(EACH DEFICIEN REGULATORY O is visit was for a censure Survey. vestigation of Co mplaint IN0038 k of evidence.	ENSBURG T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION A Recertification and State This visit included the omplaint IN00388344. 18344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022 00244	r í	ILDING NG STREET 7 1620 N GREEN ID PREFIX TAG	ADDRESS, CITY, STATE, ZIP COD LINCOLN ST SBURG, IN 47240 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY) This Plan of Correction cons the written allegation of compliance for deficiencies of However, submission of this of Correction is not an admis that a deficiency exists or tha was cited correctly. This Plan	e RATE titutes cited. Plan ssion	
IDER OR SUPPLIE REEK AT GRE SUMMARY (EACH DEFICIEN REGULATORY O is visit was for a censure Survey. vestigation of Co mplaint IN0038 k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	155353 R ENSBURG STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION A Recertification and State This visit included the omplaint IN00388344. 8344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022 00244	B. WI	NG STREET / 1620 N GREEN ID PREFIX TAG	ADDRESS, CITY, STATE, ZIP COD LINCOLN ST NSBURG, IN 47240 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY) This Plan of Correction cons the written allegation of compliance for deficiencies of However, submission of this of Correction is not an admiss that a deficiency exists or that was cited correctly. This Plan	09/08	(X5) COMPLETION
REEK AT GRE SUMMARY (EACH DEFICIEN REGULATORY O is visit was for a censure Survey. vestigation of Co mplaint IN0038 k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	R ENSBURG STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION A Recertification and State This visit included the omplaint IN00388344. 8344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022 00244		STREET / 1620 N GREEN ID PREFIX TAG	LINCOLN ST SBURG, IN 47240	e RATE titutes cited. Plan ssion	(X5) COMPLETION
REEK AT GRE SUMMARY (EACH DEFICIEN REGULATORY O is visit was for a censure Survey. vestigation of Co mplaint IN0038 k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	ENSBURG T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION A Recertification and State This visit included the omplaint IN00388344. 18344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022 00244	F 00	1620 N GREEN ID PREFIX TAG	LINCOLN ST SBURG, IN 47240	titutes cited. Plan ssion	COMPLETION
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(EACH DEFICIEN <u>REGULATORY O</u> is visit was for a censure Survey. vestigation of Co mplaint IN0038 k of evidence. rvey dates: Sept cility number: 0 povider number: 1	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION A Recertification and State This visit included the omplaint IN00388344. 8344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022 00244	F 00	PREFIX TAG	This Plan of Correction cons the written allegation of compliance for deficiencies of However, submission of this of Correction is not an admis that a deficiency exists or tha was cited correctly. This Plan	titutes cited. Plan ssion	COMPLETION
REGULATORY O is visit was for a censure Survey. vestigation of Co mplaint IN0038 k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	R LSC IDENTIFYING INFORMATION a Recertification and State This visit included the omplaint IN00388344. 8344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022	F 00	TAG	This Plan of Correction cons the written allegation of compliance for deficiencies of However, submission of this of Correction is not an admis that a deficiency exists or tha was cited correctly. This Plan	titutes cited. Plan ssion	
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censure Survey. vestigation of Co mplaint IN0038 k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	This visit included the omplaint IN00388344. 8344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022 00244	F 00	000	the written allegation of compliance for deficiencies of However, submission of this of Correction is not an admis that a deficiency exists or tha was cited correctly. This Plan	cited. Plan ssion	
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censure Survey. vestigation of Co mplaint IN0038 k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	This visit included the omplaint IN00388344. 8344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022 00244	F 00	000	the written allegation of compliance for deficiencies of However, submission of this of Correction is not an admis that a deficiency exists or tha was cited correctly. This Plan	cited. Plan ssion	
censure Survey. vestigation of Co mplaint IN0038 k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	This visit included the omplaint IN00388344. 8344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022 00244	1 00		the written allegation of compliance for deficiencies of However, submission of this of Correction is not an admis that a deficiency exists or tha was cited correctly. This Plan	cited. Plan ssion	
vestigation of Co mplaint IN0038 k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	omplaint IN00388344. 8344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022 00244			compliance for deficiencies of However, submission of this of Correction is not an admis that a deficiency exists or tha was cited correctly. This Plan	Plan ssion	
mplaint IN0038 k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	8344 - Unsubstantiated due to ember 1, 2, 6, 7, and 8, 2022 00244			However, submission of this of Correction is not an admis that a deficiency exists or tha was cited correctly. This Plan	Plan ssion	
k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	ember 1, 2, 6, 7, and 8, 2022 00244			of Correction is not an admis that a deficiency exists or tha was cited correctly. This Plan	ssion	
k of evidence. rvey dates: Sept cility number: 0 ovider number: 1	ember 1, 2, 6, 7, and 8, 2022 00244			that a deficiency exists or the was cited correctly. This Plan		
cility number: 0	00244			was cited correctly. This Plan		
cility number: 0	00244			-	n of	
ovider number:				Correction is submitted to me		
ovider number:				requirements established by	State	
				and Federal law.		
M number 100	155353					
wi number: 1002	288790					
nsus Bed Type:						
IF/NF: 29						
tal: 29						
nsus Payor Type	ð:					
edicare: 4						
edicaid: 21						
her: 4						
tal: 29						
ese deficiencies	reflect State findings cited in					
	10 IAC 16.2-3.1.					
ality review cor	npleted on September 14, 2022.					
3.12						
ee from Misapp	propriation/Exploitation					
83.12	· ·					
	the right to be free from					
	-					
perty, and exp	loitation as defined in this					
· ,	ludes but is not limited to					
bpart. This inc						
3. 8; e	12 e from Misapp 3.12 resident has se, neglect, m perty, and exp	e from Misappropriation/Exploitation 3.12 resident has the right to be free from se, neglect, misappropriation of resident perty, and exploitation as defined in this part. This includes but is not limited to dom from corporal punishment,	12 e from Misappropriation/Exploitation 3.12 resident has the right to be free from se, neglect, misappropriation of resident perty, and exploitation as defined in this part. This includes but is not limited to dom from corporal punishment,	12 e from Misappropriation/Exploitation 3.12 resident has the right to be free from se, neglect, misappropriation of resident perty, and exploitation as defined in this part. This includes but is not limited to	12 e from Misappropriation/Exploitation 3.12 resident has the right to be free from se, neglect, misappropriation of resident perty, and exploitation as defined in this part. This includes but is not limited to dom from corporal punishment,	12 e from Misappropriation/Exploitation 3.12 resident has the right to be free from se, neglect, misappropriation of resident perty, and exploitation as defined in this part. This includes but is not limited to dom from corporal punishment,

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

TITLE

000244

(X6) DATE

PRINTED: 10/14/2022

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.

Event ID: 58Z011

1 Facility ID:

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	.ETED
		155353	B. WI	NG		09/08	/2022
AME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
	Y CREEK AT GRE				I LINCOLN ST NSBURG, IN 47240		
X4) ID		STATEMENT OF DEFICIENCIE		ID			(¥5)
REFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
	ί.	R LSC IDENTIFYING INFORMATION			CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	
TAG			_	TAG			DATE
		t not required to treat the					
	resident's medica		-				10/07/000
		eview and interview, the facility	F 06	602	It is the standard of this facili	-	10/07/2022
		nisappropriation of resident			to prevent misappropriation of	of	
		of 11 residents reviewed.			resident medications.		
	(Resident 9)				1)		
					What corrective action will		
	Findings include:				be accomplished for those		
					residents found to have been		
		ble Incident, dated 08/16/22,			affected by the deficient prac	tic	
	indicated Resident	9 was missing his Xanax (a			e?		
	controlled substan	ce anxiety medication) from a			The pharmacy and physician w	vere	
	locked medication	cart. The medication carts were			notified of the missing medicati	ion	
	searched without r	esults, the nurses were			and a new prescription was		
	questioned on delivery. The pharmacy and				obtained. The local police		
	physician were not			department was notified and a			
	was obtained. The			report was filed. Resident #9's	5		
	notified, and a rep			medication was replaced by the	е		
	was replaced by th	e facility and a suspected			facility and the suspected		
	employee was term	ninated.			employee was terminated.		
					2)		
	A Pharmacy Deliv	ery Receipt, dated 08/07/22,			How other residents having		
	indicated a count of	of 60, 1 mg (milligram) tablets of			the potential to be affected by	v t	
		t 9 were delivered to the facility			he	-	
	and signed by an F	-			same deficient practice will b	е	
	0,				identified and what corrective		
	During an intervie	w on 09/06/22 at 2:48 P.M., the			action(s) will be taken.		
	-	cated she had been notified that			All residents receiving controlle	ed	
		issing two pill packs with 30			substances had the potential to		
		k, of his Xanax. Herself, the			affected, a controlled substanc		
	-	Nursing), and ADON (Assistant			audit was completed. No other		
		g) had all looked for the cards of			residents were found to be	•	
		ould not find them. Upon			affected.		
		nedications were ordered and			Staff were interviewed by		
		pharmacy. The narcotic count			ED/Designee regarding the		
		g but was able to locate the			missing medication with no res	ulte	
		had signed for the delivery of			identified.	ano	
		he DON had spoken with RN 5,				udit	
	and she said she no	-			DNS/Designee completed an a of all controlled substance to	auult	
		-				oro	
	medications. The I	ocal police were called, and a			ensure all other medications w	ele	

NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COME	e survey pleted 8/2022
PROVIDER OR SUPPLIE		1620 N	ADDRESS, CITY, STATE, ZIP COI I LINCOLN ST NSBURG, IN 47240)	
Y CREEK AT GRE SUMMARY (EACH DEFICIE REGULATORY O report was filed. A and filled for the r no show for her ne let go. There were discrepancies in th not harmed. The current facility Prohibition, Repor revised date of Fet the DON on 09/06 "Provide guideli abuse, neglect, exp misappropriation o each resident with from abuse, neglec property, and expl Resident Fund or I misplacement, exp			A LINCOLN ST NSBURG, IN 47240 PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY) available as prescribed. The DON or designee re the facility nurses on the Prohibition, Reporting, at Investigation Policy relate misappropriation of reside property." 3) What measures will be into place or what syste changes will be made to e that the deficient praction not recur? The DON or designee in- facility nurses on the "Ab Prohibition, Reporting, at Investigation Policy relate misappropriation of reside property." DON or designee in- facility nurses on the "Ab Prohibition, Reporting, at Investigation Policy relate misappropriation of reside property." DON or design complete daily controlled substance checks to ensise controlled substances are accounted for properly we delivered. 4) How the corrective action will be monitored to ensise DNS/Designee will comp	-educated "Abuse nd ed to lent put emic o ensur ce does -serviced ouse nd ed to lent nee will lent ure e being then on(s) sure the ot recur rance o place?	(X5) COMPLETIC DATE
		daily controlled substance verification for one month then monthly for 5 month nurse manager or design controlled substance del verification CQI audit too	e delivery h, and hs by a hee. The ivery		

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	COMP) date survey completed 09/08/2022	
	PROVIDER OR SUPPLIE		1620	T ADDRESS, CITY, STATE, ZIP COD N LINCOLN ST ENSBURG, IN 47240			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	^{BE} PRIATE	(X5) COMPLETION DATE	
				audit tool will be reviewed r by the CQI Committee for s months after which the QAI will re-evaluate the continue for the audit. If a 95% thres not achieved an action plar developed. Deficiency in th practice will result in discipl action up to and or includin termination of the responsite employee.	ix PI team ed need hold is will be is inary g		
= 0684 SS=D Bldg. 00	applies to all treat facility residents. comprehensive a facility must ensu- treatment and ca professional stan comprehensive p and the residents Based on record re- failed to follow the complete neurolog of 3 residents revia 13) Findings include: 1. The clinical reco on 09/08/22 at 9:19 (Minimum Data So indicated the resident	a fundamental principle that tment and care provided to Based on the ssessment of a resident, the re that residents receive re in accordance with dards of practice, the erson-centered care plan,	F 0684	It is the standard of this fat to follow the physicians of and complete neurological assessments after falls. 1) What corrective action to be accomplished for those residents found to have be affected by the deficient p e? Resident #15 and 13's fall effective were reviewed on 9/29/22 at time the physician was contained and notified of the missed neurological assessments at orthostatic b/p checks.	rders I will e een ractic events at which tacted	10/07/202	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	x3) date survey completed 09/08/2022
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
HICKOF	Y CREEK AT GRE	EENSBURG		N LINCOLN ST INSBURG, IN 47240	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	E COMPLETI
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	· · · · · ·	ed 07/28/22 at 8:10 P.M.,		How other residents having	
		lent had a fall in the bathroom		the potential to be affected by	r t
		d by staff. The resident was		he	
		sfer herself to the commode		same deficient practice will be	e
	when she had gott	en dizzy and tried to sit back		identified and what corrective)
	down.			action(s) will be taken.	
				All residents having falls have t	he
	A Fall Event, dated 07/29/22 at 9:19 P.	,		potential to be affected by the	
	indicated the resid	lent had an unwitnessed fall in		alleged deficient practice	
	her bedroom.			A fall audit was completed on a	all
				residents who fell in the last 30	
		linary Team) Note, dated		days to ensure neurological	
	08/01/22 at 10:10 A.M., indicated the IDT was for a	A.M., indicated the IDT was for a		assessments and root cause	
	-	$\frac{7}{28}$. The root cause of the		interventions were initiated and	
	fall was orthostati	c hypotension.		followed. The DON or designee	9
				re-educated the facility nurses	on
		linary Team) Note, dated		post fall neurological assessme	ent
		P.M., indicated the IDT was for a		will be initiated on all unwitness	sed
		The root cause of the fall was		falls.	
	orthostatic hypote	nsion.		3)	
				What measures will be put	
	0 /	dated 08/01/22 at 2:25 P.M.,		into place or what systemic	
		ers were received for the		changes will be made to ensu	r
		urinalysis and orthostatic blood		е	
	pressures and hear	rt rate.		that the deficient practice doe	es
				not recur?	
	•	ew on 09/08/22 at 10:34 A.M.,		The DON or designee in-servic	ed
		actical Nurse) 2 indicated		facility nurses on post fall	
	-	pressures were obtained lying,		neurological assessment being	
	-	ng. The blood pressures would		initiated on all unwitnessed falls	S.
		the EMAR (Electronic		When a resident has an	
	Medication Admin	nistration Record).		unwitnessed fall a neurological	
				assessment will be initiated. Th	
	-	ew on 09/08/22 at 10:44 A.M., the		oncoming nurse will review the	tall
		Nursing) indicated orthostatic		event and continue the	.
	-	ere obtained lying, sitting, and		neurological assessments per t	ine
	-	od pressures would be		schedule. If there are missing	
	documented in the	EMAK.		neurological assessment, the	
	During an intervie	ew on 09/08/22 at 1:21 P.M., the		nurse will contact the physician The DON or designee will).

155353			09/08/2022
^{ER} EENSBURG	1620	T ADDRESS, CITY, STATE, ZIP COD N LINCOLN ST ENSBURG, IN 47240	
Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION ere were no neurological checks ne resident's fall on 07/29/22. d lacked any neurological the unwitnessed fall on orthostatic blood pressures with cord for Resident 13 was reviewed 55 P.M. A Quarterly MDS 106/30/22, indicated the resident ognitively impaired. The ed, but were not limited to, ion, anxiety, and depression. one fall with no injury, and one 7 that was not major, since the n 05/06/22. ord, dated 06/12/22, was provided 9/08/22 at 2:02 P.M. The record dent had an unwitnessed fall on P.M. The resident had been sitting in his room and was first e fall, lying on his left side in tchair. es for June 2022, were provided Nurse on 09/08/22 at 2:22 P.M. A /22 at 9:10 P.M., indicated the but of his wheelchair during a	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) complete a review of the neurological assessment sche during the daily clinical meetin 4) How the corrective action(s) will be monitored to ensure t deficient practice will not rec , i.e. what quality assurance program will be put into plac To ensure compliance the DNS/Designee will complete a event/neurological assessment/intervention initiat CQI audit tool for six months w audits being completed once weekly for one month, and the monthly for 5 months by a nur- manager or designee. The fall event/neurological assessment/intervention initiat CQI audit tool CQI audit tool w be reviewed monthly by the CM Committee for six months afte which the QAPI team will re-evaluate the continued need the audit. If a 95% threshold is achieved an action plan will be	dule g. he er a fall tion vith se tion rill Ql r d for a not
rd lacked documentation that ssments had been completed on 06/12/22. ew on 09/08/22 at 1:23 P.M., the		termination of the responsible employee.	
	RY STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION here were no neurological checks the resident's fall on 07/29/22. rd lacked any neurological r the unwitnessed fall on orthostatic blood pressures with ecord for Resident 13 was reviewed t55 P.M. A Quarterly MDS d 06/30/22, indicated the resident cognitively impaired. The ed, but were not limited to, sion, anxiety, and depression. one fall with no injury, and one y that was not major, since the on 05/06/22. ord, dated 06/12/22, was provided 09/08/22 at 2:02 P.M. The record ident had an unwitnessed fall on P.M. The resident had been sitting rin his room and was first ne fall, lying on his left side in elchair. tes for June 2022, were provided P.Murse on 09/08/22 at 2:22 P.M. A 2/22 at 9:10 P.M., indicated the out of his wheelchair during a The resident was assisted up off e aid of three staff members. rd lacked documentation that essments had been completed <td>RY STATEMENT OF DEFICIENCIEIDPRENCY MUST BE PRECEDED BY FULLPREFIXOR LSC IDENTIFYING INFORMATIONTAGhere were no neurological checksthe resident's fall on 07/29/22.rd lacked any neurologicalr the unwitnessed fall onorthostatic blood pressures withexcord for Resident 13 was reviewed:55 P.M. A Quarterly MDSd 06/30/22, indicated the residentcognitively impaired. Theed, but were not limited to,sion, anxiety, and depression.one fall with no injury, and oney that was not major, since them 05/06/22.ord, dated 06/12/22, was provided19/08/22 at 2:02 P.M. The recordident had an unwitnessed fall onP.M. The resident had been sittingrin his room and was firstne fall, lying on his left side inelchair.tes for June 2022, were providedNurse on 09/08/22 at 2:22 P.M. A2/22 at 9:10 P.M., indicated theout of his wheelchair during aThe resident was assisted up offe aid of three staff members.rd lacked documentation thatessments had been completedl on 06/12/22.iew on 09/08/22 at 1:23 P.M., thehere should have beenessments completed for the</td> <td>ID PREFIXID PREFIXPROVIDENCE PLAN OF CONNECTIONOR LSC IDENTIFYING INFORMATIONTAGPREFIX TAGOR LSC IDENTIFYING INFORMATIONTAGCOMPLETERMENT OF CONNECTION PREFIX TAGhere were no neurological checks the resident's fall on 07/29/22.complete a review of the neurological assessment sche during the daily clinical meetin 4)rd lacked any neurological rt he unwitnessed fall on oorthostatic blood pressures withdeficient practice will not rec r, i.e. what quality assurance program will be put into plac To ensure compliance the DNS/Designee will complete a event/neurological assessment/intervention initiat CQI audit tool for six months v a undits being completed once weekly for one month, and the monthly for 5 months by a nur manager or designee. The fall event/neurological assessment/intervention initiat CQI audit tool CQI audit tool We be reverved monthly by the C Committee for six months v a udit tool CQI audit tool Mereshol is achieved an action plan will be developed. Deficiency in this practice will result in disciplina action up to and or including a adi of three staff members.rd lacked documentation that sessments and been completed 1 on 06/12/22.iew on 09/08/22 at 1:23 P.M., the here should have been sesments and be nownpleted 1 on 06/12/22.iew on 09/08/22 at 1:23 P.M., the here should have been sesments completed for the</td>	RY STATEMENT OF DEFICIENCIEIDPRENCY MUST BE PRECEDED BY FULLPREFIXOR LSC IDENTIFYING INFORMATIONTAGhere were no neurological checksthe resident's fall on 07/29/22.rd lacked any neurologicalr the unwitnessed fall onorthostatic blood pressures withexcord for Resident 13 was reviewed:55 P.M. A Quarterly MDSd 06/30/22, indicated the residentcognitively impaired. Theed, but were not limited to,sion, anxiety, and depression.one fall with no injury, and oney that was not major, since them 05/06/22.ord, dated 06/12/22, was provided19/08/22 at 2:02 P.M. The recordident had an unwitnessed fall onP.M. The resident had been sittingrin his room and was firstne fall, lying on his left side inelchair.tes for June 2022, were providedNurse on 09/08/22 at 2:22 P.M. A2/22 at 9:10 P.M., indicated theout of his wheelchair during aThe resident was assisted up offe aid of three staff members.rd lacked documentation thatessments had been completedl on 06/12/22.iew on 09/08/22 at 1:23 P.M., thehere should have beenessments completed for the	ID PREFIXID PREFIXPROVIDENCE PLAN OF CONNECTIONOR LSC IDENTIFYING INFORMATIONTAGPREFIX TAGOR LSC IDENTIFYING INFORMATIONTAGCOMPLETERMENT OF CONNECTION PREFIX TAGhere were no neurological checks the resident's fall on 07/29/22.complete a review of the neurological assessment sche during the daily clinical meetin 4)rd lacked any neurological rt he unwitnessed fall on oorthostatic blood pressures withdeficient practice will not rec r, i.e. what quality assurance program will be put into plac To ensure compliance the DNS/Designee will complete a event/neurological assessment/intervention initiat CQI audit tool for six months v a undits being completed once weekly for one month, and the monthly for 5 months by a nur manager or designee. The fall event/neurological assessment/intervention initiat CQI audit tool CQI audit tool We be reverved monthly by the C Committee for six months v a udit tool CQI audit tool Mereshol is achieved an action plan will be developed. Deficiency in this practice will result in disciplina action up to and or including a adi of three staff members.rd lacked documentation that sessments and been completed 1 on 06/12/22.iew on 09/08/22 at 1:23 P.M., the here should have been sesments and be nownpleted 1 on 06/12/22.iew on 09/08/22 at 1:23 P.M., the here should have been sesments completed for the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155353	B. WI			09/08/	/2022
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
HICKOR	Y CREEK AT GRE	ENSBURG			NSBURG, IN 47240		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		anagement Program policy,					
		of 11/2017, was provided by 22 at 10:33 A.M. The policy					
		allA neurological assessment					
		all unwitnessed falls"					
	3.1-37(a)						
0686	483.25(b)(1)(i)(ii)						
SS=D		o Prevent/Heal Pressure					
Bldg. 00	Ulcer						
5	§483.25(b) Skin I	ntearity					
	§483.25(b)(1) Pre						
		nprehensive assessment of					
		cility must ensure that-					
	(i) A resident rece	eives care, consistent with					
	professional stan	dards of practice, to prevent					
	pressure ulcers a	nd does not develop					
		nless the individual's clinical					
		strates that they were					
	unavoidable; and						
	· · /	pressure ulcers receives					
		ent and services, consistent					
		standards of practice, to					
		prevent infection and prevent					
	new ulcers from o	on, interview, and record	E OC	0.0	It is the standard of this facil		10/07/2020
		failed to administer wound	F 06	86	It is the standard of this facil	-	10/07/2022
	-	2 residents reviewed for			to administer wound treatme	nt	
	pressure ulcers. (Re				for pressure ulcers.		
	pressure uteers. (IN	esident 4)			1) What corrective action will		
	Findings include:				be accomplished for those		
	i manigo menude.				residents found to have beer	,	
	On 09/06/22 at 9:3	0 A.M., Resident 4 was			affected by the deficient prac		
		om sitting in her wheelchair.			e?		
		earing pressure reducing			Resident #4's treatment order	s	
		r extremities. The resident was			were reviewed on 9/29/22 at w		
		ted she had just received a			time physician was and notifie		
		-					1

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	155353	B. WING	<u> </u>	09/08/2022
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
HICKOR	Y CREEK AT GRE	ENSBURG		N LINCOLN ST NSBURG, IN 47240	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	on her foot, but it	was healed now.		How other residents having	
				the potential to be affected by	't
	The resident's clinical record was reviewed on 09/06/22 at 10:00 A.M. An Admission MDS			he	
				same deficient practice will be	e
	(Minimum Data S	et) assessment, dated 02/07/22,		identified and what corrective	
	indicated the resid	ent was moderately cognitively		action(s) will be taken.	
		gnoses included, but were not		All residents with pressure are	as
	-	zheimer's dementia,		had the potential to be affected	
	hypertension, MS	(Multiple Sclerosis),		the alleged deficient practice.	•
		uscle weakness. The resident		skin check was completed on a	
		assistance from two staff		residents who currently have	
	-	nobility and was totally		pressure ulcers to ensure	
		for transfers and locomotion		treatment orders are in place for	or
		. One of the resident's upper		all open areas. The DON or	
		paired. The resident did not		designee re-educated the facilit	tv
		heelchair. The resident was at		nurses on assessing the skin a	-
		lcers and utilized pressure		ensuring the physician is	
	_	or the bed and chair. There		contacted for treatment orders	
	-	lcers present during the		continue until the area heals.	
	assessment review			3)	
		pencer		What measures will be put	
	A Wound Manage	ment Report, dated 02/15/2022		into place or what systemic	
		icated a pressure ulcer was		changes will be made to ensu	r l
		op of the resident's right foot.		e	·
		red 2 cm (centimeters) x (by) 1.5		that the deficient practice doe	
		s section indicated the resident		not recur?	3
		ed area that was dark purple/red		The DON or designee in-servic	be
		ent had pressure reducing		facility nurses on assessing the	
		ace and denied pain or		skin and ensuring the physiciar	
		ound was described as stable.		contacted for treatment orders	115
	disconnort. The w	ound was described as stable.		continue until the area heals.	
	An MD visit note	dated 02/15/22, indicated the		When a resident is identified as	
		(Deep Tissue Pressure Injury),		having a skin issue the physicia	
		1 localized area of discolored			
		d filled blister due to damage of		will be notified, a treatment orde	
		ssue from pressure and/or		obtained with a root cause bein	-
				identified. The wound nurse wi	"
		ght foot. The treatment orders		monitor the wound weekly and	
		Prep (a liquid film forming		verify the treatment order to	
	- · ·	itor the wound. The MD		ensure continued appropriatene	
	indicated it would	be difficult to offload the		and need. If there are treatmer	π

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 09/08/2022	
NAME OF	PROVIDER OR SUPPLIE	ĒR		i address, city, state, zip cod N LINCOLN ST		
HICKOR	Y CREEK AT GRE	ENSBURG		INSBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETIC	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	resident's heel bec	ause of her chronic MS related		orders missing, the nurse will		
	issues.			contact the physician that day		
				the appropriate treatment orde		
	-	March 2022 TARs (Treatment		The DON or designee will revi		
		cord) were provided by the		wounds weekly for accuracy a	nd	
	-	n 09/08/22 at 11:22 A.M. The		appropriate treatment use.		
	-	R included an open ended		4)		
		with a start date of $02/15/22$, to		How the corrective action(s)		
		the resident's right foot for the		I be monitored to ensure the		
	-	he treatment was administered		deficient practice will not rec		
	as ordered. The M			, i.e. what quality assurance		
	documentation of	a treatment to the resident's		program will be put into plac	e?	
	foot.			To ensure compliance the		
				DNS/Designee will complete a	a l	
	A Wound Manage	ement Report, dated 03/17/22 at		wound review CQI audit tool for	or six	
	7:05 P.M., indicate	ed the wound measured 2 cm x		months with audits being		
	1.5 cm. The comm	nents section indicated the		completed once weekly for on	e	
	wound remained a	hard calloused area that was		month, and then monthly for 5		
	dark purple/brown	in color. The resident had		months by a nurse manager o	r	
		interventions in place and		designee. The new admission		
	reported some disc	comfort to the wound site at		treatment CQI audit tool will be	e	
	times. The wound	was described as stable.		reviewed monthly by the CQI		
				Committee for six months afte	r	
	A Progress note da	ated 03/22/22 at 6:09 P.M.		which the QAPI team will		
	indicated the MD	was in to see the resident and		re-evaluate the continued nee	d for	
	new orders were re	eceived.		the audit. If a 95% threshold is achieved an action plan will be		
	An MD visit note,	dated 03/22/22, indicated the		developed. Deficiency in this		
		he resident's lateral right foot		practice will result in disciplina	ry	
	contained eschar (dark necrotic skin), and was no		action up to and or including	,	
		tissue injury. New orders		termination of the responsible		
		ent of Medihoney and a dressing		employee.		
	to be changed even	ry 48 hours. They might need to				
		clinic or podiatry referral if the				
	wound did not imp					
		TAR and ETAR (Electronic				
		stration Record) lacked				
		administration of a treatment for				
	the resident's right	foot from 03/01/22 until				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/08/2022 155353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1620 N LINCOLN ST HICKORY CREEK AT GREENSBURG GREENSBURG, IN 47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 03/22/22 when the Medihoney treatment began. On 09/01/22 at 10:47 A.M., the Wound Management Report indicated the wound was considered healed and treatment was discontinued. The wound was closed with good tissue covering the area. On 09/08/22 at 10:21 A.M., the resident's right foot was observed with the ADON (Assistant Director of Nursing). There was an area of thick calloused skin that measured approximately 2 cm x 1.5 cm. The thick skin was somewhat transparent, and there was a very small darker area that measured approximately 4 mm (millimeters) x 2 mm in the center of the skin. The ADON indicated that was where the wound was, and the wound was considered healed. The current treatment was a foam cushion to the area for protection. During an interview on 09/08/22 at 2:02 P.M., the DON (Director of Nursing) indicated they tried a few different treatments for the resident. All treatment orders should be administered and documented as administered on the treatment record. The current facility policy, titled "Skin Management Program", and dated 05/22, was provided by the DON on 09/08/22 at 1:21 P.M. The policy indicated, "...a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing ... " 3.1-40(a)(2) F 0692 483.25(g)(1)-(3) SS=E Nutrition/Hydration Status Maintenance Bldg. 00 §483.25(g) Assisted nutrition and hydration. 58Z011 Facility ID: 000244 Page 10 of 33 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/08/2022 155353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1620 N LINCOLN ST HICKORY CREEK AT GREENSBURG GREENSBURG, IN 47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility F 0692 It is the practice of this facility 10/07/2022 failed to ensure residents received ordered must ensure residents receive nutritional supplements for 5 of 12 residents ordered nutritional reviewed. (Residents 10, 3, 6, 22, and 13) supplementations ordered. What corrective action will be Findings include: accomplished for those residents found to have been 1. The clinical record for Resident 10 was reviewed affected by the deficient on 09/06/22 at 1:38 P.M. A Significant Change practice? MDS (Minimum Data Set) assessment, dated Residents 10, 3, 6, 22, 13 were 06/22/22, indicated the resident was severely reviewed for appropriateness and cognitively impaired. The diagnoses included, but acceptance of oral supplements, were not limited to, Alzheimer's disease, COPD oral supplements given at meals (Chronic Obstructive Pulmonary Disease), and will only be placed in Dietary dysphagia. The resident required extensive staff orders under special instructions assistance with eating. The resident was admitted and provided by culinary. Oral to hospice services on 07/28/22. supplements between meals will continue as ordered and be A Registered Dietician Progress Note, dated provided by nursing. All residents Event ID: 58Z011 Facility ID: 000244 Page 11 of 33 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE CON A. BUILDING B. WING	INTRUCTION	x3) date survey completed 09/08/2022
	PROVIDER OR SUPPLIE		1620 N L	DDRESS, CITY, STATE, ZIP COD LINCOLN ST SBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	08/04/2022 at 8:54 experienced a 7 lb a 13 lb. weight loss loss in 180 days. T hospice services at expected. The resi stimulant and nutr The resident's curr an open ended ord that indicated the r Mighty Shake (a p nutritional suppler a day). The July, A EMARs (Electron Record) were revi- had not received th dates and times du available: - 07/11/22 from 12 - 07/12/22 from 8: - 07/13/22 from 8: - 07/13/22 from 8: - 07/16/22 from 12 P.M. to 7:00 P.M., - 07/25/22 from 12 P.M. to 7:00 P.M., - 07/26/22 from 12 P.M. to 7:00 P.M., - 07/26/22 from 5: - 08/04/22 from 5: - 08/04/22 from 5: - 08/08/22 from 5: - 08/13/22 from 8: - 09/01/22 from 5: - 08/13/22 from 5: - 09/01/22 from	 A.M., indicated the resident had . (pound) weight loss in 30 days, s in 90 days, and a 24 lb. weight The resident was receiving nd further weight loss could be dent received an appetite itional supplements. rent physician's orders included er, with a start date of 05/16/22, resident was to receive a brotein and calorie dense ment) with all meals (three times August, and September 2022 ic Medication Administration ewed and indicated the resident the shakes on the following the to the supplement not being 2:00 P.M. to 2:00 P.M., 00 A.M. to 10:00 A.M., 00 P.M. to 7:00 P.M., 2:00 P.M. to 2:00 P.M., and 5:00 . O0 A.M. to 10:00 A.M., 12:00 P.M., 2:00 P.M. to 7:00 P.M., 3:00 P.M. to 7:00		on supplements will be added to the supplement tracking form. How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be taker All residents who reside in facil have the potential to be affected by this deficient practice. Nursing/culinary staff in-service With oral supplements with me under culinary, culinary will ale CM, Nursing of residents acceptance/refusal along with offering comparable substitute drug item unavailable. With oral supplement between meals, Nursing will provide oral supplements as ordered, if drug item unavailable, Nursing will a DNS/CM/RD of appropriate substitute. DNS will keep supplement tracking form up to date as new or D/C orders corr in. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Inservice completing with Culinary/nursing staff as above IDT to review in morning meeti for new orders of supplementary with meals and between meals ensure Hot charting for new supplement orders completed a add/remove resident from supplement tracking form. All	o I I I I I I I I I I I I I I I I I I I

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58Z011 Facility ID: 000244

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STATEMENT OF D AND PLAN OF COR		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	СОМ	'e survey pleted 8/2022
NAME OF PROVID			1620	T ADDRESS, CITY, STATE, ZIP CC N LINCOLN ST	DD	
HICKORY CRE	EKAIGRE	ENSBURG	GREE	ENSBURG, IN 47240		
	EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETIC
to 2: 2. TH on 00 asses was diagr Alzh perip The an op that Migl The (Elec were receid dates - 07/ - 08/ - 09/ - 08/ - 09/ - 00	00 P.M., and ne clinical rec 9/06/22 at 2:4 ssment, dated moderately co noses includer eimer's diseas oheral vascula resident's curr pen ended ord indicated the r ty Shake sup July, August, etronic Medic reviewed and ved the shake a due to the su 21/22, 22/22, 25/22, 26/22, 30/22, 31/22, 04/22, 05/22, 13/22, 14/22, 19/22, 21/22, 22/22, 22/22, 22/22, 22/22, 30/22, 31/22, 14/22, 22/22,	NR LSC IDENTIFYING INFORMATION 5:00 P.M. to 7:00 P.M. ord for Resident 3 was reviewed 0 P.M. A Quarterly MDS 05/25/22, indicated the resident ognitively impaired. The d, but were not limited to, se, diabetes, COPD, and r disease. The the disease of the the the the the the the the the r, with a start date of 09/15/21, resident was to receive a plement once a day at 2:00 P.M. and September 2022 EMARs ation Administration Record) d indicated the resident had not r supplement on the following pplement not being available: w on 09/08/22 at 10:23 A.M., the indicated the kitchen staff	TAG	resident on supplement adding to supplement tr form. How the corrective act will be monitored to er deficient practice will r recur? Dietary Manager/DNS// will complete the Supple QAPI (QA) tool weekly fr month, bi-weekly for two and then monthly for six The results of these aud reviewed by the QAPI c overseen by the ED. If t threshold of 95% is not an action plan will be de ensure compliance. De this practice will result in disciplinary action up to including termination of responsible employee.	acking ion(s) neure the not designee ement for one o months, a months. dits will be ommittee he achieved eveloped to ificiency in n and	DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/08/2022 155353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1620 N LINCOLN ST HICKORY CREEK AT GREENSBURG GREENSBURG, IN 47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE ordered the Mighty Shakes and the fortified ice cream. There was a standing order, they received a case of the shakes each week. They did have some problems getting their shipment a couple of weeks ago, but the kitchen had a recipe they could use to make the shakes in house, so they always had the shakes available. They did not have a shortage of shakes in July or August. For most residents, the shakes were delivered with meals, so they were placed on the meal trays and delivered with the food. The shakes were listed on the residents' meal tickets. Resident 10 and Resident 13 received them 3 times a day. They almost always drank them. Resident 3 received shakes at lunch and seemed to like them, she thought they were a special treat just for her. During an interview on 09/08/22 at 2:48 P.M., CNA (Certified Nurse Aide) 3 indicated mighty shakes were delivered on meal trays. Staff really encouraged the residents to drink their shakes. If a resident didn't eat much of their meal, staff would go to the kitchen and see if they could get a shake for the resident (if it wasn't already on their meal ticket), just to try and make sure they were getting something nutritious. Mighty shakes were always available, she had never not been able to give a resident a mighty shake because they didn't have any. 3. The clinical record for Resident 13 was reviewed on 09/06/22 at 2:55 P.M. A Quarterly MDS assessment, dated 06/30/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, cancer, hypertension, anxiety, and depression. The August and September 2022 EMARS were provided by the DON on 09/08/22 at 1:21 P.M. The record indicated the resident had an Event ID: 58Z011 Facility ID: 000244 Page 14 of 33 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/08/2022 155353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1620 N LINCOLN ST HICKORY CREEK AT GREENSBURG GREENSBURG, IN 47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE open-ended physician's order, with a start date of 05/06/22, to receive Boost nutritional supplement three times a day for weight loss and had not received the supplement on the following dates and times due to the supplement not being available: - 08/28/22 from 2:00 P.M. to 10:00 P.M., - 09/02/22 from 6:00 A.M. to 2:00 P.M., and 2:00 P.M. to 10:00 P.M., - 09/05/22 from 2:00 P.M. to 10:00 P.M., and - 09/07/22 from 6:00 A.M. to 2:00 P.M. The record indicated the resident had an open-ended physician's order, with a start date of 06/16/22, to receive Mighty Shakes nutritional supplements, 177 ml, three times a day with all meals and had not received the supplement on the following dates and times due to the supplement not being available: - 08/04/22 at 9:00 A.M. - 08/05/22 at 6:00 P.M., - 08/13/22 at 9:00 A.M., and 1:00 P.M., - 08/14/22 at 9:00 A.M., 1:00 P.M., and 6:00 P.M., - 08/27/22 at 9:00 A.M., 1:00 P.M., and 6:00 P.M., - 09/01/22 at 6:00 P.M., - 09/02/22 at 9:00 A.M., 1:00 P.M., and 6:00 P.M., and - 09/05/22 at 1:00 P.M., and 6:00 P.M. The Nutritional Status Care Plan was provided by the DON on 09/08/22 at 1:21 P.M. The record indicated the resident was as at risk for altered nutrition and weight status and was to receive Mighty Shakes with all meals.4. The clinical record for Resident 6 was reviewed on 09/06/22 at 10:05 A.M. An Admission MDS assessment, dated 06/01/22, indicated the resident was cognitively intact. The diagnoses included, but were not Event ID: 58Z011 Facility ID: 000244 Page 15 of 33 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/08/2022 155353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1620 N LINCOLN ST HICKORY CREEK AT GREENSBURG GREENSBURG, IN 47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE limited to, cancer, anemia, hypertension, renal insufficiency, diabetes, end stage renal disease. The resident had received dialysis while a resident in the facility. An open-ended physicians' order, with a start date of 08/04/22, indicated the resident was to receive Nepro (a nutrition supplement), with meals. The August and September 2022 EMARS were reviewed and indicated the resident had not received the Nepro supplement on the following dates and times due to the supplement not being available: - 08/05/22 from 6:00 A.M. to 8:00 A.M., 11:00 A.M. to 1:00 P.M., and 4:00 P.M. to 6:00 P.M., - 08/06/22 from 11:00 A.M. to 1:00 P.M. and 4:00 P.M. to 6:00 P.M., - 08/07/22 from 6:00 A.M. to 8:00 A.M., 11:00 A.M. to 1:00 P.M., and 4:00 P.M. to 6:00 P.M., - 08/08/22 from 6:00 A.M. to 8:00 A.M. and 4:00 P.M. to 6:00 P.M.. - 08/09/22 from 6:00 A.M. to 8:00 A.M., 11:00 A.M. to 1:00 P.M., and 4:00 P.M. to 6:00 P.M., - 08/28/22 from 11:00 A.M. to 1:00 P.M. and 4:00 P.M. to 6:00 P.M.. - 09/02/22 from 6:00 A.M. to 8:00 A.M. and 4:00 P.M. to 6:00 P.M., and - 09/05/22 from 6:00 A.M. to 8:00 A.M., 11:00 A.M. to 1:00 P.M., and 4:00 P.M. to 6:00 P.M. The Complete Care Plan for Resident 6 was provided by the DON (Director of Nursing) on 09/08/22 at 2:02 P.M. A Care Plan titled, "Nutritional Status", included an intervention, but not limited to, "...oral supplement as ordered ... " The clinical record lacked any indication the 58Z011 Facility ID: 000244 Page 16 of 33 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/08/2022 155353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1620 N LINCOLN ST HICKORY CREEK AT GREENSBURG GREENSBURG, IN 47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE physician was notified that the resident had not received the supplement. 5. The clinical record for Resident 22 was reviewed on 09/08/22 at 10:08 A.M. An Admission MDS assessment, dated 07/29/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, fractures, anemia, hypertension, and malnutrition. A physicians' order, dated 08/12/22 through 09/18/22, indicated the resident was to receive Mighty Shakes supplement, 177 ml, three times a day. The August and September 2022 EMARS were reviewed and indicated the resident had not received the Mighty Shake supplement on the following dates and times due to the supplement not being available: - 08/13/22 at 8:00 A.M., 12:00 P.M, and 5:00 P.M., - 08/14/22 at 8:00 A.M., 12:00 P.M., and 5:00 P.M., - 08/22/22 at 8:00 A.M., 12:00 P.M., and 5:00 P.M., - 08/23/22 at 5:00 P.M., - 08/24/22 at 12:00 P.M., - 08/27/22 at 8:00 A.M., 12:00 P.M., and 5:00 P.M., - 08/28/22 at 8:00 A.M., 12:00 P.M., and 5:00 P.M., - 09/01/22 at 5:00 P.M., - 09/02/22 at 8:00 A.M., 12:00 P.M., and 5:00 P.M., and - 09/05/22 at 8:00 A.M., 12:00 P.M., and 5:00 P.M. During an interview on 09/06/22 at 2:37 P.M., LPN 4 indicated when medications or supplements were not available to give it would be documented in the EMAR and the physician should be notified. She would also document in a progress note that she had notified the physician. Event ID: 58Z011 Facility ID: 000244 Page 17 of 33 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

10/14/2022

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION IG <u>00</u>	COMI	e survey pleted 8/2022
	PROVIDER OR SUPPLIE		162	EET ADDRESS, CITY, STATE, ZIP (20 N LINCOLN ST EENSBURG, IN 47240	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O During an intervie LPN 2 indicated if	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION w on 09/08/22 at 10:20 A.M., the residents received mighty	ID PREFI TAG	CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETION DATE
	the kitchen and oth 2-cal, and Glucern nursing departmen					
	and Nourishments was provided by th The policy indicate facility to ensure r and nourisments a	v policy titled, "Supplements ', with a revised date of 06/19, he DON on 09/08/22 at 1:21 P.M. ed, "It is the policy of this esidents receive supplements oppropriate to their nutritional order, and preferences"				
	3.1-46(a)(1)					
= 0698 SS=D Bldg. 00	require dialysis re consistent with p practice, the com care plan, and th preferences. Based on record re failed to monitor b for 1 of 1 resident 6) Findings include: The clinical record 09/06/22 at 10:05 (Minimum Data So indicated the resid diagnoses included cancer, anemia, hy	is. ensure that residents who eccive such services, rofessional standards of prehensive person-centered e residents' goals and view and interview, the facility ruit and thrill for a dialysis site reviewed for dialysis. (Resident for Resident 6 was reviewed on A.M. An Admission MDS et) assessment, dated 06/01/22, ent was cognitively intact. The l, but were not limited to, pertension, renal insufficiency, tage renal disease. The	F 0698	It is the standard of to monitor bruit and to dialysis site. 1) What corrective actions be accomplished for residents found to har affected by the deficited of the deficited	trill for a on will those ave been ent practic s orders 3/22 at which ntacted and	10/07/2022

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155353	B. WING	09/08/2022		
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	-	
	Y CREEK AT GRE	ENSBURG		N LINCOLN ST NSBURG, IN 47240		
X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETIO DATE	
IAU		red dialysis while a resident in	IAG		DATE	
	the facility.	ed diarysis while a resident in		2) How other residents having		
	the facility.			the potential to be affected l		
	A Progress Note of	lated 08/05/22 at 5:14 P.M.,		he	Jyt	
	-	ent had a vascular access		same deficient practice will	ha	
		s port and a fistula in the left		identified and what correctiv		
	forearm.	s port and a fistula in the left		action(s) will be taken.		
				All dialysis residents admitted	thad	
in th ev	An open-ended ph	ysician's order, dated 08/13/22,		the potential to be affected by		
		ent had a dialysis access site in		alleged deficiency.		
		he site was to be monitored		An order review was complete	ed on	
		as and symptoms of infection,		all dialysis residents to ensure		
		pness, bleeding, and leaks, and		treatment orders are in place		
	-	-		check for Bruit and Thrill ever		
	ensure the access site was clean, or dressing was intact as ordered. The potified of unusual findings and d	-		shift. The DON or designee	у	
		l findings and document in a		re-educated the facility nurses	son	
	progress note.	i indings and document in a		obtaining order to assess the		
	progress note.			and thrill every shift on all dia		
	A Care Plan indica	ated the resident was receiving		residents on day of admit.	19515	
		was at risk for complications		3)		
		lance, bleeding, or infection		What measures will be put		
		the left arm. Interventions		into place or what systemic		
		not limited to, "Assess		changes will be made to ens		
		e every shift for excessive		e		
	-	, swelling, redness, warth		that the deficient practice do	nes	
	0, 0	uit/thrill. Document findings,		not recur?		
		o MD and dialysis"		The DON or designee in-serv	viced	
		,		facility nurses on obtaining or		
	The clinical record	l indicated the resident's dialysis		to assess the Bruit and thrill e		
		rill was only monitored on the		shift on all dialysis residents of	-	
		August and September 2022:		the day of admit. When a resi		
		- •		admits to the facility the admi		
	- 08/05/22 at 4:30	P.M.		nurse will assess request ord	-	
	- 08/06/22 at 3:23 A.M.,			check bruit and thrill on all dia		
	- 08/08/22 at 3:30	P.M.,		residents on day of admit. If	-	
	- 08/10/22 at 3:45			are orders missing, the nurse		
	- 08/12/22 at 3:30	P.M.,		contact the physician the day		
	- 08/15/22 at 2:15	P.M.,		admission for the appropriate		
	- 08/19/22 at 3:03	Р.М.,		monitoring. The DON or desig		
	- 08/22/22 at 4:15	РМ		will complete an admission at	-	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 09/08/2022 155353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1620 N LINCOLN ST HICKORY CREEK AT GREENSBURG GREENSBURG, IN 47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE - 08/24/22 at 2:16 P.M., and on the day of admission to ensure - 09/02/22 at 3:10 P.M. all dialysis resident have orders to assess bruit and thrill. During an interview on 09/08/22 at 10:20 A.M., 4) LPN (Licensed Practical Nurse) 2 indicated the How the corrective action(s) resident's bruit and thrill should be monitored will be monitored to ensure the once a shift and document in the EMAR (Electronic Medication Administration Record). deficient practice will not recur , i.e. what quality assurance During an interview on 09/08/22 at 10:42 A.M., the program will be put into place? DON (Director of Nursing) indicated the bruit and To ensure compliance the thrill should be monitored every shift and there DNS/Designee will complete a should have been a physician's order to monitor bruit and thrill CQI audit tool for six it. months with audits being completed once weekly for one The current facility policy titled, "Dialysis Care" month, and then monthly for 5 with a revision date of 11/2017, was provided by months by a nurse manager or the DON on 09/08/22 at 2:02 P.M. The policy designee. The dialysis bruit and indicated, "...to ensure that residents requiring thrill CQI audit tool CQI audit tool dialysis receive such services, consistent with will be reviewed monthly by the professional standards of practice, the CQI Committee for six months comprehensive person-centered care, and the after which the QAPI team will residents' goals and preferences. The facility will re-evaluate the continued need for assure that each resident receives care and the audit. If a 95% threshold is not services for the provision of hemodialysis and/or achieved an action plan will be peritoneal dialysis consistent with professional developed. Deficiency in this standards of practice ... " practice will result in disciplinary action up to and or including 3.1-37(a) termination of the responsible employee. F 0727 483.35(b)(1)-(3) SS=F RN 8 Hrs/7 days/Wk, Full Time DON Bldg. 00 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. 58Z011

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Event ID:

Facility ID: 000244

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/08/2022 155353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1620 N LINCOLN ST HICKORY CREEK AT GREENSBURG GREENSBURG, IN 47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. F 0727 Based on interview and record review, the facility What corrective action(s) will 10/07/2022 failed to provide the required RN (Registered be accomplished for those Nurse) on duty for eight hours a day for 2 of the 8 residents found to have been days during the survey time period. affected by the deficient practice? Findings include: The facility has obtained RN coverage for 8 consecutive hours a During an interview on 09/08/22 at 2:27 P.M., the day/ 7 days a week. DON (Director Of Nursing) indicated the facility RN waiver submitted. did not have an RN working in the facility for Pending approval. eight consecutive hours on the weekends. She, How will you identify other the DON, was on call every weekend and would residents having the potential come in when needed. There was always an LPN to be affected by the same (Licensed Practical Nurse) in the building. They deficient practice and what were actively trying to hire more RNs. The DON corrective action will be taken? and RN 6 were the only two RNs currently All residents have the working in the facility and RN 6 only worked potential to be affected by the part-time. The corporation required her to come in alleged deficient practice. and make rounds at least once a day on the The daily staffing is reviewed weekends and on any other day an RN was not on by the Executive Director and the duty. She was not required to stay the full 8 Director of Nursing to ensure that hours. She did not clock in when working on the RN coverage is in place. floor. They had used agency nursing services at What measures will be put into times but were having difficulty in regards to the place or what systemic availability of RNs. They did not currently have changes you will make to any nursing waivers. ensure that the deficient practice does not recur? During an interview on 09/08/22 at 2:58 P.M., the RN waiver submitted. Corporate Nurse indicated they had an RN come Pending approval in a couple of times a day and make rounds when The daily staffing is reviewed there was no RN on duty. They were aware of the by the Executive Director and the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID:

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If continuation sheet

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10/14/2022

PRINTED:

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING IDENTIFICATION NUMBER AND PLAN OF CORRECTION 00

HICKOR	Y CREEK AT GRE	ENSBURG		LINCOLN ST ISBURG, IN 47240	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION
TAG	regulation to have a and they were activ did not have a polio duty for 8 hours ea From September 1 schedule indicated	A LSC IDENTIFYING INFORMATION an RN on duty 8 hours a day ely trying to hire an RN. They ey related to having an RN on ch day. through September 8 as worked there had not been an RN on g on Saturday, 09/03/22, or	TAG	Director of Nursing to ensure that RN coverage is in place. If RN coverage is needed, the facility will contact staffing agencies and the in-company staffing group to obtain an RN. The Executive Director and Director of Nursing are continuing to recruit and hire RNs, full and part time. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place? To ensure compliance the ED/DNS will review the staffing schedule showing RN coverage monthly for 6 months with the CQI team will re-evaluate the continue need for review. If RN coverage has not been achieved as required, an action plan will be developed, and review will continuent until RN coverage has been achieved 7 days a week for 8 consecutive hours.	ί g Qί ed
F 0755 SS=E Bldg. 00	§483.45 Pharmad The facility must p emergency drugs residents, or obta described in §483 permit unlicensed	/Pharmacist/Records			

(X3) DATE SURVEY

COMPLETED

OMB NO. 0938-039

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		X3) DATE SURVEY COMPLETED 09/08/2022	
	PROVIDER OR SUPPLIE		1620	T ADDRESS, CITY, STATE, ZIP COD N LINCOLN ST ENSBURG, IN 47240	•	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETIC	
	provide pharmacc procedures that a acquiring, receivi administering of a meet the needs of §483.45(b) Servic must employ or of licensed pharmacc §483.45(b)(1) Pro aspects of the pro in the facility. §483.45(b)(2) Es records of receipi controlled drugs i an accurate record §483.45(b)(3) De are in order and t controlled drugs i periodically record Based on record re failed to have med residents reviewed (Residents 6 and 9) Findings include:	ce Consultation. The facility btain the services of a cist who- ovides consultation on all ovision of pharmacy services cablishes a system of and disposition of all n sufficient detail to enable nciliation; and termines that drug records hat an account of all s maintained and iciled. view and interview, the facility cations available for 2 of 5 for unnecessary medications.	F 0755	It is the standard of this to provide pharmaceutic services (including proce that assure the accurate acquiring, receiving, dispensing and administ of all drugs and biologica meet the needs of each	al edures ering	
	(Minimum Data Se indicated the reside diagnoses included cancer, anemia, hy	05 A.M. An Admission MDS (b) assessment, dated 06/01/22, (c) twas cognitively intact. The , but were not limited to, pertension, renal insufficiency, tage renal disease. The		resident. 1) What corrective action w be accomplished for those residents found to have affected by the deficient	se been	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2022	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD I LINCOLN ST		
HICKOR	Y CREEK AT GRE	ENSBURG		NSBURG, IN 47240		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E COMPLETIC	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ved dialysis while a resident in		e?		
	the facility.			Resident #6's EMARs were		
				reviewed on 9/29/22 at which ti	me	
		ysicians' order, with a start date		physician was contacted and		
		ated the resident was to take		notified of Eliquis being unavail		
		medication) 5 mg (milligrams),		on 7/14/22, 7/15/22, 7/16/22, a	nd	
	twice a day.			7/17/22 as well has		
				Carbamazepine on 9/8/22.		
	· ·	ysicians' order, with a start date		Resident #9's EMARs were		
	of 09/07/22, indica	ated the resident was to take		reviewed on 9/21/22 at which ti	me	
	carbamazepine (ar	n anticonvulsant medication) 100		the physician was contacted ar	nd	
	mg, twice a day.			notified of Levothyroxine being		
			unavailable on 6/23/22, 6 September 2022 EMARS 7/19/22, 7/20/22, 7/21/22		<u>2,</u>	
	The July, August,	and September 2022 EMARS			/22,	
	(Electronic Medic	ectronic Medication Administration Record) for		8/14/22, 8/15/22, 8/16/22, 8/18	/22,	
	Resident 6 indicat	ed the resident had not received		Symbicort on 6/14/22, 6/17/22,		
	the following med	ications due to being		Bupropion 7/19/22, Fish Oil		
	unavailable:			7/27/22, and 7/28/22, Gabaper	ntin	
				7/03/22, Guaifenesin 7/21/22,		
	- Eliquis on 07/14	/22 at 7:00 A.M. to 11:00 A.M.,		7/22/22, 7/26/22, Metoprolol		
	07/15/22 at 7:00 A	A.M. to 11:00 A.M., 07/16/22 at		7/22/22 and Mirtazapine 9/6/22	, 	
	7:00 A.M. to 11:0	0 A.M. and 6:00 P.M. to 10:00		2)		
	P.M., and 07/17/2	2 at 7:00 A.M. to 11:00 A.M., and		How other residents having		
				the potential to be affected by	/t	
	-carbamazepine or	n 09/08/22 at 7:00 A.M. to 11:00		he		
	A.M.,			same deficient practice will be	e	
				identified and what corrective	,	
	The clinical record	d lacked documentation the		action(s) will be taken.		
	physician was not	ified of the resident not		All residents receiving medicati	ons	
	receiving the med	ications.		from pharmacy have the potent	tial	
				to be affected by the alleged		
	2. The clinical rec	ord for Resident 9 was reviewed		deficient practice. All medicatio	ns	
	on 09/06/22 at 11:	16 A.M. A Significant Change		were reviewed by DNS/Design		
	MDS assessment,	dated 06/21/22, indicated the		to ensure medications are		
		itively intact. The diagnoses		available as ordered by the MD).	
		e not limited to, stroke, anemia,		All nurses have been re-educa		
		rtension, anxiety, depression,		on notifying the physician if a		
	and non-Alzheime			resident does not receive a		
				medication in the clinical record	d. I	
	An open ended ph	ysician's order, with a start date		3)		

	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155353	B. WING		09/08/2022
NAME OF I	PROVIDER OR SUPPLIEF	-		ADDRESS, CITY, STATE, ZIP COD	-
INTIME OF 1	ROVIDER OR SOTTEIET	ς τ		LINCOLN ST	
HICKOR	Y CREEK AT GREE	ENSBURG	GREEM	NSBURG, IN 47240	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	BE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ed the resident was to take		What measures will be pu	t
	levothyroxine (a th	yroid medication) 88 mcg		into place or what systemi	c
	(micrograms), once	a day.		changes will be made to en	nsur
				е	
	An open ended phy	sician's order, with a start date		that the deficient practice	does
	of 11/16/21, indicat	ed the resident was to take		not recur?	
	Symbicort (an inhal	ler) two puffs, twice a day.		All nurses have been re-ed	ucated
				on notifying the physician if	a
	An open ended phy	sician's order, with a start date		resident does not receive a	
	of 11/16/21, indicat	ed the resident was to take		medication in the clinical red	cord.
	buspirone (an anxie	ety medication) 10 mg		The DON/ADON/designee	will
	(milligrams), twice			complete daily audits on-	
		-		scheduled days of work to e	ensure
	An open ended phy	sician's order, with a start date		all notifications are being for	
	of 05/25/22, indicat	ed the resident was to take Fish		when a medication is not	
	Oil (a supplement)	1 (gram), twice a day.		available. Any noted conce	erns
				notification will be addresse	
	An open ended phy	sician's order, with a start date		immediately with the nurse	
		ed the resident was to take		duty and noted on the daily	
		pain medication) 100 mg,		form. The daily audits comp	
	three times a day.			by DON/ADON will be turne	
				the Administrator on schedu	
	An open ended phy	sician's order, with a start date		days of work as proof of one	
		ed the resident was to take		compliance.	
		medication) 600 mg, twice a		4)	
	day.	, 6,		How the corrective action	(s)
				will be monitored to ensur	.,
	An open ended phy	sician's order, with a start date			-
		the resident was to take		deficient practice will not r	ecur
		l pressure medication) 50 mg,		, i.e. what quality assuran	
	twice a day.			program will be put into pl	
	, in the second s			.	
	An open ended phy	sician's order, with a start date		To ensure compliance the	
		ed the resident was to take		DNS/Designee will complete	ea I
		idepressant medication) 30 mg,		medication availability CQI	
	once a day.			tool for six months with aud	
				being completed once week	
	The June. July. Aug	gust, and September 2022		one month, and then month	•
		c Medication Administration		months by a nurse manage	-
		nt 6 indicated the resident had		designee. The medication	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

58Z011

Facility ID: 000244

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PRINTED: 10/14/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	A.	MULTIPLE CO BUILDING WING	DNSTRUCTION 00	COMI	3) DATE SURVEY COMPLETED 09/08/2022	
	PROVIDER OR SUPPLIE			1620 N	ADDRESS, CITY, STATE, ZIP C LINCOLN ST NSBURG, IN 47240	OD		
HICKOF (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O not received the for being unavailable: - levothyroxine on 07/20/22, 07/21/22 08/16/22, 08/18/22 - Symbicort on 06/ A.M., 06/17/22 fro - buspirion on 07/1 A.M., - Fish Oil on 07/27 A.M., 07/28/22 fro - gabapentin on 07 8:00 A.M., - guaifenesin on 07 A.M., 07/22/22 fro 07/26/22 from 7:00 - metoprolol on 07 A.M., and - mirtazepine on 00 A.M.	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION llowing medications due to 06/23/22, 06/24/22, 07/19/22, 2, 07/22/22, 08/14/22, 08/15/22,				HOULD BE APPROPRIATE DOI WIII be the CQI nths after II ued need for shold is not n will be in this sciplinary uding	(X5) COMPLETIO DATE	
	receiving the medi During an intervie 4 indicated when r were not available in the EMAR and notified. She woul note that she had n	fied of the resident not cations. w on 09/06/22 at 2:37 P.M., LPN nedications or supplements to give it would be documented the physician should be d also document in a progress otified the physician. be ordered from the pharmacy						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/08/2022 155353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1620 N LINCOLN ST HICKORY CREEK AT GREENSBURG GREENSBURG, IN 47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE every day. If the script was recurrent the medication could be ordered before 4 P.M. for it to arrive the same evening. The current facility policy titled, "1.0 Providing Pharmacy Products and Services", with a revision date of 01/01/13, was provided by the DON (Director of Nursing) on 09/08/22 at 1:21 P.M. The policy indicated, "...During the normal business hours set forth in the Facility-Specific Information Sheet, facility staff may contact pharmacy by phone or fax at the phone/fax numbers provided in the Facility-Specific Information Sheet, or by mail or hand delivery, as specified by applicable law ... " 3.1-25(a) F 0757 483.45(d)(1)-(6) SS=D Drug Regimen is Free from Unnecessary Bldg. 00 Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 58Z011 Page 27 of 33 Event ID: Facility ID: 000244 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

10/14/2022

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 09/08/2022		
	PROVIDER OR SUPPLIE			1620 N	ADDRESS, CITY, STATE, ZIP COD			
	IT CREEK AT GRE	ENSBORG		GREEN	NSBURG, IN 47240			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	reasons stated in (5) of this section Based on record re failed to follow phy parameters for a bl of 5 residents revie medications. (Resi Findings include: The clinical record on 09/06/22 at 2:55 (Minimum Data Se indicated the reside impaired. The diag limited to, cancer, depression. The August and Se (Electronic Medica were provided by t on 09/08/22 at 1:22 The record indicate open-ended physic 07/20/22, to receiv twice a day for a d medication was to than 55, SBP [Syst than] 110" The record	eview and interview, the facility ysician's orders related to hold ood pressure medication for 2 ewed for unnecessary dent 13) I for Resident 13 was reviewed 5 P.M. A Quarterly MDS et) assessment, dated 06/30/22, ent was moderately cognitively moses included, but were not hypertension, anxiety, and eptember 2022 EMARS ation Administration Records) the DON (Director of Nursing)	F 07	757	It is the standard of this fact to follow physician orders related to hold parameters for a blood pressure medication 1) What corrective action will be accomplished for those residents found to have bee affected by the deficient pra- e? Resident #13's physician was contacted and notified of hold parameters not being follower related to resident Metoprolol 8/3/22, 8/4/22, 8/5/22, 8/7/22, 8/8/22, 8/9/22, 8/10/22, 8/13/2 8/20/22, 8/21/22, 8/22/22, 8/13/2 8/20/22, 8/21/22, 8/22/22, 8/2 9/1/22, 9/2/22, 9/3/22, 9/4/22, 9/5/22, and 9/6/22. 2) How other residents having the potential to be affected to he same deficient practice will identified and what corrective action(s) will be taken. All residents having hold parameters related to their bloc	or n. ctic s d on 22, 9/22, 9/22, 9/22, 9/22, 9/22,	10/07/2022	
	out of the specified - 08/03/22 from 6:0 pressure was 99/59 - 08/04/22 from 6:0 pressure was 98/62	00 P.M. to 10:00 P.M., the blood), 00 P.M. to 10:00 P.M., the blood	s: potential to be aff alleged deficient p review was comp residents who cur parameters relate pressure medicati		pressure medication have the potential to be affected by the alleged deficient practice. A review was completed on all residents who currently have parameters related to their blo pressure medication are bein followed as ordered. The DOI	hold bod g		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	onstruction ((X3) DATE SURVEY COMPLETED 09/08/2022	
		155353	B. WING			
NAME OF	PROVIDER OR SUPPLIE	ZR.		ADDRESS, CITY, STATE, ZIP COD		
HICKOR	Y CREEK AT GRE	ENSBURG		I LINCOLN ST NSBURG, IN 47240		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	E CO	MPLETIO
TAG	REGULATORY O	PR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	pressure was 98/62	2,		designee re-educated the facili	ty	
	- 08/07/22 from 7:	00 A.M. to 11:00 A.M., the blood		nurses following physician orde	ers	
	pressure was 96/54	4,		related to hold parameters for		
	- 08/08/22 from 6:	00 P.M. to 10:00 P.M., the blood		blood pressure medications.		
	pressure was 102/6			3)		
		00 A.M. to 11:00 A.M., the blood		What measures will be put		
	-	6, and from 6:00 P.M. to 10:00		into place or what systemic		
	P.M., the blood pr			changes will be made to ensu	ır 🛛	
	- 08/10/22 from 6:	00 P.M. to 10:00 P.M., the blood		е		
	pressure was 100/6			that the deficient practice doe	es	
		00 A.M. to 11:00 A.M., the blood		not recur?		
	-	3, and from 6:00 P.M. to 10:00		The DON or designee in-servic	ed	
	P.M., the blood pr			facility nurses on following		
	- 08/14/22 from 7:	00 A.M. to 11:00 A.M., the blood		physician orders related to hold	ł	
	pressure was 90/58	8, and from 6:00 P.M. to 10:00		parameters for blood pressure		
	P.M., the blood pr	essure was 96/62,		medications. When a resident h	nas	
	- 08/17/22 from 7:	00 A.M. to 11:00 A.M., the blood		a blood pressure outside the ho	bld	
	pressure was 101/5	58, and from 6:00 P.M. to 10:00		parameters the physician order	rs	
	P.M., the blood pr	essure was 105/64,		will be followed as appropriate.	lf	
	- 08/18/22 from 6:	00 P.M. to 10:00 P.M., the blood		there are hold parameters not		
	pressure was 105/6	54,		being followed, the nurse will		
	- 08/19/22 from 7:	00 A.M. to 11:00 A.M., the blood		contact the physician and		
	pressure was 109/6	51,		re-educated the nurse. The DC	N	
	- 08/20/22 from 7:	00 A.M. to 11:00 A.M., the blood		or designee will review blood		
	pressure was 102/5	· · · · · · · · · · · · · · · · · · ·		pressure medications with, hold	d l	
		00 A.M. to 11:00 A.M., the blood		parameters daily during the		
	pressure was 106/5			clinical meeting,		
		00 P.M. to 10:00 P.M., the blood		4)		
	pressure was 101/5			How the corrective action(s)		
	- 08/23/22 from 6: pressure was 109/6	00 P.M. to 10:00 P.M., the blood 63,		will be monitored to ensure th	ne	
	-	00 A.M. to 11:00 A.M., the blood		deficient practice will not recu	ur 🛛	
	pressure was 97/65			, i.e. what quality assurance		
	-	00 P.M. to 10:00 P.M., the blood		program will be put into place	?	
	pressure was 95/55			To ensure compliance the		
	-	00 P.M. to 10:00 P.M., the blood		DNS/Designee will completed		
	pressure was 101/7			blood pressure medication revi	ews	
	-	00 A.M. to 11:00 A.M., the blood		if they include hold parameters		
	pressure was 104/7			CQI audit tool for six months wi		
		00 A.M. to 11:00 A.M., the blood		audits being completed once		

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Event ID:

58Z011 Facility ID: 000244

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 09/08/2022	
	PROVIDER OR SUPPLIE		1620 N	ADDRESS, CITY, STATE, ZIP CO I LINCOLN ST NSBURG, IN 47240	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PPROPRIATE	(X5) COMPLETION DATE
	P.M., the blood pro- - 09/06/22 from 7: pressure was 97/57 P.M., the blood pro- During an intervie DON (Director of	w on 09/08/22 at 11:49 A.M., the Nursing) indicated the facility following MD orders and it was		weekly for one month, a monthly for 5 months by manager or designee. T pressure medication rev they include hold param audit tool CQI audit tool reviewed monthly by the Committee for six month which the QAPI team w re-evaluate the continue the audit. If a 95% three achieved an action plan developed. Deficiency in practice will result in dis action up to and or inclu- termination of the respon- employee.	y a nurse The blood views if neters CQI will be e CQI hs after ill ed need for shold is not n will be n this sciplinary uding	
= 0761 SS=D Bldg. 00	S=D Label/Store Drugs and Biologicals					

PRINTED: 10/14/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155353	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		00	(X3) DATE SURVEY COMPLETED 09/08/2022	
	PROVIDER OR SUPPLI			1620 N	address, city, state, zip cod I LINCOLN ST NSBURG, IN 47240		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſE	(X5) COMPLETION DATE
	Drug Abuse Pret 1976 and other of except when the package drug dit the quantity store dose can be rea Based on observat failed to store med medication carts r Findings include: During an observat two medication car (Licensed Practica observed: - a lispro insulin p opened and undat medication should date on the packag when the medicat refrigerator becau package for a new - a bottle of liquid 40 ml (milliliters) - a used albuterol open date, - a bottle of liquid open date,	tion and interview, the facility dications appropriately for 2 of 2 eviewed. ation on 09/01/22 at 10:07 A.M., arts were reviewed with LPN al Nurse) 2. The following was ben for Resident 6 was not ed. The LPN indicated the 1 have been dated. The delivery ge was not a good indication ion was pulled from the se they will use the same 7 pen, Colace for Resident 10 that had left with no open date, inhaler for Resident 21 with no in pen for Resident 5 with 200 open date, Colace for Resident 19 with no	F 0'	761	It is the standard of this facilit to ensure labeling of drugs a biological drugs and biologicals used in the facilit must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expirati date when applicable. 1) What corrective action will be accomplished for those residents found to have been affected by the deficient prace e? The insulin pen for resident 6 5, liquid Colace for resident 10 19, Albuterol inhaler for reside 21, ocean nasal spray for reside 16, and Budesonide inhaler for resident 22 have been replace and currently have a date oper 2) How other residents having the potential to be affected by he same deficient practice will b identified and what corrective action(s) will be taken. All residents using insulin pens inhaler, and liquid medication for	nd y ce on stic and nt dent re d hed. y t	10/07/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 09/08/2022		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1620 N LINCOLN ST GREENSBURG, IN 47240				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETIC DATE	
	 - an almost empty Resident 22 with r LPN 2 indicated a had an open date a medication carts. The current facilit Expiration of Med and Needles", with was provided by th 3:41 P.M. The pol ensure that medica have and expired of retained longer that manufacturer or su medication or biol Facility should fol guidelines with re- opened medication the date opened on when the medicatin date once opened. 	inhaler of budesonide for no open date II the medications should have and removed them from the y policy titled, "Storage and lications, Biological's, Syringes in a revision date of 10/31/16, the Administrator on 09/07/22 at icy indicated, "Facility should ations and biological's that: (1) date on the label; (2) have been an recommended by upplier guidelinesOnce any ogical package is opened, low manufacturer/supplier spect to expiration dates for ns. Facility staff should record in the medication container on has a shortened expiration Facility staff may record the for date based on date opened		the potential to be affected alleged deficient practice. insulin pens, inhalers and medication were audited of DON to ensure that they a currently labeled with an of date. All nurses have bee re-educated on labeling a storage of drugs policy. 3) What measures will be p into place or what system changes will be made to e that the deficient practic not recur? All nurses have been re-e on labeling and storage of policy. The DON/ADON w complete daily audits on scheduled days of work to all policies related to label storage of medications an followed. Any noted conce labeling and storage of medications will be address immediately with the nurs duty and noted on the dai form. The daily audits con by DON/ADON will be turn the Administrator on sche days of work as proof of c compliance. 4) How the corrective action will be monitored to ensu- deficient practice will no , i.e. what quality assura program will be put into	All liquid (1 by the are open n nd out mic ensur e does educated f drugs vill o ensure ling and e being erns with ssed e on ly audit npleted ned into duled ongoing on(s) ure the t recur ince	DATE	

	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155353		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		x3) date survey completed 09/08/2022		
	JAME OF PROVIDER OR SUPPLIER		1620 N	ADDRESS, CITY, STATE, ZIP COD I LINCOLN ST NSBURG, IN 47240	•	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION	
				To ensure compliance the DNS/Designee will complet insulin storage CQI audit to six months with audits being completed once weekly for month, and then monthly fo months by a nurse manage designee. The insulin storag audit tool will be reviewed in by the CQI Committee for s months after which the CQI will re-evaluate the continue for the audit. If a 95% thresh not achieved an action plan developed. Deficiency in thi practice will result in discipli action up to and or including termination of the responsite employee.	ol for g one r 5 r or ge CQI nonthly ix team ed need hold is will be s inary g	

58Z011 Facility ID: 000244

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