STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155430	A. BUILDING 00 B. WING	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT ROCHESTER	340 E 18TH STREET ROCHESTER, IN 46975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00455366. Complaint IN00455366 - Federal deficiencies related to the allegations are cited at F609 & F842 Survey dates: April 15, 2025 Facility number: 000326 Provider number: 155430 AIM number: 100290770 Census Bed Type: SNF/NF: 27 Total: 27 Census Payor Type: Medicare: 1 Medicaid: 18 Other: 8 Total: 27 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 4/22/2025	F 0000		
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on record review and interview, the facility failed to ensure an allegation of misappropriation of resident property was reported to the appropriate state agency for 1 of 2 residents reviewed for misappropriation of resident property. (Resident E)	F 0609	We are requesting paper compliance. **F 609 Reporting of Alleged Violations** **What corrective action(s) will be accomplished for those**	05/04/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tommi Pruitt	Executive Director	04/30/2025

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

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	Finding includes: During an interview, on 4/15/2025 at 2:35 P.M., the Regional Director of Clinical Services (RDCS) indicated she had received a call from a facility nurse, on 3/8/2025, concerning an allegation of another nurse taking antibiotic medications from the medication room. The RDCS indicated there had been an investigation concerning the antibiotic medication, and tas a result of the investigation, it was determined an antibiotic medication had been signed off every day as being administered to Resident F. The RDCS indicated there was no confirmed misappropriation of medication as a result of the investigation. During an interview, on 4/15/2025 at 3:30 P.M., the Administrator indicated she had not reported the allegation of misappropriation to the state because the result of the investigation was antibiotic medication for Resident F had been signed for and the resident had received all ordered doses of the antibiotic. During an interview, on 4/15/2025 at 3:32 P.M., the RDCS indicated no other residents on antibiotics were investigated because the allegation had described description of the container the facility nurse had given her only matched Resident F's medications. On 4/15/2025 at 3:42 P.M., the RDCS provided the policy titled, "Long-Term Care Abuse and Reporting Policy" , dated 12/8/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... 9. Misappropriation of resident property: Misappropriation of resident property means the deliberate misplacement, exploitation,		**residents found to have been affected by the deficient practice?** All reports of alleged abuse will be reported to ISDH timely and investigated. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All residents will be interviewed utilizing the QIS interview to assess signs and or symptoms of any type of abuse, if any type of abuse, if any allegations arose, reported to ISDH per policy. All staff in-service to conducted by the ED/designee by on Abuse Prohibition, Reporting and Investigation Policy and Procedures. Any allegations of abuse will be reported to the Executive Director immediately, reported to ISDH and investigated. **What measures will be put into place of what systemic changes you will make to ensure that the deficient practice does not recur?** All staff in-service by the ED of designee on abuse Prohibition, Reporting and Investigation Policy and Procedures. Home office support staff in serviced the ED and DNS on	

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	or wrongful, temporary, or permanent use of a residents belongings or money without the resident's consent... Abuse and incidents will be reported and submitted to the Indiana Department of Health in compliance with federal regulations and/or state rules and this policy, as applicable... B. Types of Incidents Reportable Under Federal and State Rules... 12. Misappropriation of resident property/exploitation...iii. Missing prescription medications...." This citation relates to Complaint IN00455366 3.1-38(c)		abuse policy including reporting and investigation Reporting – Reporting pending investigation immediately and at the conclusion of the investigation will be reported to ISDH Care Companion Managers will interview residents to ensure proper care and treatment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?** The ED/Designee will be responsible for the completion of the Abuse Prohibition and Investigation QA Tool weekly times 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow- up Compliance date 5/4/2025	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure medication destruction form was completed for a resident that was hospitalized for 1 of 3 residents reviewed for medications. (Resident E) Finding includes: On 4/15/2025 at 11:48 A.M., the Regional Director of Clinical Services (RDCS) provided a	F 0842	We are requesting paper compliance. **F 842 Resident Records** It is the practice of this facility to ensure resident records maintained in a complete, accurate, organized and accessible manor. **What corrective action(s) will**	05/04/2025

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	Surveillance Log of Resident Infections and Antibiotic Use form, dated February 2025. The form indicated Resident E had a wound infection with an onset date of 2/17/2025. An antibiotic, Augmentin 875/125 mg (milligram) was ordered with a start date of 2/17/2025 and a stop dated of 2/27/2025. The record for Resident E was reviewed on 4/15/2025 at 2:00 P.M. Diagnoses included, but were not limited to paraplegia, psychosis, hypertension and fusion of the spine. A Physician's Order, dated 2/17/2025, indicated Resident E was to receive Amoxicillian-Clauvulante (Augmentin), an antibiotic, 875/125 mg 1 tablet twice a day for 20 doses. The Medication Administration Record (MAR) for February 2025 indicated Resident E had received the first dose of Augmentin on 2/17/2025 at 8:00 P.M. He had received another 13 doses from 2/18/2025 through 2/23/2025, and had refused the morning dose on 2/24/2025. Resident E was admitted to the hospital on 2/24/2025 and did not return until 3/7/2025. The current physician's orders did not include the Augmentin order. There should have been 6 remaining tablets that had not been administered of the antibiotic for Resident E. Resident E's record lacked the documentation to show a Drug Disposition form had been completed for the remaining antibiotic pills. During an interview, on 4/15/2025 at 2:21 P.M., RN		**be accomplished for those residents found to have been affected by the deficient practice?** Documentation for affected resident cannot be corrected. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. A facility audit will be completed by DNS/designee for all residents' medication administration. All residents identified in this audit will be reviewed and ensure medication administration has been completed as ordered. **What measures will be put into place of what systemic changes you will make to ensure that the deficient practice does not recur?** The DNS/designee will in-service the nursing staff on medication administration on or before 4/28/2025. **How the corrective action(s) 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 through the facility Quality Assurance and Performance Improvement Program (QAPI). The	

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	2 indicated if the nurses documented correctly, they should have filled out a drug destruction sheet and placed the form in the pharmacy bag, along with the medication. A copy of the form should have gone to the medical records staff so she could have scanned the form into the electronic chart. RN 2 checked the forms yet to be scanned into the records, but there were no sheets yet to be scanned in for Resident E. In addition, there were no scanned forms in Resident E's electronic chart for the mediction disposition. The medication cart holding Resident E's medications was observed, on 4/15/2025 at 2:00 P.M. and no antibiotic medications were located in the cart for Resident E. During an interview, on 4/15/2025 at 2:28 P.M., the Director of Nursing indicated there were no forms that needed to be scanned into charts at this time. The RDCS indicated she had completed some drug destructions recently but she could not provide a drug destruction sheet for Resident E's remaining Augmentin tablets. On 4/15/2025 at 3:40 P.M., the RDCS provided the policy titled, " Drug Disposition Policy", dated 11.2024, and indicated the policy was the one currently used by the facility. The policy indicated "...This policy provides procedural guidance on how to properly destroy, return or waste medications and document disposition of those medications... 1. When a non-controlled substance or medication is discontinued by physician's order it will be removed from the medication cart at time of order and placed in the designated location in the locked medication room. 2. The discontinued items need to either be destroyed or sent back to the pharmacy within 7 days via [name of pharmacy]...."		DNS/designee will be responsible for completing the QAPI Audit tool 'Medication storage" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow-up. **By what date the systemic changes will be completed**: Compliance Date: 5/04/2025	

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	This citation relates to Complaint IN00455366. 3.1-50(a)			