STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING _____ B. WING _____	**08/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HICKORY CREEK AT NEW CASTLE	**901 N 16TH STREET NEW CASTLE, IN 47362**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physical abuse by a contracted employee toward a resident did not occur for 1 of 3 residents reviewed for abuse. (Resident B, Contracted LPN 4) Findings include: In an interview on 8-27-20 at 5:30 a.m. with CNA 2, she indicated she was working with Contracted LPN 4 and CNA 3 on 3-23-20. She heard a loud noise, followed by screaming and crying between 2:00 a.m., to 2:30 a.m. She and CNA 2 went to investigate the noises and she observed Contracted LPN 4 grab Resident B by one arm above the elbow and jerk her out of the nurse's station. CNA 3 wasn't able to see her grab (name of Resident B) from her position, but I did. CNA 2 indicated she and CNA 3 immediately separated Contracted LPN 4 and Resident B, taking Resident B to the bathroom to inspect her for any injuries. CNA 2 observed a fingerprint-type bruising around the same location where she had observed the nurse grab the resident's arm above the elbow, as well as observing the hip area was slightly reddened. Resident B was crying and indicating her hip area hurt. The Administrator and Director of Nursing (DON) were called immediately to inform them of the situation, estimating the time of notification by phone at approximately 3:00 a.m. CNA 2 indicated Resident B's only complaint of pain was related to the hip area. She and CNA 3 ensured Resident B did not come in contact with Contracted LPN 4 while awaiting the arrival of the DON. In a written statement, dated 3-23-20, CNA 2 indicated on the same date at 2:17 a.m., she and co-worker, CNA 3, heard screaming and immediately got up to check who was screaming .heard a load (sic) slam that was a door and heard (name of Resident B) scream louder and start to cry. I started down the hall and I saw (name of Contracted LPN 4) grab (name of Resident B)'s arm and aggressively tried to pull her out of the nurse's station .took (name of Resident B) .to the bathroom and checked her out .was complaining of severe pain in her left leg and the way down and the middle of her back . In an interview with CNA 3 on 8-27-20 at 5:12 a.m., she indicated on 3-23-20 during a night shift, she was working with CNA 2 and Contracted LPN 4. She indicated she heard a loud noise, similar to a door slamming, followed by loud voices that she could not discern as to what was being spoken, as well as a scream. Upon investigation, CNA 3 and CNA 2 then found Resident B near the nurse's station. Resident B was removed from the presence of Contracted LPN 4 and taken to the bathroom to be checked for injuries. Resident B was able to walk to the bathroom with her. Some redness was observed to Resident B's arm, but her hip appeared normal. Resident B just said it (the hip) hurt .didn't say anything about her arm hurting. CNA 3 could not recall if the affected areas were on the right or left side. I immediately called the DON and Administrator . the DON came in and sent the nurse home. In a written statement, dated 3-23-20, CNA 3 indicated on the same date at 2:17 a.m., she heard a resident start screaming/crying and a loud band. I went to look and found (name of Resident B) standing by the nurse's station holding her hip. On my way to see what happened I could hard (sic) the nurse (name of Contracted LPN 4) yelling something at (name of Resident B), but I could not make out what she was saying. In a written statement, dated 3-23-20, Contracted LPN 4 indicated on 3-23-20 at approximately 2:00 a.m., Resident B was walking around, looking for food .given a (brand-name) candy bar which she asked for. She came behind the nurse's station looking for more food, touching a pizza box and grabbing other items on the counter. Writer asked client to stop and client was not easily redirected; writer assisted client from behind the nurse's station. Client was yelling, as she does yell frequently. Writer assisted client to sit on couch, as she continued to yell and swear. A reportable incident, filed by the facility and faxed to the Indiana State Department of Health on 3-23-20 at 10:24 a.m., indicated two night-shift CNAs witnessed Contracted LPN 4 grabbing Resident B by the arms and pull her out of the nurse's station. An assessment was conducted and identified three bruises, located to Resident B's left elbow, one measuring 1.8 by 1.5 centimeters (cm), a second one measuring 1.0 by 0.5 cm and a third one measuring 2.0 by 1.8 cm, plus a reddened area to the left wrist, with no documentation of pain or discomfort to the area. It indicated the resident complained of pain to the left hip and leg. The clinical record of Resident B was reviewed on 8-27-20 at 7:15 a.m. Her [DIAGNOSES REDACTED]. A significant change Minimum Data Set (MDS) assessment, dated 4-10-20, and a quarterly MDS assessment, dated 7-8-20, indicated she was severely cognitively impaired, but was able to understand and be understood. Review of Resident B's care plans for identified concerns related to wandering, attempting to assist other resident and then becoming upset when redirected, physical aggression toward peers, impaired cognition, dementia and risk for falls. On 8-27-20 at 6:12 a.m., the Administrator provided a copy of a policy entitled, Resident Mistreatment, Neglect, Abuse and Misappropriation of Property. This policy had a revision date of 6/2018 and was identified as the current policy utilized by the facility. This policy indicated, It is the policy of this facility that each resident will be free from any 'Abuse' .Physical Abuse: Includes hitting, slapping, pinching and kicking .spanking, slapping of hands, flicking or hitting with an object. Possible indicators of physical abuse include an injury that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time . This Federal tag relates to Complaint IN 991. 3.1-27(a)(1)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure policies and procedures developed to prevent abuse were implemented related to physical abuse of a contracted nursing employee towards a resident and not ensuring an allegation of abuse was reported to state agencies, including the Indiana State Department of Health (ISDH) within two hours of notification of the abuse allegation for 1 of 3 residents reviewed for abuse. (Resident B, Contracted LPN 4) Findings include: The clinical record of Resident B was reviewed on 8-27-20 at 7:15 a.m. Her [DIAGNOSES REDACTED]. A significant change Minimum Data Set (MDS) assessment, dated 4-10-20, and a quarterly MDS assessment, dated 7-8-20, indicated she was severely cognitively impaired, but was able to understand and be understood. Review of Resident B's care plans included, but were not limited to, identified concerns related to wandering, attempting to assist other resident and then becoming upset when redirected, physical aggression toward peers, impaired cognition, dementia and risk for falls. In an interview on 8-27-20 at 5:30 a.m. with CNA 2, she indicated she was working with Contracted LPN 4 and CNA 3 on 3-23-20. She heard a loud noise, followed by screaming and crying between 2:00 a.m., to 2:30 a.m. She and CNA 2 went to investigate the noises and she observed Contracted LPN 4 grab Resident B by one arm above the elbow and jerk her out of the nurse's station. CNA 3 wasn't able to see her grab (name of Resident B) from her position, but I did. CNA 2 indicated she and CNA 3 immediately separated Contracted LPN 4 and Resident B, taking Resident B to the bathroom to inspect her for any injuries. CNA 2 observed a fingerprint-type bruising around the same location where she had observed the nurse grab the resident's arm above the elbow, as well as observing the hip area was slightly reddened. Resident B was crying and indicating her hip area hurt. The Administrator and Director of Nursing (DON) were called immediately to inform them of the situation, estimating the time of notification by phone at approximately 3:00 a.m. CNA 2 indicated Resident B's only complaint of pain was

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

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) related to the hip area. She and CNA 3 ensured Resident B did not come in contact with Contracted LPN 4 while awaiting the arrival of the DON. In a written statement, dated 3-23-20, CNA 2 indicated on the same date at 2:17 a.m., she and co-worker, CNA 3, heard screaming and immediately got up to check who was screaming .heard a load (sic) slam that was a door and heard (name of Resident B) scream louder and start to cry. I started down the hall and I saw (name of Contracted LPN 4) grab (name of Resident B)'s arm and aggressively tried to pull her out of the nurse's station .took (name of Resident B) .to the bathroom and checked her out .was complaining of severe pain in her left leg and the way down and the middle of her back . In an interview with CNA 3 on 8-27-20 at 5:12 a.m., she indicated on 3-23-20 during a night shift, she was working with CNA 2 and Contracted LPN 4. She indicated there was a loud noise similar to a door slamming, followed by loud voices that she could not discern as to what was being spoken, as well as a scream. Upon investigation, CNA 3 and CNA 2 found Resident B near the nurse's station. CNA 3 indicated Resident B was removed from the presence of Contracted LPN 4 and taken to the bathroom to be checked for injuries. Resident B was able to walk to the bathroom with her. She observed some redness to Resident B's arm, but her hip appeared normal. Resident B just said it (the hip) hurt .didn't say anything about her arm hurting. CNA 3 could not recall if the affected areas were on the right or left side. I immediately called the DON and Administrator .DON came in and sent the nurse home. The Administrator and DON were notified of the incident by at approximately 3:00 a.m. In a written statement, dated 3-23-20, CNA 3 indicated on the same date at 2:17 a.m., she heard a resident start screaming/crying and a loud band. I went to look and found (name of Resident B) standing by the nurse's station holding her hip. On my way to see what happened I could hard (sic) the nurse (name of Contracted LPN 4) yelling something at (name of Resident B), but I could not make out what she was saying. In a written statement, dated 3-23-20, Contracted LPN 4 indicated on 3-23-20 at approximately 2:00 a.m., Resident B was walking around, looking for food .given a (brand-name) candy bar which she asked for. She came behind the nurse's station looking for more food, touching a pizza box and grabbing other items on the counter. Writer asked client to stop and client was not easily redirected; writer assisted client from behind the nurse's station. Client was yelling, as she does yell frequently. Writer assisted client to sit on couch, as she continued to yell and swear. A reportable incident filed by the facility was faxed to ISDH on 3-23-20 at 10:24 a.m. It identified the time of occurrence of the incident as 2:30 a.m. It indicated two night-shift CNAs witnessed Contracted LPN 4 grabbing Resident B by the arms and pull her out of the nurse's station. An assessment was conducted and identified three bruises, located to Resident B's left elbow, one measuring 1.8 by 1.5 centimeters (cm), a second one measuring 1.0 by 0.5 cm and a third one measuring 2.0 by 1.8 cm, plus a reddened area to the left wrist, with no documentation of pain or discomfort to the area. It indicated the resident complained of pain to the left hip and leg. In an interview with the Administrator on 8-27-20 at 8:40 a.m., she indicated she had no recollection of any type of allegations of verbal or physical abuse, prior to or since, of issues related to Resident B on 3-23-20, for Contracted LPN 4 or any other staff. She recalled submitting a reportable incident to ISDH and other state agencies on 3-23-20. She recalled the facility notified the staffing agency on the same date regarding the abuse allegation related to Contracted LPN 4 and to inform the staffing agency the facility will not allow Contracted LPN 4 to return to work. The Administrator indicated the facility did notify the state's professional licensing board in regard to the allegation of abuse with Contracted LPN 4. On 8-27-20 at 6:12 a.m., the Administrator provided a copy of a policy entitled, Resident Mistreatment, Neglect, Abuse and Misappropriation of Property. This policy had a revision date of 6/2018 and was identified as the current policy utilized by the facility. This policy indicates, It is the policy of this facility that each resident will be free from any 'Abuse' .Physical Abuse: Includes hitting, slapping, pinching and kicking .spanking, slapping of hands, flicking or hitting with an object. Possible indicators of physical abuse include an injury that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time .All reported incident of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source .are reported to the Administrator immediately and reported per state and federal law (typically within 24 hours of witness/identification) . On 8-27-20 at 6:46 a.m., the Administrator provided a copy of a policy entitled, Accident/Incident/Reportable/State Officials - Indiana. This policy had a revision date of 7/2015 and was identified as the current policy utilized by the facility. This policy indicates, This facility will make sure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of 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 & Certification Agency). The Administrator or designee will report all incidents, accidents, and other unusual occurrences to the Indiana State Department of Health (ISDH), in accordance with the ISDH, Division of Long Term Care, requirements as outlined in the 'Incident Reporting Policy,' effective 7-15-15 .The following are examples of occurrences that the Long Term Care Division at the Indiana State Department of Health considers reportable under both the state and federal regulations. These occurrences will be reported by the facility and will be tracked and monitored. Physical Abuse - a willful act against a resident by another resident, staff, or other individuals. Examples: hitting, beating, slapping, punching, shoving, spitting, striking with an object, pulling/twisting, squeezing, pinching, scratching, tripping, biting, burning, using overly hot/cold water, and/or improper use of restraints .An incident identified as mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property must be reported immediately after providing care and protection for the resident(s) and determining the incident meets the reporting criteria. This Federal tag relates to Complaint IN 991. 3.1-28(a) 3.1-28(c)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an allegation of abuse was reported to the Indiana State Department of Health (ISDH), within two hours of notification of the abuse allegation for 1 of 3 residents reviewed for abuse. (Resident B) Findings include: The clinical record of Resident B was reviewed on 8-27-20 at 7:15 a.m. Her [DIAGNOSES REDACTED]. A significant change Minimum Data Set (MDS) assessment, dated 4-10-20, and a quarterly MDS assessment, dated 7-8-20, indicated she was severely cognitively impaired, but was able to understand and be understood. In an interview on 8-27-20 at 5:30 a.m. with CNA 2 and an interview with CNA 3 on 8-27-20 at 5:12 a.m., each indicated they had notified the Administrator and Director of Nursing by phone of an allegation of physical abuse by Contracted LPN 4 towards Resident B on 3-23-20 at approximately 3:00 a.m. on 3-23-20. Written statements by CNA 2 and CNA 3, dated 3-23-20, indicated the time of occurrence of the allegation of physical abuse as 2:17 a.m. Review of a reportable incident filed by the facility, documented the report was faxed to ISDH on 3-23-20 at 10:24 a.m. It identified the time of occurrence of the allegation of abuse as 2:30 a.m. On 8-27-20 at 6:12 a.m., the Administrator provided a copy of a policy entitled, Resident Mistreatment, Neglect, Abuse and Misappropriation of Property. This policy had a revision date of 6/2018 and was identified as the current policy utilized by the facility. This policy indicates, It is the policy of this facility that each resident will be free from any 'Abuse' .Physical Abuse: Includes hitting, slapping, pinching and kicking .spanking, slapping of hands, flicking or hitting with an object. Possible indicators of physical abuse include an injury that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time .All reported incident of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source .are reported to the Administrator immediately and reported per state and federal law (typically within 24 hours of witness/identification) . On 8-27-20 at 6:46 a.m., the Administrator provided a copy of a policy entitled, Accident/ Incident/ Reportable/ State Officials - Indiana. This policy had a revision date of 7/2015 and was identified as the current policy utilized by the facility. This policy indicates, This facility will make sure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of 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 & Certification Agency). The Administrator or designee will report all incidents, accidents, and other unusual occurrences to the Indiana State Department of Health (ISDH), in accordance with the ISDH, Division of Long Term Care, requirements as outlined in the 'Incident Reporting Policy,' effective 7-15-15 .The following are examples of occurrences that the Long Term Care Division at the Indiana State Department of Health considers reportable under both the state and federal regulations. These occurrences will be reported by the facility and will be tracked and monitored. Physical Abuse - a willful act against a

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) resident by another resident, staff, or other individuals. Examples: hitting, beating, slapping, punching, shoving, spitting, striking with an object, pulling/twisting, squeezing, pinching, scratching, tripping, biting, burning, using overly hot/cold water, and/or improper use of restraints .An incident identified as mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property must be reported immediately after providing care and protection for the resident(s) and determining the incident meets the reporting criteria. This Federal tag relates to Complaint IN 991. 3.1-28(c)