STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00388344. Complaint IN00388344 - Unsubstantiated due to lack of evidence. Survey dates: September 1, 2, 6, 7, and 8, 2022 Facility number: 000244 Provider number: 155353 AIM number: 100288790 Census Bed Type: SNF/NF: 29 Total: 29 Census Payor Type: Medicare: 4 Medicaid: 21 Other: 4 Total: 29 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 14, 2022.	F 0000	This Plan of Correction constitutes the written allegation of compliance for deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	chemical restraint not required to treat the resident's medical symptoms. Based on record review and interview, the facility failed to prevent misappropriation of resident medications for 1 of 11 residents reviewed. (Resident 9) Findings include: A Facility Reportable Incident, dated 08/16/22, indicated Resident 9 was missing his Xanax (a controlled substance anxiety medication) from a locked medication cart. The medication carts were searched without results, the nurses were questioned on delivery. The pharmacy and physician were notified, and a new prescription was obtained. The local police department was notified, and a report was filed. The medication was replaced by the facility and a suspected employee was terminated. A Pharmacy Delivery Receipt, dated 08/07/22, indicated a count of 60, 1 mg (milligram) tablets of Xanax for Resident 9 were delivered to the facility and signed by an RN. During an interview on 09/06/22 at 2:48 P.M., the Administrator indicated she had been notified that the resident was missing two pill packs with 30 tablets in each pack, of his Xanax. Herself, the DON (Director of Nursing), and ADON (Assistant Director of Nursing) had all looked for the cards of medications and could not find them. Upon investigating the medications were ordered and delivered from the pharmacy. The narcotic count sheets were missing but was able to locate the paper where RN 5 had signed for the delivery of the medications. The DON had spoken with RN 5, and she said she never signed for the medications. The local police were called, and a	F 0602	**It is the standard of this facility to prevent misappropriation of resident medications.** **1)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** The pharmacy and physician were notified of the missing medication and a new prescription was obtained. The local police department was notified and a report was filed. Resident #9's medication was replaced by the facility and the suspected employee was terminated. **2)** **How other residents having the potential to be affected by t he same deficient practice will be identified and what corrective action(s) will be taken.** All residents receiving controlled substances had the potential to be affected, a controlled substance audit was completed. No other residents were found to be affected. Staff were interviewed by ED/Designee regarding the missing medication with no results identified. DNS/Designee completed an audit of all controlled substance to ensure all other medications were	10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	report was filed. A new prescription was obtained and filled for the resident. The nurse was a no call no show for her next shift, but would have been let go. There were no other medication discrepancies in the building and the resident was not harmed. The current facility policy, titled "Abuse Prohibition, Reporting, and Investigation", with a revised date of February 2020, was provided by the DON on 09/06/22. The policy indicated, "...Provide guidelines to prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property...provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation...Misappropriation of Resident Fund or Property- Deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's property or money without the resident's consent..." 3.1-28(a)		available as prescribed. The DON or designee re-educated the facility nurses on the “Abuse Prohibition, Reporting, and Investigation Policy related to misappropriation of resident property.” **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DON or designee in-serviced facility nurses on the “Abuse Prohibition, Reporting, and Investigation Policy related to misappropriation of resident property.” DON or designee will complete daily controlled substance checks to ensure controlled substances are being accounted for properly when delivered. **4)** **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 DNS/Designee will complete a daily controlled substance delivery verification for one month, and then monthly for 5 months by a nurse manager or designee. The controlled substance delivery verification CQI audit tool CQI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			audit tool will be reviewed monthly by the CQI Committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to follow the physicians' orders and complete neurological assessments after falls for 2 of 3 residents reviewed for falls. (Residents 15 and 13) Findings include: 1. The clinical record for Resident 15 was reviewed on 09/08/22 at 9:19 A.M. An Admission MDS (Minimum Data Set) assessment, dated 06/24/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, orthostatic hypotension, diabetes, and osteoporosis.	F 0684	**It is the standard of this facility to follow the physicians orders and complete neurological assessments after falls.** **1) What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident #15 and 13's fall events were reviewed on 9/29/22 at which time the physician was contacted and notified of the missed neurological assessments and orthostatic b/p checks. **2)**	10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Fall Event, dated 07/28/22 at 8:10 P.M., indicated the resident had a fall in the bathroom that was witnessed by staff. The resident was attempting to transfer herself to the commode when she had gotten dizzy and tried to sit back down. A Fall Event, dated 07/29/22 at 9:19 P.M., indicated the resident had an unwitnessed fall in her bedroom. An IDT (Interdisplinary Team) Note, dated 08/01/22 at 10:10 A.M., indicated the IDT was for a resident's fall on 07/28/22. The root cause of the fall was orthostatic hypotension. An IDT (Interdisplinary Team) Note, dated 08/01/22 at 1:36 P.M., indicated the IDT was for a fall on 07/29/22. The root cause of the fall was orthostatic hypotension. A Progress Note, dated 08/01/22 at 2:25 P.M., indicated new orders were received for the resident to have a urinalysis and orthostatic blood pressures and heart rate. During an interview on 09/08/22 at 10:34 A.M., LPN (Licensed Practical Nurse) 2 indicated orthostatic blood pressures were obtained lying, sitting, and standing. The blood pressures would be documented in the EMAR (Electronic Medication Administration Record). During an interview on 09/08/22 at 10:44 A.M., the DON (Director of Nursing) indicated orthostatic blood pressures were obtained lying, sitting, and standing. The blood pressures would be documented in the EMAR. During an interview on 09/08/22 at 1:21 P.M., the		**How other residents having the potential to be affected by t he same deficient practice will be identified and what corrective action(s) will be taken.** All residents having falls have the potential to be affected by the alleged deficient practice A fall audit was completed on all residents who fell in the last 30 days to ensure neurological assessments and root cause interventions were initiated and followed. The DON or designee re-educated the facility nurses on post fall neurological assessment will be initiated on all unwitnessed falls. **3)** **What measures will be put into place or what systemic changes will be made to ensur e that the deficient practice does not recur?** The DON or designee in-serviced facility nurses on post fall neurological assessment being initiated on all unwitnessed falls. When a resident has an unwitnessed fall a neurological assessment will be initiated. The oncoming nurse will review the fall event and continue the neurological assessments per the schedule. If there are missing neurological assessment, the nurse will contact the physician. The DON or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	DON indicated there were no neurological checks completed after the resident's fall on 07/29/22. The clinical record lacked any neurological assessments after the unwitnessed fall on 07/29/22 or any orthostatic blood pressures with heart rates. 2. 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 resident had one fall with no injury, and one fall with an injury that was not major, since the last assessment on 05/06/22. A Fall Event record, dated 06/12/22, was provided by the DON on 09/08/22 at 2:02 P.M. The record indicated the resident had an unwitnessed fall on 06/12/22 at 6:30 P.M. The resident had been sitting in his wheelchair in his room and was first observed, after the fall, lying on his left side in front of his wheelchair. The Progress Notes for June 2022, were provided by the Corporate Nurse on 09/08/22 at 2:22 P.M. A note, dated 06/12/22 at 9:10 P.M., indicated the resident had slid out of his wheelchair during a coughing event. The resident was assisted up off the floor with the aid of three staff members. The clinical record lacked documentation that neurological assessments had been completed following the fall on 06/12/22. During an interview on 09/08/22 at 1:23 P.M., the DON indicated there should have been neurological assessments completed for the resident's fall on 06/12/22.		complete a review of the neurological assessment schedule during the daily clinical meeting. **4)** **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 DNS/Designee will complete a fall event/neurological assessment/intervention initiation CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The fall event/neurological assessment/intervention initiation CQI audit tool CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The current Fall Management Program policy, with a revised date of 11/2017, was provided by the DON on 09/08/22 at 10:33 A.M. The policy indicated, "...Post fall...A neurological assessment will be initiated on all unwitnessed falls..." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to administer wound treatments for 1 of 2 residents reviewed for pressure ulcers. (Resident 4) Findings include: On 09/06/22 at 9:30 A.M., Resident 4 was observed in her room sitting in her wheelchair. The resident was wearing pressure reducing boots on both lower extremities. The resident was pleasant and indicated she had just received a shower and was doing well. She had had a wound	F 0686	**It is the standard of this facility to administer wound treatment for pressure ulcers.** **1)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident #4's treatment orders were reviewed on 9/29/22 at which time physician was and notified. **2)**	10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on her foot, but it was healed now. The resident's clinical record was reviewed on 09/06/22 at 10:00 A.M. An Admission MDS (Minimum Data Set) assessment, dated 02/07/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, non-Alzheimer's dementia, hypertension, MS (Multiple Sclerosis), depression, and muscle weakness. The resident required extensive assistance from two staff members for bed mobility and was totally dependent on staff for transfers and locomotion on and off the unit. One of the resident's upper extremities was impaired. The resident did not walk and used a wheelchair. The resident was at risk for pressure ulcers and utilized pressure reducing devices for the bed and chair. There were no pressure ulcers present during the assessment review period. A Wound Management Report, dated 02/15/2022 at 10:43 A.M., indicated a pressure ulcer was identified on the top of the resident's right foot. The wound measured 2 cm (centimeters) x (by) 1.5 cm. The comments section indicated the resident had a hard calloused area that was dark purple/red in color. The resident had pressure reducing interventions in place and denied pain or discomfort. The wound was described as stable. An MD visit note, dated 02/15/22, indicated the resident had a DTI (Deep Tissue Pressure Injury), a purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlaying soft tissue from pressure and/or shearing) on her right foot. The treatment orders were to apply Skin Prep (a liquid film forming dressing) and monitor the wound. The MD indicated it would be difficult to offload the		**How other residents having the potential to be affected by t he same deficient practice will be identified and what corrective action(s) will be taken.** All residents with pressure areas had the potential to be affected by the alleged deficient practice. A skin check was completed on all residents who currently have pressure ulcers to ensure treatment orders are in place for all open areas. The DON or designee re-educated the facility nurses on assessing the skin and ensuring the physician is contacted for treatment orders continue until the area heals. **3)** **What measures will be put into place or what systemic changes will be made to ensur e that the deficient practice does not recur?** The DON or designee in-serviced facility nurses on assessing the skin and ensuring the physician is contacted for treatment orders continue until the area heals. When a resident is identified as having a skin issue the physician will be notified, a treatment order obtained with a root cause being identified. The wound nurse will monitor the wound weekly and verify the treatment order to ensure continued appropriateness and need. If there are treatment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident's heel because of her chronic MS related issues. The February and March 2022 TARs (Treatment Administration Record) were provided by the Corporate Nurse on 09/08/22 at 11:22 A.M. The February 2022 TAR included an open ended physician's order, with a start date of 02/15/22, to apply Skin Prep to the resident's right foot for the DTI every shift. The treatment was administered as ordered. The March TAR lacked documentation of a treatment to the resident's foot. A Wound Management Report, dated 03/17/22 at 7:05 P.M., indicated the wound measured 2 cm x 1.5 cm. The comments section indicated the wound remained a hard calloused area that was dark purple/brown in color. The resident had pressure reducing interventions in place and reported some discomfort to the wound site at times. The wound was described as stable. A Progress note dated 03/22/22 at 6:09 P.M. indicated the MD was in to see the resident and new orders were received. An MD visit note, dated 03/22/22, indicated the pressure ulcer on the resident's lateral right foot contained eschar (dark necrotic skin), and was no longer just a deep tissue injury. New orders included a treatment of Medihoney and a dressing to be changed every 48 hours. They might need to consider a wound clinic or podiatry referral if the wound did not improve. The March 2022 TAR and ETAR (Electronic Treatment Administration Record) lacked documentation of administration of a treatment for the resident's right foot from 03/01/22 until		orders missing, the nurse will contact the physician that day for the appropriate treatment orders. The DON or designee will review wounds weekly for accuracy and appropriate treatment use. **4)** **How the corrective action(s) wil l 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 DNS/Designee will complete a wound review CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The new admission treatment CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 SS=E Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(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 failed to ensure residents received ordered nutritional supplements for 5 of 12 residents reviewed. (Residents 10, 3, 6, 22, and 13) Findings include: 1. The clinical record for Resident 10 was reviewed on 09/06/22 at 1:38 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 06/22/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's disease, COPD (Chronic Obstructive Pulmonary Disease), and dysphagia. The resident required extensive staff assistance with eating. The resident was admitted to hospice services on 07/28/22. A Registered Dietician Progress Note, dated	F 0692	It is the practice of this facility must ensure residents receive ordered nutritional supplementations ordered. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Residents 10, 3, 6, 22, 13 were reviewed for appropriateness and acceptance of oral supplements, oral supplements given at meals will only be placed in Dietary orders under special instructions and provided by culinary. Oral supplements between meals will continue as ordered and be provided by nursing. All residents	10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	08/04/2022 at 8:54 A.M., indicated the resident had experienced a 7 lb. (pound) weight loss in 30 days, a 13 lb. weight loss in 90 days, and a 24 lb. weight loss in 180 days. The resident was receiving hospice services and further weight loss could be expected. The resident received an appetite stimulant and nutritional supplements. The resident's current physician's orders included an open ended order, with a start date of 05/16/22, that indicated the resident was to receive a Mighty Shake (a protein and calorie dense nutritional supplement) with all meals (three times a day). The July, August, and September 2022 EMARs (Electronic Medication Administration Record) were reviewed and indicated the resident had not received the shakes on the following dates and times due to the supplement not being available: - 07/11/22 from 12:00 P.M. to 2:00 P.M., - 07/12/22 from 8:00 A.M. to 10:00 A.M., - 07/13/22 from 8:00 A.M. to 10:00 A.M., - 07/16/22 from 5:00 P.M. to 7:00 P.M., - 07/22/22 from 12:00 P.M. to 2:00 P.M., and 5:00 P.M. to 7:00 P.M., - 07/25/22 from 8:00 A.M. to 10:00 A.M.,12:00 P.M. to 2:00 P.M., and 5:00 P.M. to 7:00 P.M., - 07/26/22 from 12:00 P.M. to 2:00 P.M., and 5:00 P.M. to 7:00 P.M., - 07/27/22 from 8:00 A.M. to 10:00 A.M., - 07/30/22 from 5:00 P.M. to 7:00 P.M., - 08/04/22 from 5:00 P.M. to 7:00 P.M., - 08/08/22 from 5:00 P.M. to 7:00 P.M., - 08/13/22 from 8:00 A.M. to 10:00 A.M., - 08/18/22 from 5:00 P.M. to 7:00 P.M., - 09/01/22 from 5:00 P.M. to 7:00 P.M., - 09/02/22 from 8:00 A.M. to 10:00 A.M.,12:00 P.M. to 2:00 P.M., and 5:00 P.M. to 7:00 P.M., and - 09/05/22 from 8:00 A.M. to 10:00 A.M.,12:00 P.M.		on supplements will be added to the supplement tracking form. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in facility have the potential to be affected by this deficient practice. Nursing/culinary staff in-serviced. With oral supplements with meals under culinary, culinary will alert CM, Nursing of residents acceptance/refusal along with offering comparable substitute if drug item unavailable. With oral supplement between meals, Nursing will provide oral supplements as ordered, if drug item unavailable, Nursing will alert DNS/CM/RD of appropriate substitute. DNS will keep supplement tracking form up to date as new or D/C orders come 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 meeting for new orders of supplementation with meals and between meals, ensure Hot charting for new supplement orders completed and add/remove resident from supplement tracking form. All	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to 2:00 P.M., and 5:00 P.M. to 7:00 P.M. 2. The clinical record for Resident 3 was reviewed on 09/06/22 at 2:40 P.M. A Quarterly MDS assessment, dated 05/25/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's disease, diabetes, COPD, and peripheral vascular disease. The resident's current physician's orders included an open ended order, with a start date of 09/15/21, that indicated the resident was to receive a Mighty Shake supplement once a day at 2:00 P.M. The July, August, and September 2022 EMARs (Electronic Medication Administration Record) were reviewed and indicated the resident had not received the shake supplement on the following dates due to the supplement not being available: - 07/21/22, - 07/22/22, - 07/25/22, - 07/26/22, - 07/30/22, - 07/31/22, - 08/04/22, - 08/05/22, - 08/13/22, - 08/14/22, - 08/19/22, - 08/21/22, - 08/22/22, - 08/27/22, - 08/28/22, - 09/02/22, and - 09/05/22. During an interview on 09/08/22 at 10:23 A.M., the Kitchen Manager indicated the kitchen staff		resident on supplements will be adding to supplement tracking form. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Dietary Manager/DNS/designee will complete the Supplement QAPI (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 09/08/22 at 10:20 A.M., LPN 2 indicated if the residents received mighty shake supplements they would be sent out from the kitchen and other supplements like Nepro, 2-cal, and Glucerna would be provided by the nursing department. The current facility policy titled, "Supplements and Nourishments", with a revised date of 06/19, was provided by the DON on 09/08/22 at 1:21 P.M. The policy indicated, "...It is the policy of this facility to ensure residents receive supplements and nourisments appropriate to their nutritional needs, physician's order, and preferences..." 3.1-46(a)(1)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to monitor bruit and thrill for a dialysis site for 1 of 1 resident reviewed for dialysis. (Resident 6) Findings include: The clinical record for Resident 6 was reviewed on 09/06/22 at 10:05 A.M. An Admission MDS (Minimum Data Set) assessment, dated 06/01/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, cancer, anemia, hypertension, renal insufficiency, diabetes, and end stage renal disease. The	F 0698	**It is the standard of this facility to monitor bruit and trill for a dialysis site.** **1)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident #6's dialysis orders were reviewed on 9/23/22 at which time physician was contacted and order received to check for Bruit and Thrill every shift.	10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident had received dialysis while a resident in the facility. A Progress Note, dated 08/05/22 at 5:14 P.M., indicated the resident had a vascular access device of a dialysis port and a fistula in the left forearm. An open-ended physician's order, dated 08/13/22, indicated the resident had a dialysis access site in the left forearm. The site was to be monitored every shift for signs and symptoms of infection, edema, pain, numbness, bleeding, and leaks, and ensure the access site was clean, dry, and a dressing was intact as ordered. The MD was to be notified of unusual findings and document in a progress note. A Care Plan indicated the resident was receiving hemodialysis and was at risk for complications such as fluid imbalance, bleeding, or infection with access site to the left arm. Interventions included, but were not limited to, "...Assess dialysis access site every shift for excessive bleeding, drainage, swelling, redness, warth [warmth], [and] bruit/thrill. Document findings, report abnormals to MD and dialysis..." The clinical record indicated the resident's dialysis fistula bruit and thrill was only monitored on the following dates in August and September 2022: - 08/05/22 at 4:30 P.M. - 08/06/22 at 3:23 A.M., - 08/08/22 at 3:30 P.M., - 08/10/22 at 3:45 P.M., - 08/12/22 at 3:30 P.M., - 08/15/22 at 2:15 P.M., - 08/19/22 at 3:03 P.M., - 08/22/22 at 4:15 P.M.,		**2)** **How other residents having the potential to be affected by t he** **same deficient practice will be identified and what corrective action(s) will be taken**. All dialysis residents admitted had the potential to be affected by the alleged deficiency. An order review was completed on all dialysis residents to ensure treatment orders are in place to check for Bruit and Thrill every shift. The DON or designee re-educated the facility nurses on obtaining order to assess the Bruit and thrill every shift on all dialysis residents on day of admit. 3**)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DON or designee in-serviced facility nurses on obtaining order to assess the Bruit and thrill every shift on all dialysis residents on the day of admit. When a resident admits to the facility the admitting nurse will assess request order to check bruit and thrill on all dialysis residents on day of admit. If there are orders missing, the nurse will contact the physician the day of admission for the appropriate monitoring. The DON or designee will complete an admission audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- 08/24/22 at 2:16 P.M., and - 09/02/22 at 3:10 P.M. During an interview on 09/08/22 at 10:20 A.M., LPN (Licensed Practical Nurse) 2 indicated the resident's bruit and thrill should be monitored once a shift and document in the EMAR (Electronic Medication Administration Record). During an interview on 09/08/22 at 10:42 A.M., the DON (Director of Nursing) indicated the bruit and thrill should be monitored every shift and there should have been a physician's order to monitor it. The current facility policy titled, "Dialysis Care" with a revision date of 11/2017, was provided by the DON on 09/08/22 at 2:02 P.M. The policy indicated, "...to ensure that residents requiring dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care, and the residents' goals and preferences. The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice..." 3.1-37(a)		on the day of admission to ensure all dialysis resident have orders to assess bruit and thrill. **4)** **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 DNS/Designee will complete a bruit and thrill CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The dialysis bruit and thrill CQI audit tool CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§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. Based on interview and record review, the facility failed to provide the required RN (Registered Nurse) on duty for eight hours a day for 2 of the 8 days during the survey time period. Findings include: During an interview on 09/08/22 at 2:27 P.M., the DON (Director Of Nursing) indicated the facility did not have an RN working in the facility for eight consecutive hours on the weekends. She, the DON, was on call every weekend and would come in when needed. There was always an LPN (Licensed Practical Nurse) in the building. They were actively trying to hire more RNs. The DON and RN 6 were the only two RNs currently working in the facility and RN 6 only worked part-time. The corporation required her to come in and make rounds at least once a day on the weekends and on any other day an RN was not on duty. She was not required to stay the full 8 hours. She did not clock in when working on the floor. They had used agency nursing services at times but were having difficulty in regards to the availability of RNs. They did not currently have any nursing waivers. During an interview on 09/08/22 at 2:58 P.M., the Corporate Nurse indicated they had an RN come in a couple of times a day and make rounds when there was no RN on duty. They were aware of the	F 0727	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The facility has obtained RN coverage for 8 consecutive hours a day/ 7 days a week. · RN waiver submitted. Pending approval. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · The daily staffing is reviewed by the Executive Director and the Director of Nursing to ensure that RN coverage is in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · RN waiver submitted. Pending approval · The daily staffing is reviewed by the Executive Director and the	10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	regulation to have an RN on duty 8 hours a day and they were actively trying to hire an RN. They did not have a policy related to having an RN on duty for 8 hours each day. From September 1 through September 8 as worked schedule indicated there had not been an RN on duty in the building on Saturday, 09/03/22, or Sunday, 09/04/22. 3.1-17(b)(3)		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 Committee, after which the CQI team will re-evaluate the continued need for review. If RN coverage has not been achieved as required, an action plan will be developed, and review will continue until RN coverage has been achieved 7 days a week for 8 consecutive hours.	
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to have medications available for 2 of 5 residents reviewed for unnecessary medications. (Residents 6 and 9) Findings include: 1. The clinical record for Resident 6 was reviewed on 09/06/22 at 10:05 A.M. An Admission MDS (Minimum Data Set) assessment, dated 06/01/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, cancer, anemia, hypertension, renal insufficiency, diabetes, and end stage renal disease. The	F 0755	**It is the standard of this facility to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) to meet the needs of each resident.** **1)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic**	10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident had received dialysis while a resident in the facility. An open ended physicians' order, with a start date of 05/25/22, indicated the resident was to take Eliquis (a platelet medication) 5 mg (milligrams), twice a day. An open ended physicians' order, with a start date of 09/07/22, indicated the resident was to take carbamazepine (an anticonvulsant medication) 100 mg, twice a day. The July, August, and September 2022 EMARS (Electronic Medication Administration Record) for Resident 6 indicated the resident had not received the following medications due to being unavailable: - Eliquis on 07/14/22 at 7:00 A.M. to 11:00 A.M., 07/15/22 at 7:00 A.M. to 11:00 A.M., 07/16/22 at 7:00 A.M. to 11:00 A.M. and 6:00 P.M. to 10:00 P.M., and 07/17/22 at 7:00 A.M. to 11:00 A.M., and -carbamazepine on 09/08/22 at 7:00 A.M. to 11:00 A.M., The clinical record lacked documentation the physician was notified of the resident not receiving the medications. 2. The clinical record for Resident 9 was reviewed on 09/06/22 at 11:16 A.M. A Significant Change MDS assessment, dated 06/21/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, anemia, heart failure, hypertension, anxiety, depression, and non-Alzheimer's dementia. An open ended physician's order, with a start date		**e?** Resident #6's EMARs were reviewed on 9/29/22 at which time physician was contacted and notified of Eliquis being unavailable on 7/14/22, 7/15/22, 7/16/22, and 7/17/22 as well has Carbamazepine on 9/8/22. Resident #9's EMARs were reviewed on 9/21/22 at which time the physician was contacted and notified of Levothyroxine being unavailable on 6/23/22, 6/24/22, 7/19/22, 7/20/22, 7/21/22, 7/22/22, 8/14/22, 8/15/22, 8/16/22, 8/18/22, Symbicort on 6/14/22, 6/17/22, Bupropion 7/19/22, Fish Oil 7/27/22, and 7/28/22, Gabapentin 7/03/22, Guaifenesin 7/21/22, 7/22/22, 7/26/22, Metoprolol 7/22/22 and Mirtazapine 9/6/22. **2)** **How other residents having the potential to be affected by t he same deficient practice will be identified and what corrective action(s) will be taken.** All residents receiving medications from pharmacy have the potential to be affected by the alleged deficient practice. All medications were reviewed by DNS/Designee to ensure medications are available as ordered by the MD. All nurses have been re-educated on notifying the physician if a resident does not receive a medication in the clinical record. **3)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of 04/19/22, indicated the resident was to take levothyroxine (a thyroid medication) 88 mcg (micrograms), once a day. An open ended physician's order, with a start date of 11/16/21, indicated the resident was to take Symbicort (an inhaler) two puffs, twice a day. An open ended physician's order, with a start date of 11/16/21, indicated the resident was to take buspirone (an anxiety medication) 10 mg (milligrams), twice a day. An open ended physician's order, with a start date of 05/25/22, indicated the resident was to take Fish Oil (a supplement) 1 (gram), twice a day. An open ended physician's order, with a start date of 08/17/21, indicated the resident was to take gabapentin (a nerve pain medication) 100 mg, three times a day. An open ended physician's order, with a start date of 07/18/22, indicated the resident was to take guaifenesin (a cold medication) 600 mg, twice a day. An open ended physician's order, with a start date of 06/01/21, indicated the resident was to take metoprolol (a blood pressure medication) 50 mg, twice a day. An open ended physician's order, with a start date of 08/22/22, indicated the resident was to take mirtazapine (an antidepressant medication) 30 mg, once a day. The June, July, August, and September 2022 EMARS (Electronic Medication Administration Record) for Resident 6 indicated the resident had		**What measures will be put into place or what systemic changes will be made to ensur e that the deficient practice does not recur?** All nurses have been re-educated on notifying the physician if a resident does not receive a medication in the clinical record . The DON/ADON/designee will complete daily audits ~~on scheduled days of work~~ to ensure all notifications are being followed when a medication is not available. Any noted concerns notification will be addressed immediately with the nurse on duty and noted on the daily audit form. The daily audits completed by DON/ADON will be turned into the Administrator on scheduled days of work as proof of ongoing compliance. **4)** **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 DNS/Designee will complete a medication availability CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not received the following medications due to being unavailable: - levothyroxine on 06/23/22, 06/24/22, 07/19/22, 07/20/22, 07/21/22, 07/22/22, 08/14/22, 08/15/22, 08/16/22, 08/18/22, - Symbicort on 06/14/22 from 7:00 A.M. to 11:00 A.M., 06/17/22 from 7:00 A.M. to 11:00 A.M., - buspirion on 07/19/22 from 7:00 A.M. to 11:00 A.M., - Fish Oil on 07/27/22 from 7:00 A.M. to 11:00 A.M., 07/28/22 from 7:00 A.M. to 11:00 A.M., - gabapentin on 07/03/22 at 8:00 A.M., 07/04/22 at 8:00 A.M., - guaifenesin on 07/21/22 from 7:00 A.M. to 11:00 A.M., 07/22/22 from 07:00 A.M. to 11:00 A.M., 07/26/22 from 7:00 A.M. to 11:00 A.M., - metoprolol on 07/22/22 from 7:00 A.M. to 11:00 A.M., and - mirtazepine on 09/06/22 from 6:00 A.M. to 11:00 A.M. The clinical record lacked documentation the physician was notified of the resident not receiving the medications. 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. Medications could be ordered from the pharmacy		availability CQI audit tool will be reviewed monthly by the CQI Committee for six mo3nths after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to follow physician's orders related to hold parameters for a blood pressure medication for 2 of 5 residents reviewed for unnecessary medications. (Resident 13) Findings include: The clinical record for Resident 13 was reviewed on 09/06/22 at 2:55 P.M. A Quarterly MDS (Minimum Data Set) 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 (Electronic Medication Administration Records) were provided by the DON (Director of Nursing) on 09/08/22 at 1:21 P.M. The record indicated the resident had an open-ended physician's order, with a start date of 07/20/22, to receive Metoprolol 50 mg (milligrams), twice a day for a diagnosis of hypertension. The medication was to be held, "...if pulse [was] less than 55, SBP [Systolic Blood Pressure] < [less than] 110..." The resident had received the medication on the following dates and times when the systolic blood pressure (the top number) was out of the specified parameters: - 08/03/22 from 6:00 P.M. to 10:00 P.M., the blood pressure was 99/59, - 08/04/22 from 6:00 P.M. to 10:00 P.M., the blood pressure was 98/62, - 08/05/22 from 6:00 P.M. to 10:00 P.M., the blood	F 0757	**It is the standard of this facility 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 been affected by the deficient practic e?** Resident #13's physician was contacted and notified of hold parameters not being followed related to resident Metoprolol on 8/3/22, 8/4/22, 8/5/22, 8/7/22, 8/8/22, 8/9/22, 8/10/22, 8/13/22, 8/14/22, 8/17/22,8/18/22, 8/19/22, 8/20/22, 8/21/22, 8/22/22, 8/23/22, 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 by t he** **same deficient practice will be identified and what corrective action(s) will be taken.** All residents having hold parameters related to their blood pressure medication have the potential to be affected by the alleged deficient practice. A review was completed on all residents who currently have hold parameters related to their blood pressure medication are being followed as ordered. The DON or	10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pressure was 98/62, - 08/07/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 96/54, - 08/08/22 from 6:00 P.M. to 10:00 P.M., the blood pressure was 102/62, - 08/09/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 94/56, and from 6:00 P.M. to 10:00 P.M., the blood pressure was 96/62, - 08/10/22 from 6:00 P.M. to 10:00 P.M., the blood pressure was 100/60, - 08/13/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 54/23, and from 6:00 P.M. to 10:00 P.M., the blood pressure was 94/48, - 08/14/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 90/58, and from 6:00 P.M. to 10:00 P.M., the blood pressure was 96/62, - 08/17/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 101/58, and from 6:00 P.M. to 10:00 P.M., the blood pressure was 105/64, - 08/18/22 from 6:00 P.M. to 10:00 P.M., the blood pressure was 105/64, - 08/19/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 109/61, - 08/20/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 102/56, - 08/21/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 106/58, - 08/22/22 from 6:00 P.M. to 10:00 P.M., the blood pressure was 101/55, - 08/23/22 from 6:00 P.M. to 10:00 P.M., the blood pressure was 109/63, - 09/01/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 97/65, - 09/02/22 from 6:00 P.M. to 10:00 P.M., the blood pressure was 95/55, - 09/03/22 from 6:00 P.M. to 10:00 P.M., the blood pressure was 101/70, - 09/04/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 104/70, - 09/05/22 from 7:00 A.M. to 11:00 A.M., the blood		designee re-educated the facility nurses following physician orders related to hold parameters for blood pressure medications. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DON or designee in-serviced facility nurses on following physician orders related to hold parameters for blood pressure medications. When a resident has a blood pressure outside the hold parameters the physician orders will be followed as appropriate. If there are hold parameters not being followed, the nurse will contact the physician and re-educated the nurse. The DON or designee will review blood pressure medications with, hold parameters daily during the clinical meeting, **4)** **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 DNS/Designee will completed blood pressure medication reviews if they include hold parameters CQI audit tool for six months with audits being completed once	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pressure was 81/48, and from 6:00 P.M. to 10:00 P.M., the blood pressure was 100/76, and on - 09/06/22 from 7:00 A.M. to 11:00 A.M., the blood pressure was 97/57, and from 6:00 P.M. to 10:00 P.M., the blood pressure was 100/68. During an interview on 09/08/22 at 11:49 A.M., the DON (Director of Nursing) indicated the facility lacked a policy for following MD orders and it was a standard of nursing practice. 3.1-48(a)(1) 3.1-48(a)(4)		weekly for one month, and then monthly for 5 months by a nurse manager or designee. The blood pressure medication reviews if they include hold parameters CQI audit tool CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to store medications appropriately for 2 of 2 medication carts reviewed. Findings include: During an observation on 09/01/22 at 10:07 A.M., two medication carts were reviewed with LPN (Licensed Practical Nurse) 2. The following was observed: - a lispro insulin pen for Resident 6 was not opened and undated. The LPN indicated the medication should have been dated. The delivery date on the package was not a good indication when the medication was pulled from the refrigerator because they will use the same package for a new pen, - a bottle of liquid Colace for Resident 10 that had 40 ml (milliliters) left with no open date, - a used albuterol inhaler for Resident 21 with no open date, - a Humalog insulin pen for Resident 5 with 200 units left with no open date, - a bottle of liquid Colace for Resident 19 with no open date, - a bottle of ocean nasal spray for Resident 16 with an open date of 04/08/22,	F 0761	**It is the standard of this facility to ensure labeling of drugs and biological drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.** **1)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** The insulin pen for resident 6 and 5, liquid Colace for resident 10 and 19, Albuterol inhaler for resident 21, ocean nasal spray for resident 16, and Budesonide inhaler fore resident 22 have been replaced and currently have a date opened. **2)** **How other residents having the potential to be affected by t he same deficient practice will be identified and what corrective action(s) will be taken.** All residents using insulin pens, inhaler, and liquid medication have	10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- an almost empty inhaler of budesonide for Resident 22 with no open date LPN 2 indicated all the medications should have had an open date and removed them from the medication carts. The current facility policy titled, "Storage and Expiration of Medications, Biological's, Syringes and Needles", with a revision date of 10/31/16, was provided by the Administrator on 09/07/22 at 3:41 P.M. The policy indicated, "...Facility should ensure that medications and biological's that: (1) have and expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines...Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened...Facility staff may record the calculated expiration date based on date opened on the medication container..." 3.1-25(j) 3.1-25(k)(6)		the potential to be affected by the alleged deficient practice. All insulin pens, inhalers and liquid medication were audited x1 by the DON to ensure that they are currently labeled with an open date. All nurses have been re-educated on labeling and storage of drugs policy. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** All nurses have been re-educated on labeling and storage of drugs policy. The DON/ADON will complete daily audits on scheduled days of work to ensure all policies related to labeling and storage of medications are being followed. Any noted concerns with labeling and storage of medications will be addressed immediately with the nurse on duty and noted on the daily audit form. The daily audits completed by DON/ADON will be turned into the Administrator on scheduled days of work as proof of ongoing compliance. **4)** **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?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			. To ensure compliance the DNS/Designee will complete an insulin storage CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The insulin storage CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	