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	155406	A. BUILDING 00 B. WING	10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT PERU	390 W BOULEVARD PERU, IN 46970

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 3, 4, 5, 6 and 10, 2023 Facility number: 000475 Provider number: 155406 AIM number: 100290540 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicare: 01 Medicaid: 21 Other: 9 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 10/18/2023.	F 0000	Hickory Creek Healthcare is requesting a face to face IDR review. Hickory Creek Healthcare requests evidentiary information be considered to reduce the scope and severity for F 864 from the 2567. The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after November 4, 2023.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status			

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

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	(that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility	F 0580	F 580	11/04/2023

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	failed to ensure a Resident with a history of constipation and ileus was assessed, medicated and had their physician notified of a lack of bowel movement after 5 days as a result the resident continued to experience bouts of constipation and nausea nad vomiting and was hospitalized 21 days later with a small bowel obstruction for 1 of 3 residents reviewed. (Resident 82) Finding includes: During an initial interview on 10/03/23 at 11:53 A.M., Resident 8 indicated she had recently been hospitalized for abdominal pain. See F684. A record review was completed on 10/05/23 at 9:09 A.M. Diagnoses included, but were not limited to: constipation, history of an ileus, gastroesophageal reflux disease, anemia, bilious vomiting, polycythemia vera, and abnormal weight loss. A Care Plan dated 6/10/2022, and revised 10/5/2023 at 9:52 A.M., indicated Resident 8 was at risk for constipation due to decreased mobility and medications. The goal was to have a soft formed bowel movement at least every three days. The interventions included for an abdominal assessment if no bowel movement for four days, bowel sounds, abdominal distension hyper/hypoactive bowel sounds, abdominal pain or tenderness, document and notify the physician of any abnormal findings, administer medications as ordered, encourage fluids, monitor bowel function, and notify the physician if no bowel movement after the third day. Resident 8's bowel movement record for June 2023, indicated the following: 6/1/2023 Medium		F580 Notify of Changes SS: D It is the policy of this facility to inform the resident, resident's responsible party, and physician of all resident changes. **1.What corrective actions will be accomplished for those residents found to have been effective by the deficient practice?** Resident 8 is the only resident identified by this practice. Resident 8 bowel movements are monitored, and physician will be contacted if resident experiences bouts of constipation and nausea. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents in this home have the potential to be affected, but no other resident has been identified as being affected by this practice. All resident's bowel movements have been monitored. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff were re-educated from 11/1/2023 through 11/4/2023 regarding Hickory Creek policies	

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	6/2/2023-6/6/2023 None (5 days, no treatment) 6/7/2023 Medium x 2 6/8/2023 Large 6/9/2023-6/10/2023 None (2 days) 6/11/2023 Medium 6/12/2023 None 6/13/2023 Large 6/14/2023-6/16/2023 None (3 days, no treatment) 6/17/2023 Large 6/18/2023 Medium 6/19/2023 Small 6/20/2023-6/21/2023 None (3 days, no treatment) 6/22/2023 Large 6/23/2023 Medium 6/24/2023 Medium 6/25/2023 Large x 2 6/26/2023-6/27/2023 (2 days) Resident 8 did not have any orders for routine bowel medications. She did have as needed medications of Milk of Magnesia suspension 400 milligrams per 5 milliliter give 30 milliliters daily for constipation, and loperamide 2 milligrams give 4 milligrams every four hours for loose stools. The Medication Administration Record for June 2023 indicated Resident 8 received loperamide 4 milligrams on 6/19/2023 at 12:07 P.M. for an unknown reason, 6/19/2023 at 6:11 P.M. for nausea and vomiting, 6/20/2023 at 2:56 P.M. for an upset stomach, and on 6/22/2023 at 9:42 A.M. for nausea and vomiting. Resident 8 received Milk of Magnesia 30 milliliters on 6/26/2023 at 2:39 P.M. for constipation. An SBAR (Situation, Background, Assessment, and Recommendation) form was completed on 6/27/2023 at 5:53 P.M., and indicated Resident 8 was lethargic and not talking clearly. Her skin was pale and warm. Her vital signs were blood		and procedures as well as state guidelines that outline notification of resident change of condition. Facility policy review held on 11/1/2023 through 11/4/2023 regarding the SBAR and Stop and Watch communication tools. Review of the facilities Hot Charting protocol and procedures. Updating the resident's care plan. Utilization of the facilities New Order Event policy. DNS/Designee will review 5 days a week record in Matrix to ensure resident have had bowel movements within the past 3 days. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.· CQI tool identified as Bowel Management will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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pressure 158/95, pulse 99, respirations 16, temperature 97.3, and oxygen saturation of 90%. The nurse's request was for a chest x-ray. No further assessment was documented.

A Progress Note on 6/27/2023 at 6:11 P.M., indicated a call was placed to the physician and updated on Resident 8's condition. A new order was obtained to send to the Emergency Department for evaluation and treatment.

An Emergency Room History & Physical report on 6/27/2023, indicated Resident 8 started to complain of some right lower quadrant abdominal pain a few days ago that progressively worsened with associated headache, decreased oral intake and nausea, but no vomiting. The abdominal assessment indicated soft, mild distension to the right lower quadrant with tenderness to palpate, and absent bowel sounds. Resident 8 was admitted to the hospital with a partial small bowel obstruction, right lower quadrant pain, and chronic constipation.

On 6/27/2023 at 7:56 P.M. a Computed Tomography scan was completed at the hospital. The results indicated, " ...Small bowel: Small bowel loops are mildly dilated and partially fluid-filled. There is a possible point in the right anterior pelvis. No bowel wall gas or free air. Colon: The sigmoid colon is filled with stool and was similar on the prior CT scan. Impression: 1. Findings consistent with early or partial small bowel obstruction. Small bowel loops are mildly dilated. Possible transition point in the right pelvis. No free air or bowel wall gas. 2. The sigmoid colon is filled with stool and could represent constipation ...."

During an interview with CNA 6 on 10/10/2023 at

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	10:40 A.M., CNA 6 indicated Resident 8 bowel movements can vary from constipation, loose stools, and sometimes Resident 8 stated she couldn't have a bowel movement at all. She indicated they document bowel movements every shift, informed the nurse if constipation or liquid diarrhea occurred, and informed the nurse if the resident requested a suppository or enema. On 10/10/2023 at 10:46 A.M., LPN 5 indicated the bowel protocol was to administer prune juice, Milk of Magnesia, a suppository, or enema if ordered after three days without a bowel movement and to notify the physician. The facility policy and procedure, titled, "Resident Change of Condition Policy," provided by the Director of Nursing on 10/10/2023 at 1:55 P.M. included the following: "...3. Non-Urgent Medical Change a. All symptoms and unusual signs will be documented in the medical recorded communicated to the attending physician promptly. Non-urgent changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening. b. The nurse in charge is responsible for notifications of physician and family/responsible party prior to the end of assigned shift when a significant change in the resident's condition is noted...." 3.1-5(a)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)			

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	and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the			

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	comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview, and record review the facility failed to care plan interventions for gastrointestinal reflux disease, tremors, and the use of an antidepressant for 1 of 5 residents reviewed. (Resident 24) Finding includes: A record review was completed on 10/6/2023 at 8:57 A.M. Diagnoses included, but were not limited to: systemic lupus erythematous, polyneuropathy, rheumatoid arthritis, depression, and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment on 9/6/2023 indicated Resident 24 received an antidepressant for seven days of the seven-day look back period. She had severe cognitive impairment. A review of Resident 24's medications indicated she received pantoprazole 40 milligrams daily for gastroesophageal reflux disease since 3/29/2023, benztropine 1.5 milligrams three times daily for tremors since 4/5/2023, and escitalopram oxalate 20 milligrams daily for depression since 7/29/2023. During an interview with the Director of Nursing on 10/10/2023 at 11:05 A.M., she indicated that the MDS (Minimum Data Set) Coordinator works in three buildings, so with the smaller building the Director of Nursing was responsible for making sure care plans were completed. On 10/10/2023 at 11:25 A.M., the Director of Nursing indicated that there were no care plans for gastroesophageal reflux disease, tremors, or	F 0656	F 656 F656 Development/Implement Comprehensive Care Plan It is the policy of this facility to develop and implement a Comprehensive Care Plan for all residents residing in the facility. **1.What corrective actions will be accomplished for those residents found to have been effective by the deficient practice?** Resident 24 is the only resident identified by this practice. Resident 24 care plan has been updated to include interventions for gastrointestinal reflux disease, tremors, and the use of antidepressants. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents in this facility have the potential to be affected, but no other resident has been identified as being affected by this practice. All residents care plans were reviewed to ensure care plans were present for gastrointestinal	11/04/2023

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	use of an antidepressant. A policy titled, "IDT [Interdisciplinary Team] Comprehensive Care Plan Policy", was provided by the Social Service Director on 10/4/2023 at 3:14 P.M. The policy indicated, " ..."Create an organized, resident-centered review on a routine basis to improve communication with residents, resident families, and/or representative regarding the resident goals, total health status, including functional status, nutritional status, rehabilitative and restorative potential, ability to participate in activities, cognitive status, psychosocial status, sensory and physical impairments, as well as care and services provided to maintain or restore health and well-being, improve functional level or relieve symptoms ...Improve relationships between resident, families and/or representative, and facility care givers through understanding of resident's social history, culture and preferences to enhance the resident's life ...Resident, resident's representative, or others as designated by resident will be invited to care plan review ...The care plan review may be conducted face to face, via phone conference, video conference, or through written communication per resident and/or representative preference ...." 3.1-35(e)		reflux disease, tremors and the use of antidepressants. No resident were identified. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff were re-educated on 10/18/2023 regarding Hickory Creek policies and procedures as well as state guidelines regarding the policy for residents Comprehensive Care Plans. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?** The Administrator, DON, and/or designee will review the residents current care plan 5 days a week and will remain on-going as a part of our clinical meeting to ensure if any resident has a new medical diagnosis or change of condition. And/or a change or update regarding the discontinuation of a medication, or service will be updated in the resident's care plan. The residents care plan will be updated accordingly. In addition, the Administrator, DON and /or designee will ensure all facility protocols were followed for a care plan change.	

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interviews, the facility failed to ensure care plan meetings, including the resident and/or their representative were conducted timely for 3 of 14 residents reviewed. (Resident 3, 11 and 27) Findings include: 1. The record for Resident 27 was reviewed on	F 0657	F 657 F 657 Care Plan Timing and Revision SS: D It is the policy of this facility to develop/implement/revise care plans according to the residents	11/04/2023

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	10/4/2023 at 1:26 P.M. Resident 27 was admitted to the facility on 7/21/2023 with diagnoses, including but not limited to: right lower quadrant abdominal swelling, mass and lump, Chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. The most recent Minimum Data Set (MDS) assessment, completed on 7/28/2023 for an initial admission assessment, indicated the resident was alert and oriented. During an interview with alert and oriented Resident 27, on 10/3/2023 at 11:31 A.M., the resident indicated she did not recall being invited to a care plan meeting. Review of the electronic record, including the observation documentation and the nursing progress notes indicated there was no care plan meeting summary notes. There were two "Transitions of care" meetings , dated 7/25/2023 and 8/1/2023 held but no care plan meeting held. The only meeting documented to have included the resident, was a "Road to Recovery" therapy meeting, held on 7/26/2023. The Transitions of Care meetings did not include all of the interdisciplinary department heads and did not include the resident and/or their representative. During an interview with the Administrator, on 10/10/2023 at 1:30 P.M., she indicated the "Road to Recovery" meeting was a therapy meeting and not a care plan meeting. During an interview with the MDS coordinator, on 10/10/2023 at 11:30 A.M., she indicated she was responsible for three buildings and was not		current level of care and function. **1.What corrective actions will be accomplished for those residents found to have been effective by the deficient practice?** Residents 3,11,27 identified by this practice and have had a care plan meeting with representative invited. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents in this home have the potential to be affected by this practice. All residents were checked to ensure a care plan meeting was held and family representatives were invited by 11/1/2023. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff were re-educated on 11/1/2023 through 11/4/2023 regarding Hickory Creek policies and procedures as well as state guidelines regarding timing and revision. Care Plan Timing and	

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	always available for resident care plan meetings. She indicated the care plan meetings were documented in the "Observation" section of the electronic record and were labeled "Care Plan Summary."2. During an interview with Resident 11 on 10/4/2023 at 9:04 A.M., Resident 11 indicated she does not have care plan meetings, and was not aware of the medications she received. A record review was completed on 10/4/2023 at 11:14 A.M. Diagnoses included history of malignant neoplasm of large intestines, heart failure, and chronic obstructive pulmonary disease. Care Plan Meeting Notes were identified for 2/17/2023 and 6/21/2023 with Resident 11 and her daughter in attendance. A Progress Note on 2/2/2023 at 11:13 A.M., indicated the Social Service Director spoke with Resident 11's daughter regarding a care plan meeting. On 6/19/2023 at 9:53 A.M., a Progress Note indicated Resident 11's daughter called and would schedule a care plan meeting after Resident 11's eye doctor appointment and the meeting was scheduled for 6/21/2023 at 1:00 P.M. During an interview on 10/4/2023 at 1:45 P.M., the Social Service Director indicated care plan meetings were completed with the Minimum Data Set (MDS) assessments. She indicated notification of the care plan meetings were documented in the progress notes. She indicated Resident 11 should have more than the two care meetings that were documented. A review of the MDS assessments indicated the		Revision. The Administrator will attend at minimum two care plan meetings per month, to ensure proper invitation of all parties involved, the content of the care plan along with documentation and care plan revision. The Administrator will also ensure the Interdisciplinary Team attends and participate in these care plan meetings. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Care Plan Review and Implementation will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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	155406	A. BUILDING 00 B. WING	10/10/2023

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	following assessments were completed: 8/16/2023 Annual 5/31/2023 Quarterly 3/8/2023 Quarterly 1/11/2023 Quarterly 10/19/2022 Annual 3. During an interview, on 10/3/2023 at 10:23 A.M., Resident 3 indicated she has not had a careplan meeting since admission. A record review was completed on, 10/4/2023 at 11:28 A.M., and indicated Resident 3's diagnoses included, but were not limited to: Hypertensive heart and chronic kidney disease with heart failure, Stage 5 chronic kidney disease/end stage renal disease, diabetes, arteriovenous fistula, hypotension, atrial fibrillation, bipolar II disorder, morbid obesity, anxiety, obstructive sleep apnea, and anemia in chronic kidney disease. A Quarterly MDS (Minimum Data Set) assessment, dated 8/16/2023 indicated Resident 3 has intact cognition. During an interview, on 10/04/2023 at 2:19 P.M., the Director of Nursing indicated the Resident had a careplan meeting in June and she should have had another one in September. On 10/10/2023, at 2:08 P.M., the Director of Nursing provided the policy titled,"IDT Comprehensive Care Plan Policy", dated 8/2023, and indicated the policy was the one currently used by the facility. The policy indicated"...Care plan review will be interdisciplinary and should include, to the extent possible, nursing, social services, activities, dietary, therapy, pharmacy, physician, direct care staff and hospice, if indicated. Resident, resident's representative, or others as designated by resident will be invited to the care plan review...."			

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	3.1-35(c)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a resident received care planned interventions during periods of constipation for 1 of 3 residents reviewed for bowel management (Resident 82)." Findings include: 1. During an initial interview on 10/03/23 at 11:53 A.M., Resident 8 indicated she had recently been hospitalized for abdominal pain. See F580. A record review was completed on 10/05/23 at 9:09 A.M. Diagnoses included, but were not limited to: constipation, history of an ileus, gastroesophageal reflux disease, anemia, bilious vomiting, polycythemia vera, and abnormal weight loss. A Care Plan dated 6/10/2022, and revised 10/5/2023 at 9:52 A.M., indicated Resident 8 was at risk for constipation due to decreased mobility and medications. The goal was to have a soft formed bowel movement at least every three days. The interventions included for an abdominal	F 0684	F 684 F 684 Quality of Care SS: G It is the policy of this facility to develop/implement/revise care plans according to the resident's change of condition. **1.What corrective actions will be accomplished for those residents found to have been effective by the deficient practice** Resident 8 is the only resident identified by this practice. 2. **How other residents having**	11/04/2023

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	assessment if no bowel movement for four days, bowel sounds, abdominal distension hyper/hypoactive bowel sounds, abdominal pain or tenderness, document and notify the physician of any abnormal findings, administer medications as ordered, encourage fluids, monitor bowel function, and notify the physician if no bowel movement after the third day. Resident 8's bowel movement record for June 2023, indicated the following: 6/1/2023 Medium 6/2/2023-6/6/2023 None (5 days, no treatment) 6/7/2023 Medium x 2 6/8/2023 Large 6/9/2023-6/10/2023 None (2 days) 6/11/2023 Medium 6/12/2023 None 6/13/2023 Large 6/14/2023-6/16/2023 None (3 days, no treatment) 6/17/2023 Large 6/18/2023 Medium 6/19/2023 Small 6/20/2023-6/21/2023 None (3 days, no treatment) 6/22/2023 Large 6/23/2023 Medium 6/24/2023 Medium 6/25/2023 Large x 2 6/26/2023-6/27/2023 (2 days) Resident 8 did not have any orders for routine bowel medications. She did have as needed medications of Milk of Magnesia suspension 400 milligrams per 5 milliliter give 30 milliliters daily for constipation, and loperamide 2 milligrams give 4 milligrams every four hours for loose stools. The Medication Administration Record for June 2023 indicated Resident 8 received loperamide 4 milligrams on 6/19/2023 at 12:07 P.M. for an		**the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents in this home have the potential to be affected by this practice. All resident records were reviewed for notification of change of condition to ensure all change of conditions were reported to the resident's physician, family member, care plan updated and appropriate measures initiated. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff were re-educated on 11/1/2023 through 11/4/2023 regarding Hickory Creek policies and procedures and use of interactive tools SBAR and Stop and Watch as well as state guidelines regarding change of condition and notification. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?**	

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	unknown reason, 6/19/2023 at 6:11 P.M. for nausea and vomiting, 6/20/2023 at 2:56 P.M. for an upset stomach, and on 6/22/2023 at 9:42 A.M. for nausea and vomiting. Resident 8 received Milk of Magnesia 30 milliliters on 6/26/2023 at 2:39 P.M. for constipation. An SBAR (Situation, Background, Assessment, and Recommendation) form was completed on 6/27/2023 at 5:53 P.M., and indicated Resident 8 was lethargic and not talking clearly. Her skin was pale and warm. Her vital signs were blood pressure 158/95, pulse 99, respirations 16, temperature 97.3, and oxygen saturation of 90%. The nurse's request was for a chest x-ray. No further assessment was documented. A Progress Note on 6/27/2023 at 6:11 P.M., indicated a call was placed to the physician and updated on Resident 8's condition. A new order was obtained to send to the Emergency Department for evaluation and treatment. An Emergency Room History & Physical report on 6/27/2023, indicated Resident 8 started to complain of some right lower quadrant abdominal pain a few days ago that progressively worsened with associated headache, decreased oral intake and nausea, but no vomiting. The abdominal assessment indicated soft, mild distension to the right lower quadrant with tenderness to palpate, and absent bowel sounds. Resident 8 was admitted to the hospital with a partial small bowel obstruction, right lower quadrant pain, and chronic constipation. On 6/27/2023 at 7:56 P.M. a Computed Tomography scan was completed at the hospital. The results indicated, " ...Small bowel: Small bowel loops are mildly dilated and partially fluid-filled.		Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Change of Condition will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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	There is a possible point in the right anterior pelvis. No bowel wall gas or free air. Colon: The sigmoid colon is filled with stool and was similar on the prior CT scan. Impression: 1. Findings consistent with early or partial small bowel obstruction. Small bowel loops are mildly dilated. Possible transition point in the right pelvis. No free air or bowel wall gas. 2. The sigmoid colon is filled with stool and could represent constipation ...." During an interview with CNA 6 on 10/10/2023 at 10:40 A.M., CNA 6 indicated Resident 8 bowel movements can vary from constipation, loose stools, and sometimes Resident 8 stated she couldn't have a bowel movement at all. She indicated they document bowel movements every shift, informed the nurse if constipation or liquid diarrhea occurred, and informed the nurse if the resident requested a suppository or enema. On 10/10/2023 at 10:46 A.M., LPN 5 indicated the bowel protocol was to administer prune juice, Milk of Magnesia, a suppository, or enema if ordered after three days without a bowel movement and to notify the physician. The facility policy and procedure, titled, "Resident Change of Condition Policy," provided by the Director of Nursing on 10/10/2023 at 1:55 P.M. included the following: "...3. Non-Urgent Medical Change a. All symptoms and unusual signs will be documented in the medical recorded communicated to the attending physician promptly. Non-urgent changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening. b. The nurse in charge is responsible for notifications of physician and family/responsible party prior to the end of			

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	assigned shift when a significant change in the resident's condition is noted...." 3.1-37			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and			

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	services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to follow through with physician recommendations for 1 of 1 residents reviewed for urinary tract infections. (Resident 11) Finding includes: During an interview with Resident 11 on 10/4/2023 at 9:07 A.M., she indicated that she recently was on an antibiotic for a urinary tract infection, and had frequent urinary tract infections. A record review was completed on 10/4/2023 at 11:14 A.M. Diagnoses included, but were not limited to: hematuria, overactive bladder, and constipation. A Quarterly Minimum Data Set (MDS) assessment on 8/16/2023, indicated Resident 11 was always incontinent of bladder and bowel. Resident 11 was cognitively intact. A review of Resident 11's urinalysis indicated the following: -On 1/24/2023 she was positive for a urinary tract infection with Citrobacter koseri (a bacteria). Sulfamethoxazole-trimethoprim (an antibiotic) 800-160 milligram twice daily for 7 days was prescribed. -On 3/24/2023 she was positive for a urinary tract infection with Proteus mirabils (a bacteria). Cephalexin (an antibiotic) 500 milligrams three times daily for seven days was prescribed. -On 4/20/2023 she had a negative urinalysis. -On 5/25/2023 she was positive for a urinary tract infection with Citrobacter koseri. Cephalexin 500 milligrams twice daily for five days was	F 0690	F Tag 690 F Tag 690 Bowel and Bladder Incontinence, Catheter, UTI. SS: D It is the policy of this facility to schedule all referred consultations to other health care providers as ordered. **1.What corrective actions will be accomplished for those residents found to have been effective by the deficient practice?** Resident 11 is the only resident identified by this practice. Resident 11 was referred to a urologist for further consult. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents in this home have the potential to be affected by this practice. All residents were reviewed to ensure physicians orders related to urinary tract infections by DNS/Designee. **3. What measures will be put into place and what systemic**	11/04/2023

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	prescribed. -On 7/22/2023 she had a negative urinalysis. A urology referral was requested by the nurse practitioner. -On 8/21/2023 she was positive for a urinary tract infection, bacteria unknown as page 2 of the urinalysis was not available. Cephalexin 500 milligrams twice daily for seven days was prescribed. A Nurse's Note on 4/6/2023 at 10:46 A.M., indicated the resident had blood in the urine, a urinalysis was collected and lab work completed. Resident 11 had a referral for urology consultation pending. On 4/10/2023 at 12:41 P.M., a Nurse's Note indicated a telephone call was made for a urology referral, and the receptionist indicated Medicaid was not accepted. A Urologist in the local area would be contacted. On 4/27/2023 at 12:45 P.M., a Nurse's Note indicated normal urinary ultrasound and lab work. The nurse practitioner indicated if changes occurred a referral to urology should be made. A Nurse Practitioner Note on 5/24/2023 at 2:30 P.M., indicated Resident 11 was being seen for blood in her brief, and nursing staff suspected it was coming from the bladder. The assessment/treatment plan indicated possible hematuria/hemorrhoids and if blood continued to have a urology consult. A Physician's Note on 7/5/2023 at 2:30 P.M., recorded as a late entry on 9/3/2023 at 3:06 P.M., indicated hematuria/hemorrhoids resolved, but if reocurred to send to urology.		**changes will be made to ensure that the deficient practice does not recur?** All nursing staff were re-educated on 11/1/2023 through 11/4/2023 regarding Hickory Creek policies and procedures as well as state guidelines regarding policy for Bowel and Bladder Program. The Administrator, DON, and/or designee will review all residents' medical record review for any recommendation for a specialty physician consultation. Any recommendation for a resident to have a consultation with a Specialty Physician from our Medical Director, Nurse Practitioner or other Health Care Professional will be acted upon. The residents responsible party will be notified of the need and given the option to attend consultation with the resident. Our Nurse Manager will assist or complete the consultation appointment for the resident and residents responsible party at their convenience as long as the suggested consultation is not of urgent nature. The Nurse Manager and/or designee will review weekly and will remain on-going that all recommended consultations are scheduled and occur at the discretion of the resident and responsible party. Ensure if the resident and or responsible party declines the	

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	A Nurse Practitioner Note on 7/19/2023 at 12:30 P.M., indicated Resident 11 was visited due to hematuria, and it was a reoccurrence of hematuria. Resident 11 had a history of urinary tract infections. The nurse practitioner spoke with the Director of Nursing (DON), and the DON was concerned that Resident 11's masturbating was causing injury. Resident 11 denied this practice during interview with the nurse practitioner. The assessment/plan indicated hematuria/hemorrhoids: urology referral, and collection of urine for a urinalysis with culture and sensitivity. On 7/24/2023 at 1:49 P.M., a Nurse's Note indicated the nurse practitioner was notified of urinalysis results, and to continue with the urology referral. A Care Plan initiated on 4/9/2023, and revised on 8/29/2023 at 11:13 A.M., indicated Resident 11 had chronic urinary tract infections and was at risk for future infections. During an interview on 10/10/2023 at 10:47 A.M., LPN 5 indicated Resident 11 had not had a urology consultation, and she believed Resident 11 did not want to go to the urologist. On 10/10/2023 at 10:49 A.M., Resident 11 indicated she wanted to see urology, and she believed she currently had another infection. She indicated she had an established urologist that she saw three to four years ago. A current policy titled, "Bowel and Bladder Program", was provided by the Director of Nursing on 10/10/2023 at 2:08 P.M. The policy indicated, " ...The care plan and resident profile must represent the appropriate program and		recommendation, the DON and or designee will provide education to the resident and or responsible party the value and importance to follow through with recommended consultation. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Consultation and Recommendations will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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	resident specific interventions ...." 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure respiratory equipment was stored properly for 1 of 1 resident reviewed for oxygen therapy. (Resident 182) Finding includes: During an observation on 10/3/2023 at 9:38 A.M. and at 1:02 P.M., the portable oxygen nasal cannula was lying on the floor under Resident 182's wheelchair, and the nebulizer mask was lying on the bedside table. On 10/4/2023 at 8:56 A.M., the portable oxygen nasal cannula was lying on the wheelchair seat. A record review was completed on 10/4/2023 at 2:31 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, anxiety disorder, and respiratory failure with hypoxia. Physician's Orders included oxygen at three liters	F 0695	Past noncompliance: No POC required.	10/23/2023

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	per nasal cannula continuously, and ipratropium-albuterol nebulizer solution 0.5 milligram-3 milligram give 3 milliliters via inhalation. A Care Plan indicated Resident 182 had symptoms of decreased oxygenation On 10/5/2023 at 9:57 A.M., and 10/6/2023 at 1:52 P.M., the portable oxygen nasal cannula was observed in a wash basin on the wheelchair cushion. During an interview on 10/10/2023 at 10:39 A.M., CNA 6 indicated nebulizer masks and nasal cannulas should be stored in a respiratory bag when not in use. A policy, titled "Oxygen Concentrator", was provided on 10/10/2023 at 2:08 P.M. by the Director of Nursing. The policy did not identify storage of oxygen equipment when not in use. 3.1-47(a)4 3.1-47(a)5 3.1-47(a)6			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician			

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HICKORY CREEK AT PERU	390 W BOULEVARD PERU, IN 46970

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	and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			
	Based on observation, record review and interview, the facility failed to ensure the physician responded timely to pharmacy recommendations for 1 of 5 residents reviewed for medication use. (Resident 4) Findings include:	F 0756	F Tag 756 F Tag 756 Drug Regimen Review SS: D It is the policy of this facility to monthly review residents drug regimen and act accordingly to	11/04/2023

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	The record for Resident 4 was reviewed on 10/4/2023 at 2:05 P.M. Resident 4 was admitted to the facility with diagnosis, including but not limited to: chronic obstructive pulmonary disease, systolic congestive heart failure, chronic respiratory failure with hypoxia, bipolar disorder and emphysema. The most recent MDS (Minimum Data Set) assessment for Resident 4, completed as a quarterly review on 7/5/2023, indicated the resident was alert and oriented and required the extensive assistance of one staff for bed mobility, ambulation needs, personal hygiene, dressing, and toileting needs. The current physician's orders for medications included adult low dose aspirin and plavix (a medication to prevent blood clotting). A pharmacy recommendation, dated March 1, 2023, recommended the physician consider discontinuing either the aspirin or the Plavix. The physician did not respond to the recommendation until 6/7/2023. During an interview with the Director of Nursing, on 10/10/2023 at 10:30 A.M., she indicated the facility policy was to have the physician address the pharmacy recommendations within 30 days. The facility policy and procedure, titled, "LTC (Long Term Care) Facility's Pharmacy Services and Procedures Manual" included the following: "...11. The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days per applicable regulation..."		Pharmacy recommendations with attending physician involvement. **1.What corrective actions will be accomplished for those residents found to have been effective by the deficient practice?** Resident 4 is the only resident identified by this practice. There are no additional pharmacy recommendations for this resident. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents in this facility have the potential to be affected by this practice. All resident pharmacy recommendations were reviewed to ensure pharmacy recommendations were reviewed by the MD. The Director of Nursing received education on 11/2/2023 and Medical Director received education on 11/2/2023 regarding timely review of Pharmacy recommendations. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**	

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	3.1-25(h)		Administrator, DON, facility Medical Director, and/or designee will monthly review all Pharmacy recommendations. Policy review will be held with facility Medical Director on 11/2/2023 whereas the facility clinical team along with Medical Director will have full knowledge of facility policy regarding Pharmacy recommendations. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Development & Implement Comprehensive Care Plan will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance	

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F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure food items in the freezer were dated/labeled with used by dates, dispose of expired foods, and failed to ensure the dishwasher, freezer, and toaster were clean and in good condition in the main kitchen. This deficient practice had the potential to affect 31 of 31 residents who received meals out of the kitchen. Findings include: During an observation of the kitchen on 10/03/2023 at 9:34 A.M., with Dietary Staff 9, the following was observed:	F 0812	F Tag 812 F Tag 812 Food Procurement, Store/Prepare/Serve-Sanitary SS: F **1.What corrective actions will be accomplished for those residents found to have been effective by the deficient practice?** No specific resident was identified by this practice. The food items listed were disposed of – frozen	11/04/2023

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	-The freezer had a zip lock bag of diced potatoes undated, a bag of frozen biscuits with a use by date of 7/14/23, an open bag of frozen fish filets with no use by date. -The refrigerator had 3 bowls of cream of wheat undated, an undated bowl of gravy, an undated bowl of mashed potatoes, an undated unopened bag of bologna, and an opened pack of gravy mix with no use by date. - The following spices were noted on the shelf and undated: garden seasoning, baking powder, parsley flakes and ground cinnamon. -The shelf and wall above the stove was covered in a grease like substance. -The top of the dishwasher was dirty and covered in crumbs. -The toaster had a dry substance around the knobs. -The bottom freezer shelf was covered in grit. During an interview, on 10/03/2023 at 10:01 A.M., Dietary Staff 9 indicated the undated items should have dates on them, the expired items should have been thrown away and the wall, shelf, dishwasher, toaster and bottom freezer shelf should have been cleaned. On 10/5/2023 at 12:35 P.M., the Executive Director provided the current policy titled, "Cleaning Freezers", dated 2/02. The policy indicated"...Freezers will be kept clean and free of ice buildup. 2. Freezer racks and walls will be deep cleaned as needed. 3. Wash shelves and walls with sudsy water. Rinse and sanitize using sanitizing solution. Allow to air dry...." On 10/5/2023 at 12:35 P.M., the Executive Director provided the policy titled, "Cleaning Toaster", dated 2/02. The policy indicated "...The toaster will be cleaned after each use...."		biscuits, frozen fish filets, bowls of cream of wheat, bowl of gravy bowl of mashed potatoes, bologna, gravy mix, garden seasoning, baking powder, parsley flakes. The shelf, dishwasher, toaster and freezer were cleaned. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents in this facility have the potential to be affected by this practice. All areas of the kitchen were deep cleaned and inspected on October 26, 2023. All food items were inspected to ensure appropriate labeled by 11/4/2023. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Culinary Manager will conduct an all staff in-service for all Culinary team members on 10/20/2023. Policy reviews will be labeling/dating and food storage along with food preparation. Culinary manager/designee will conduct audits to ensure appropriate cleaning and food labeling is present.	

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	On 10/5/2023 at 12:35 P.M., the Executive Director provided the policy titled, "Labeling and Dating", dated 5/18. The policy indicated"...Processed meats and any item that has been cooked and cooled should be kept no longer than 3 days. Label with the date of storage and the date of discard. The date the product must be consumed or discarded may not exceed the manufacturer's use by date...." 3.1-21(i)(3)		**4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Daily AM Culinary Check List will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	