarding the resident menu board. This discussion took place in front of the menu board which is in a hallway across from room #1. The Dietary Services Manager had on more than one occasion positioned the daily menus on the menu board incorrectly. The Administrator had addressed this on more than one occasion. On the day in question when the Administrator asked the Dietary Services Manager why he could not "hang this correctly" the Dietary Services Manager questioned the Administrator's direction. Although both employees admit there was some disagreement and frustration, at no time was the discussion directed toward any resident. At no time was the Administrator "screaming and yelling".* *On page 11 of the survey document, the title Regional Operations Manager is inaccurate as the correct title is Director of Operations, (DO) and the DO has been misquoted. During the telephone conversation with the Surveyor – TC, on 11-3-/11 at*	

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	155424	A. BUILDING 00 B. WING	11/03/2011

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	couple of weeks." The Social Services Director provided a blank "Resident / Family Concern Form" per request. On 11/2/2011 at 10:50 A.M., the Administrator was observed to enter Resident #H's room and asked about his missing ring, she began searching his room, and informed him they would be searching his room for the ring. During interview with Resident #H on 11/3/2011, he indicated that a grievance form was completed on 11/2/2011, and he is happy that the facility is looking into this issue. During a confidential interview with Employee #L, on 11/2/2011 at 11:48 A.M., the employee stated, "If I get a concern from resident, family, or staff, I notify the charge nurse and then I fill out a grievance form to be turned in to the Administrator." "If it is a big problem, I notify the DON and the Administrator immediately." "I fill out a grievance form for any missing items." Grievance Log dated 9/27/11, indicated family states wallet was in bedside table drawer, room has been searched, and wallet has not been found, staff interviewed no one was aware of the wallet or money." There were no staff		*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 that time. The DO stated that had she been informed on 11-2-11 the Administrator would have been placed on suspension. The DO did return to the facility to participate in the Exit Conference held on 11-3-11 at 5:04 P.M. The quote made by the "Regional Operations Manager" is taken out of context and does not reflect the nature of the discussion that took 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 incident she could recall. After listening to this discussion, the Director of Operations did state to the survey team that "if this is the extent of the complaint, I think this is a stretch.* *Resident #G asked to attend the group resident meeting, but was not identified on the Resident List as a resident to be interviewed. This resident's most recent MDS, a copy is provided, demonstrates a score of 10 on her BIMS*	

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	interviews identified with dates or times of their investigation. On 11/2/2011 at 4:30 P.M., any other investigations of concerns/missing items were requested to review from the Administrator. The Administrator returned at 4:35 P.M. on 11/2/2011 and stated, "I don't have any (investigations)." Confidential Interview with Employee #J on 11/1/2011 at 5:30 P.M., indicated she had talked with the Administrator regarding residents with money missing, but she wouldn't listen. "One of the residents called the Corporate Compliance line and someone from corporate called one of the department heads and that person immediately went to the Administrator. I didn't know who to call to help the residents." She indicated she called the Ombudsman and Adult Protective Services, and was advised to send a complaint anonymously to ISDH. She stated, "No, I did not call corporate office, because I didn't think it would help the residents." Review of "Hickory Creek Healthcare Foundation, Inc. Resident Mistreatment, Neglect, Abuse & Misappropriation of Property Administrative Policy & Procedure" provided by the Administrator on 10/31/2011 at 12:01 P.M., with Issue Date 12/1999, and last Revision Date:		*assessment. A score of 10 indicates cognitive impairment. The facility was unaware that Resident #G had voiced a concern of missing items because this was not reported to anyone at the time of the survey by the surveyor(s). It was when the survey document was received and reviewed by the Administrator that this concern was brought to the facility's attention. After investigation to determine the resident's identity, the Administrator interviewed Resident #G who stated that her wedding band and watch were missing. The resident's room was searched and the resident's watch was located in her bedside cabinet where it is always kept. Resident #G's daughter was contacted regarding the reported missing wedding band and resident's daughter indicated that her mother has never had her wedding band at the nursing home, that the wedding band is at the daughter's home for safekeeping. This incident, upon discovery by the facility upon receipt of the survey document was reported to the ISJH, although the facility does not believe the incident meets the Reportable Unusual Occurrences Policy in that the resident is confused, the watch was located in the bedside cabinet where it is always kept and per interview of the residents daughter, her mother's wedding band has never*	

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	9/10, indicated "Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property....J. Investigation: All reported incidents of alleged violations involving mistreatment, neglect, abuse....are to be reported to the Administrator immediately, investigated and reported per state and federal law....If the report of alleged abuse involves the facility Administrator, the person reporting the allegation will call the Director of Operations for the facility and/or the Corporate Compliance Call Line immediately...." This federal tag relates to complaint IN00099165. 3.1-28(a) 3.1-28(c) 3.1-28(d) 3.1-28(e)		*been at the facility. There was no deliberate misplacement, exploitation, or wrongful, temporary or permanent use of the ring without the resident's consent. In fact, there is no incident; no items were and never have been missing.* *Based upon the above provided documentation that a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did not occur and respectfully requests 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. After 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 26, 2011. The Administrator has been advised by the Director of 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 and procedure dealing with missing items, the resident was made*	

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			whole and the facility did not violate State or Federal guidelines dealing with missing items. *The facility contends that the first time management was 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 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 a while. When queried if Resident #H had told anyone the response was "I don't recall". Resident #H's wife indicated that Resident #H was going through his jewelry a few weeks ago and the ring was in a white jewelry bag. Resident #H's wife indicated she thinks Resident #H threw the white bag away before he took the ring out. Resident #H agreed with this version of events. With permission, Resident #H's jewelry box and dresser drawers were searched and the ring was not found. Resident #H 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 of jewelry. The facility is working with the*	

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			residents to inventory the jewelry box as a majority of these items are not listed on the facility Inventory Sheet. The facility has a Guardian Angel program in place consisting of frequent visits by Department Managers to their assigned residents. No one recalls Resident #H indicating that he had a missing ring until it was brought to the Administrators attention by the surveyor(s). This incident, upon being brought forth by the surveyor(s) was reported to the ISDH, although the facility does not believe the incident meets the Reportable Unusual Occurrences Policy in that per interview or Resident #H and his wife, it does not appear that there 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 belongings, and when the matter was brought to the facility's attention, it was handled in accordance with facility policy and procedure. *Based upon the above provided documentation that a violation of the facility's abuse protocol including that of misappropriation of resident property as defined by federal / state regulation did not occur and respectfully requests*	

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			that this section of the survey citation be deleted from the record. *Resident #F's family member reported a missing black wallet with roses on it which contained $32.00 to the Administrator on September 27, 2011. The family member indicated that wallet was in Resident #F's drawer on the left hand side, but he had not seen it for two months. According to the Administrator, no report of a missing sweater was made at this time. Resident #F has a diagnosis of dementia and was unable to provide any information regarding the wallet. The Administrator contacted Resident #F's family member on November 23 and family member indicated the sweater was missing a long time ago. Due to the time frames involved and Resident #F dementia 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 family on November 9, 2011. The facility agrees that this incident meets the state / federal regulations regarding possible misappropriation of resident property and the incident should have been reported to the ISDH per the Reportable Unusual Occurrences Policy.* *Resident #A through surveyor(s) interview on 11/2/11 at 2:00 P.M.*	

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			alleges that the Administrator disposed of her clothes and her 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 from at least eight other Hickory Creek nursing homes and approximately eight of Hickory Creek's home office staff all were at Hickory Creek at Columbus to perform the tasks of unloading the semi-truck, unpacking the furniture items, putting the beds together, removing the old furniture and replacing it with the new. After the conclusion of the furniture move-in, just before the supper meal, Resident #A voiced that she had some items missing. The Administrator followed-up with her and attempted to locate the items in her room without success. The Administrator was one of the individuals who earlier in the day during the furniture conversion assisted with putting things into the new wardrobe but told the resident she did not recall seeing any of the items the resident indicated were missing. The Administrator apologized to Resident #A and assured her that the search for the missing items	

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			would continue, but if the items could not be located, they would be replaced. On Friday, October 14, 2011 the Maintenance Man did a thorough search of the dumpster and found the missing items. Per interview with the Maintenance Supervisor by Hickory Creek's Vice President of 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 plastic bag 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. All these items belonged to Resident #A. The Administrator was scheduled off the following day – Friday, October 14, 2011, but was contacted by the Director of Nursing Services early in the A.M. and advised that Resident #A was still upset regarding the missing items even though they had been found. The Administrator came in to the facility to speak with Resident #A 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 to the ISDH because the facility	

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			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 a resident's belongings or money without the resident's consent. The report must be submitted within 24 hours after the preliminary investigation has determined that resident property or funds have been misappropriated. It is unfortunate that Resident #A's belongings got co-mingled with trash type items 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 Resident #A's belongings. In fact, the Administrator made an extraordinary effort in initially searching for the items upon discovery that they were missing and even came back to the facility on the morning. of a day she was scheduled off to console Resident #A and apologize that she had accidentally disposed of the items during the renovation of the resident's living quarters. *Based upon the above provided documentation that a violation of the facility's abuse protocol including that of misappropriation*	

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	155424	A. BUILDING 00 B. WING	11/03/2011

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			of resident property as defined by federal / state regulation did not occur and respectfully requests 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 not be limited to the resident's right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion and misappropriation of resident property and that employees of this facility are not to allow or participate in any verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion by December 3, 2011. Employees will be reminded during these re-in-services that this is the resident's home and that employees should be courteous and conscientious, that business matters need to be discussed in private in an office or non-resident care area and that staff should refrain from speaking loudly, or making excessive noise in resident care areas. The Director of Operations who is the Administrator's immediate supervisor will do one-on-one	

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	155424	A. BUILDING 00 B. WING	11/03/2011

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			documented re-training regarding Hickory Creek's Abuse Protocol, Hickory Creek's Resident Mistreatment, Neglect, Abuse & Misappropriation of Property Administrative Policy and Procedure, the federal regulations and interpretive guidelines at §483.13 et al, (F tags 223, 224, 225 & 226), and the Indiana State Department of Health – Division of Long Term Care Policy and Procedure regarding Reportable Unusual Occurrences. In addition, the Director of Operations will review with the Administrator regarding the importance of not conducting nursing home business which might result in disagreement with subordinates in a direct resident care area. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to be affected, but particularly those residents with dementia, who are confused, unable to freely communicate, have behavioral symptoms and totally dependent residents. What measures will be put into place to ensure this practice does not recur? During re-in-services, staff will be reminded that any allegation of	

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	155424	A. BUILDING 00 B. WING	11/03/2011

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			verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion, including misappropriation of resident's property must be reported immediately in accordance with the facility's abuse protocols and not reporting is also considered abuse / neglect. During routine Guardian Angel Rounds Department Managers will inquire with their assigned residents regarding the overall atmosphere of the nursing home and whether the resident has any concerns. Any identified concerns will be transferred to the Resident/Family Concern Form and the facility will follow its investigative protocol and grievance procedures. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Resident/Family Concern forms will be brought to the monthly QA Committee for review and further recommendations. This reporting will continue monthly for the next 90 days and then at least one time per quarter thereafter. In addition, the Director of Operations will review the Resident/Family Concern forms monthly for at least 90 days and will conduct random interviews with Residents and	

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			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 and federal / state regulations for the next 90 days, with quarterly reviews to follow thereafter.	

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to develop a care plan for a resident receiving an antiplatelet medication. This deficient practice affected 1 of 10 residents reviewed for care plans in a sample of 10. (Resident # 20) Findings include: Resident # 20's clinical record was reviewed on 11-1-11 at 9:35 a.m. His diagnoses included, but were not limited to, bilateral lower extremity paraplegia (paralysis), history of gastrointestinal (stomach) bleeding and anemia.	F0279	F279 Comprehensive Care Plans It is the standard of this facility to develop a care plan that includes measurable objectives to meet the resident's medical, nursing, mental and psychosocial needs, including medications that are ordered by the physician. What corrective action will be done by the facility? Resident #20 Plavix was care planned on 11/1/11. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?	11/07/2011

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	Review of Resident # 20's most recent recapitulation orders (physician orders), dated October 2011, indicated he was to receive Plavix 75 mg (milligrams) by mouth once daily. Review of his current care plans indicated a lack of any care plan related to the use of this antiplatelet medication, the potential side affects or monitoring of this medication. In interview with LPN # 1 on 11-1-11 at 11:47 a.m., she indicated there was not a care plan for the antiplatelet medication. 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)		An audit was completed on 11/7/11 on all residents who receive an antiplatelet medicine to ensure he or she had a current care plan in place. All resident's have a current care plan to address antiplatelet medicine use. However, if the DON or designee finds that a resident receiving antiplatelet medication does not have a care plan in place, she will bring that issue to the next scheduled interdisciplinary morning management meeting for review and development of an appropriate care plan with interventions recommended by the IDT team. Once that care plan has been developed and is in place, the DON will review the facility policy regarding the development of pertinent care plans for residents on antiplatelet medication with the staff involved. What measures will be put into place to ensure this practice does not recur? All resident orders will be reviewed at least 5 times a week by the Director of Nursing or designee. The results of this review will be shared with the Interdisplinary Team during the morning interdisciplinary management meeting that also occurs at least 5 times a week. Any identified issues will be	

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			addressed as indicated in question #2. The MDSC will then write a care plan for ordered medication, including any interventions that are a result of the interdisciplinary team discussion at the morning meeting. The care plan will be placed on that resident's chart at that time. The interdisciplinary team will continue to monitor care plans during the weekly care plan meeting and as physician order changes are received. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Director of Nursing or designee will monitor all new orders for residents at least 5 days a week New medication orders, including those for antiplatelet drugs, will be discussed with the interdisciplinary team as indicated above. The DON will bring the results of her reviews to the monthly QA Committee for review and further recommendations. This reporting will continue for the next 60 days and the QA Committee members may decide to stop the requirement for reporting results to them when 100% compliance has been reported. However, even when the QA Committee no longer wants to review this issue, the DON/designee's review of all new	

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			orders for residents and the processes outline previously will continue on an ongoing basis.	

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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, sanitary and comfortable environment to	12/08/2011

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	observation and during a dressing change. This deficient practice affected 1 of 1 resident observed during a dressing change (#20) and had the potential to affect all 35 residents of the facility. Findings include: The environmental observation was conducted on 11-1-11 between 1:40 p.m. and 2:10 p.m. with the Administrator and the Maintenance Supervisor. 1. During the observation of Bathroom #4 on 11-1-11 at 1:48 p.m., the Administrator was observed to run her ungloved hand over the toilet seat while demonstrating an area on the seat was a scratch. She was not observed to wash her hands after leaving Bathroom #4 and prior to entering Rooms 1, 3, 5, 7, Bathroom #2 and Bathroom #1. While in Rooms 1 and 5, the Administrator was observed to de-activate the call lights at the bedsides of the residents in those rooms with ungloved hands. Upon entering Bathroom #1 at 2:04 p.m., the Administrator was observed to remove a plastic trash bag of unknown waste from the room without the use of gloves. She was observed to return to Bathroom #1 without washing her hands after removing the unknown waste material. She was then observed to enter Room 9 without		prevent the development and transmission of disease and infection, including appropriate handwashing during administration of treatments. What corrective action will be done by the facility? The facility would like on record that the Administrator did not "run her ungloved hand over the toilet seat" on 11/1/11. When asked by the surveyor what an area was on the toilet seat the Administrator touched the area with her pointer finger on left hand. The administrator was inserviced on 11/16/11 regarding the facility hand washing policy and procedure. The administrator completed a handwashing skills checklist 11/16/11. LPN #1 was inserviced on 11/16/11 regarding the facility hand washing policy and procedure. LPN #1 completed a handwashing skills checklist on 11/16/11. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents have been affected by this practice. In the future if any staff, including the Administrator and LPN #1, is noticed to not wash their hands at appropriate times, they will be provided with re-education concerning the facility's policy and procedure for handwashing at that time. The staff involved in the inappropriate practice will also be asked to perform a return	

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	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 handwashing skills checklist until 100% compliance has been achieved. What measures will be put into place to ensure this practice does not recur? All staff were inserviced on hand washing on 11/16/11. Handwashing skills checklists will be completed on staff by 12/6/11. Licensed staff will be inserviced on appropriate handwashing during treatment administration as of by 12/9/11. The Director of Nursing will then conduct monthly hand washing skills observations with various staff members, including the Administrator and LPN #1 for a total of five staffmembers a month. Once staff members have been observed, the Director of Nursing will conduct quarterly handwashing skills observations on random staff, departments, and shifts for no less than 6 employees. Every nurse will be observed for handwashing during treatment administration by 12/9/11. Any identified issues will be addressed as indicated in question #2. How will corrective action be monitored to ensure the deficient practice does not recur 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 monthly meeting until all staff has been	

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	2. Resident # 20's clinical record was reviewed 11-1-11 at 9:35 a.m. His diagnoses included, but were not limited to, bilateral lower extremity paraplegia (paralysis), diabetes mellitus, malnutrition, and stage IV (deep/extensive) decubitus (bed sore). A dressing change observation was conducted with LPN #1 on 11-2-11 at 10:45 a.m. for 2 of 3 wounds for Resident #20. LPN #1 began by washing her hands and putting on clean gloves. She removed the old dressing from the wound on the left lower leg and proceeded to apply the new dressing without changing gloves or washing her hands. Later in the dressing change process, LPN #1 washed and dried her hands. She then noticed a needed item laying on the floor. She was observed to bend down and pick up the item. She was not observed to rewash her hands prior to opening a sterile package of gauze as she continued with her dressing change. Near the end of the dressing change, LPN		observed. When the DON starts her quarterly random handwashing observations, she will report those results quarterly to the QA Committee – this will continue on an ongoing basis. Date of Compliance:	

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	#1 was observed to remove her gloves and place them in the trash bag. She then proceeded to remove the trash bag from the container with ungloved hands and tie the bag up. She picked up the soiled linen with ungloved hands and placed the soiled linen in a trash bag and again tied it up. In interview with LPN #1 on 11-2-11 at 5:18 p.m. she indicated, "I can't think of anything I could have done different with hand washing or glove use. I bet I changed gloves at least 15 times." A policy entitled, "Handwashing/Alcohol-Based Hand Rub," with a revision date of 7-10, was provided by the Administrator on 11-2-11 at 10:15 a.m. This policy indicated, "Guidelines: The absolute indications for and the ideal frequency of handwashing are not known. However, in the absence of a true emergency, personnel should always wash their hands (even when gloves are worn):...After gloves are removed;...After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes (including oral and vaginal surfaces), blood and body fluids, secretions, or excretions, or items contaminated with these substances; After touching			

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	inanimate sources that are likely to be contaminated with virulent or epidemiologically important microorganisms (including urinary catheter components and containers used to collect and measure urine); When otherwise indicated to avoid transfer of microorganisms to other residents and environments; And when indicated between tasks and procedures on the same resident to prevent cross-contamination of different body sites;...Before and after each resident contact; After touching a resident or handling his/her belongings;..." 3.1-18(l)			