AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/25/2024			ETED		
	PROVIDER OR SUPPLIE			1945 CF	ADDRESS, CITY, STATE, ZIP COD RAGMONT ST ON, IN 47250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0000 Bldg. 00	Licensure survey.	155427	F 00	00	The creation and submission of this plan of correction does no constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. It to the relative low scope and severity of this survey, the faci respectfully requests a desk review in lieu of a post-survey revisit.	t s forth s, or Due ility	
F 0695 SS=D Bldg. 00	Quality review con 483.25(i) Respiratory/Track Suctioning Based on observati interview, the facil concentrator filters	reflect State Findings cited in	F 06	95	F 695 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 16, 29, 21 oxygen concentrator filters have been	1	11/10/2024

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

TITLE

(X6) DATE

Markietta Burns Administrator 11/05/2024

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155427		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/25/2024			
NAME OF P	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP COD 1945 CRAGMONT ST				
HICKORY CREEK AT MADISON				MADIS	ON, IN 47250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	ICY 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	
	_	ervation on 10/21/24 at 11:15			cleaned.			
		bilateral oxygen concentrator			How will you identify other			
	-	tely (100 percent) covered with			residents having the potenti	al		
		bstance. The humidifier bottle			to be affected by the same			
	was sitting on the fl	loor.			deficient practice and what	•		
	D 1 1	. 10/22/24 + 10.00			corrective action will be take			
	_	ion on 10/22/24 at 10:00 a.m.,			Up to 3 residents who receive			
		eral oxygen concentrator filters			oxygen via concentrators hav			
		overed with a white powdery			potential to be affected by the			
	substance.				alleged deficient practice.	l h a		
	Dramin a an ahaamaati	ion with the Director of			The Maintenance Director will			
	-	10/23/24 at 11:05 a.m., Resident			in-serviced on weekly cleanin	-		
		en concentrator filters were			oxygen concentrator filters by			
		with a white powdery			ADMIN or designee on or beful	Sie		
		N removed and shook the			All nursing orders on MAR ha			
		centrator and the white			been d/c to clean weekly filter			
		erved in the air. There were			TELS has been updated to in-			
		orners of the filters. The			cleaning filters weekly by the	Jiuue		
		s sitting on the floor. The DON			Maintenance Director.			
		was broken and she obtained a			What measures will be put in	nto		
	-	entrator tank, humidifier bottle			place or what systemic	110		
	and tubing for the r				changes you will make to			
					ensure that the deficient			
	The record for Resi	dent 16 was reviewed on			practice does not recur?			
		m. The resident's diagnoses			The Maintenance Director will	l be		
	-	not limited to, acute and			in-serviced on weekly cleanin	g of		
	· ·	failure with hypoxia or			oxygen concentrator filters by	-		
		ic obstructive pulmonary			ADMIN or designee on or before			
	disease (COPD), hy	pertensive heart disease with			11/10/24			
	heart failure, severe	e morbid obesity with alveolar			TELS has been updated for			
	hypoventilation, ob	structive sleep apnea, and			maintenance to check and cle	an		
	seasonal allergic rh	initis.			filters weekly. If there is lack	of		
					documentation to reflect the			
	The physician's ord	ler, dated 11/12/22, indicated			cleaning was not done, the			
		minister the resident's oxygen			ADMIN/ Designee will	ļ		
	at 3 liters (L) per m	inute by nasal cannula (NC)			educate/re-train the Maintena	nce		
	continuously for Co	OPD.			Director regarding the facility	ļ		
					policy for cleaning. Written	ļ		
	The physician's ord	ler, dated 11/14/22, indicated			counseling will be rendered for	r		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>00</u> B. WING		COMPLETED		
155427		B. W	'ING		10/25/2024		
NAME OF T	DROWNED OF CURPLIES		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		1945 C	RAGMONT ST		
HICKOR'	Y CREEK AT MADI	SON	_	MADIS	ON, IN 47250		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLET	ION
TAG		R LSC IDENTIFYING INFORMATION ange the resident's oxygen		TAG	continued noncompliance.	DATE	
		y bottle, and clean the			ED/Designee will round to ens	ure	
		ter once a day on Sundays.			oxygen filters are clean per	uie	
		on ence a day on edinadys.			protocol		
	The care plan, dated	d 7/26/23 and last revised			How the corrective action(s)		
	10/3/24, indicated t	he resident had a diagnosis of			will be monitored to ensure t	he	
	respiratory failure v	vith hypoxia and required			deficient practice will not		
		en by NC. The interventions,			recur, i.e., what quality		
		ided, but were not limited to,			assurance program will be p	ut	
		as ordered by NC and observe			into place?		
	decreased or wo	rsening symptoms of			To ensure compliance the ADMIN/Designee will complete		
	decreased oxygenat	ion.			treatment CQI audit tool for six		
	The nurse's note, da	ated 12/23/23 at 6:29 a.m.,			months with audits being	•	
		nt complained of a sore throat			completed once weekly for on	e	
		ne resident's lung sounds (LS)			month, and then monthly for 5		
	were diminished wi	th an oxygen saturation of 93%			months. The treatment CQI a	udit	
	(percent) on 3 L per	r NC. The resident tested Covid			tool will be reviewed bi-monthl	y	
	positive.				during QAPI for six months. If		
					95% threshold is not achieved	, an	
		ated 12/26/23 at 3:37 p.m.,			action plan will be developed.		
		nt's respirations were non ag sounds were diminished in			Deficiency in this practice will		
		ent's O2 saturations were at			result in disciplinary action up and or including termination of		
		al cannula and her voice was			responsible employee.	uie	
	hoarse.				Compliance Date: 11/10/24		
	The Quarterly Mini	mum Data Set (MDS)					
		0/2/24, indicated the resident					
		gnitively impaired. She required					
	continuous oxygen	therapy.					
	During an interview	on 10/23/24 at 11:13 a.m., the					
	~	filters should not have been so					
	coated with dust on	the Monday after the					
		nem on the prior Friday. During					
		w, the DON indicated she had					
		lical Equipment company, and					
		ters were like furnace filters					
	and they would be	cleaned or replaced as needed.					

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STATEMENT OF DEFICIENCIES X1) PF		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER				COMPI	
155427		B. W	/ING		10/25	/2024	
NAME OF P	DOMINED OF CLIPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIEF			1945 CF	RAGMONT ST		
HICKOR	Y CREEK AT MADI	SON		MADISC	ON, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview	on 10/23/24 at 11:15 a.m., the					
	-	nat on Friday, the guy came					
		ok at the oxygen concentrator,					
	but didn't clean or r						
	2 During on observ	vation on 10/21/24 at 10:59 a.m.,					
	_	ral oxygen concentrator filters					
		vered with a light white					
	powdery substance.	_					
	Duning on the confi	ion on 10/22/24 at 10:00					
	-	ion on 10/22/24 at 10:09 a.m., ral oxygen concentrator filters					
	were completely covered with a light white powdery substance.						
	F						
	-	ion with Licensed Practical					
		0/23/24 at 10:54 a.m., Resident					
		n concentrator filters were					
		with a light white powdery					
	substance.						
	The record for Resi	dent 29 was reviewed on					
		.m. The resident's diagnoses					
		not limited to, dementia with					
		nce, chronic obstructive					
	*	obstructive sleep apnea, body					
	` ′	of 19.9 or less, and severe					
	dementia with anxio	ciy.					
	The care plan, dated	d 3/22/24, indicated Resident					
	-	for impaired gas exchange					
		ith shortness of breath (SOB)					
		dependence on supplemental					
		entions, dated 3/22/24,					
		ot limited to, the nurse was to					
	administer oxygen	as ordered.					
	The physician's ord	er, dated 3/22/24, indicated					
		e the resident's oxygen tubing					
			1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155427		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING 00 COMPLI B. WING 10/25/2			LETED	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT MADISON		1	945 CF	DDRESS, CITY, STATE, ZIP COD RAGMONT ST DN, IN 47250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	NTC.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)	AIE.	DATE
	and humidity bottle and filter once a day	e, and clean the concentrator y on Sundays.					
	The Quarterly MDS	S assessment, dated 8/1/24,					
		nt was severely cognitively					
		ired oxygen therapy.					
	The nurse's note, daindicated the reside normally and she will blood pressure of 5 (mmHG), pulse of respirations of 28 bigs of 97.6 degrees Fahobtain an O2 satura remained on 2 liters emergency medicat and report was called hospital indicated the diagnoses of a urina pneumonia.	ated 9/15/24 at 10:35 a.m., ant was still not responding vasn't alert. Her vitals were 8/48 millimeters of mercury 100 beats per minute, reaths per minute, temperature arenheit, Staff were unable to tion at this time. The resident is of O2 (oxygen) per NC, ion services (EMS) was called, and to the local hospital. The the resident was admitted with any tract infection (UTI) and ter, dated 9/26/24, indicated the is to administer 2 liters of					
		nnula for saturations below					
	90% every shift as	needed.					
	4 indicated she wou the oxygen concent Medical Supply con	v on 10/23/24 at 10:59 a.m., LPN ald have to check how often rator filters were cleaned. A mpany cleaned the oxygen If they weren't cleaned, the pumped.					
	DON indicated the cleaned the oxygen Friday. The nursing filters if needed. Sh	w on 10/23/24 at 11:00 a.m., the Medical Supply company concentrator filters every a staff could also clean the le placed the Medical Supply a the shredder, but could					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155427		A. BUILDING 00 COMPLETED B. WING 10/25/2024				
		100441			10/23/2024	
NAME OF F	PROVIDER OR SUPPLIEF	ł		ADDRESS, CITY, STATE, ZIP COD		
HICKORY CREEK AT MADISON				SON, IN 47250		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
TAG		CLSC IDENTIFYING INFORMATION copy. She later provided a copy	TAG	DLI ICILICE I	DATE	
		he document only indicated				
	1	elt that the filters shouldn't be				
	coated with dust on	the Monday after the				
	company cleaned th	nem on the prior Friday.				
	3. During an observ	ration on 10/22/24 at 10:11 a.m.,				
	Resident 21's bilate	ral oxygen concentrator filter				
	· ·	d white chunks on the left				
	, ,,	privacy curtain was covering				
	the right filter.					
	During an observati	ion on 10/23/24 at 11:03 a.m.,				
	_	ral oxygen concentrator filter				
		d white chunks on the left				
	oxygen filter.					
	The record for Resi	dent 21 was reviewed on				
		.m. The resident's diagnoses				
		not limited to, chronic				
		ary disease with acute				
		and chronic respiratory failure on chronic diastolic				
		lure, atherosclerotic heart				
	_	ronary artery without angina				
		sorder, dementia, mild, with				
	agitation, mild dem	entia with agitation, insomnia,				
	and a personal histo	ory of nicotine dependence.				
	The physician's ord	er, dated 6/11/24, indicated for				
	staff to maintain the	e resident's oxygen at 2 liters				
	per nasal cannula tv	vice daily.				
	The physician's ord	er, dated 6/12/24, indicated				
	_	e the resident's oxygen tubing				
		lean the concentrator and filter				
	on Sundays.					
	The care plan, dated	d 6/18/24, indicated the				
		for ineffective tissue				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
AND PLAN OF CORRECTION		155427	B. WI	NG		10/25/	/2024
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
		1001			RAGMONT ST		
HICKORY CREEK AT MADISON			MADISC	ON, IN 47250			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	perfusion. The inter	rventions, dated 6/18/24,					
	included, but was n	ot limited to, administer					
	oxygen as ordered.						
	The Significant Cha	ange in Condition MDS					
	assessment, dated 8	3/30/24, indicated the resident					
	was moderately cog	gnitively impaired. The resident					
	required continuous						
	The nurse's note, da	ated 9/13/24 at 2:21 a.m.,					
	indicated the reside	nt remained in Covid isolation.					
	The lung sounds ha	d mild wheezes with an O2					
	saturation of 95% o	on 2 liters of oxygen.					
	The nurse's note, da	ated 10/2/24 at 9:36 p.m.,					
	indicated during the	e cardiac and respiratory					
	assessment, the resi	ident's breath sounds were					
	unclear or absent. T	The resident required and used					
	oxygen at 2 liters pe	er minute per NC. Her LS were					
	diminished in all lo	bes.					
	The nurse's note, da	ated 10/6/24 at 10:53 a.m.,					
	indicated during the	e cardiac and respiratory					
	assessment, the resi	ident's breath sounds were					
	diminished. She rec	quired and used oxygen at 2 L					
	per minute per NC.	Her LS were diminished, also.					
	1	ated 10/9/24 at 9:28 p.m.,					
	indicated during the	e cardiac and respiratory					
	l '	ident breath sounds were					
		she required and used oxygen					
	at 2 L per minute po	er NC. Her LS remained					
	diminished in all lo	bes.					
		v on 10/23/24 at 11:00 a.m., the					
		staff should try to make sure					
		was kept off of the oxygen					
	concentrator filters.						
	The Oxygen Therap	by policy, dated April 2023,					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155427	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/25/2024		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT MADISON				1945 CF	DDRESS, CITY, STATE, ZIP COD RAGMONT ST DN, IN 47250		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	on oxygen shall be in concerning storage a e. Contamination	ot limited to, " 6. Residents instructed of safety measures and administration of oxygen of oxygen equipment with oil, bustible is to be avoided."					

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