| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155424 | A. BUILDING 00<br>B. WING | 06/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HICKORY CREEK AT COLUMBUS | 5480 E 25TH STREET<br>COLUMBUS, IN 47203 |

| (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<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00406709.<br><br>Complaint IN00406709 - No deficiencies related to the allegations are cited.<br><br>Survey dates: June 6, 7, 8, 9, and 12, 2023<br><br>Facility number: 000284<br>Provider number: 155424<br>AIM number: 100290690<br><br>Census Bed Type:<br>SNF/NF: 31<br>Total: 31<br><br>Census Payor Type:<br>Medicare: 3<br>Medicaid: 23<br>Other: 5<br>Total: 31<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on June 16, 2023. | F 0000 | br><br>br><br>br><br>br><br>/p><br>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance. | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent | | | |

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

Jessica Crafton-Hundley | Health Facility Administrator | 06/30/2023

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155424 | A. BUILDING 00<br>B. WING | 06/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HICKORY CREEK AT COLUMBUS | 5480 E 25TH STREET<br>COLUMBUS, IN 47203 |

| (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 ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(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.<br>Based on interview and record review, the facility failed to identify pressure ulcers in a timely manner and document treatment administrations for 1 of 2 residents reviewed for pressure ulcers. (Resident 1)<br><br>Findings include:<br><br>During an interview on 06/07/23 at 9:31 A.M., Resident 1 indicated she had pressure wounds on her bottom that had recently healed.<br><br>The resident's record was reviewed on 06/11/23 at 4:51 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 05/19/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, heart failure, renal disease, and hypertension. The resident required extensive staff assistance with transferring, toileting, and personal hygiene. The resident was at risk for pressure ulcers, and currently had one Unstageable pressure ulcer (obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough [moist, non-viable tissue] or eschar [dead tissue]).<br><br>A Wound Management Detail Report, dated 05/10/23, indicated a pressure ulcer was identified on the resident's left buttock that measured 1.3 cm | F 0686 | =”” span=””><br>=”” p=””><br><br>**F 686 Treatment/Services to Prevent/Heal Pressure Ulcers.**<br>**Based on record review, interview, and observation, the facility failed to ensure a resident's Weekly Skin Assessments were completed and accurate to identify and prevent the development or worsening of a pressure ulcer resulting in an unstageable pressure ulcer worsening to a Stage IV pressure ulcer for 1 of 5 residents reviewed for pressure ulcers.**<br>**(Resident 62)**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>· Resident #1 did have ill effects related to this alleged deficient practice.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective** | 07/07/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155424 | A. BUILDING 00<br>B. WING | 06/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HICKORY CREEK AT COLUMBUS | 5480 E 25TH STREET<br>COLUMBUS, IN 47203 |

| (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 |
|---|---|---|---|---|
| | (centimeters) x (by) 0.6 cm. The wound was unstageable, as it was 100% (percent) covered by slough.<br><br>A Progress Note, dated 05/10/23 at 3:02 P.M., indicated a new, unstageable pressure ulcer was identified on the resident's left buttock. A new physician's order was obtained for treatment. The treatment was the daily application of Santyl (a medication that removed dead tissue from wounds) and an Optifoam dressing (a waterproof foam dressing with a high fluid-handling capacity).<br><br>A Wound Management Detail Report, dated 05/26/23, indicated the pressure ulcer on the resident's left buttock measured 1 cm x 1 cm. The wound was still unstageable, as it was 100% covered by slough.<br><br>A Wound Management Detail Report, dated 05/26/23, indicated a new pressure ulcer was identified on the resident's right buttock that measured 1.6 cm x 2 cm. This wound was unstageable, as it was 100% covered by slough.<br><br>A Progress Note, dated 05/26/23, indicated a new, unstageable pressure ulcer was identified on the resident's right buttock. New interventions included a new wound treatment order, a low air loss mattress, and new physician's orders for a multivitamin and zinc supplements. The progress note indicated the current treatment order for the right buttock wound was Medihoney (a honey wound gel) and an Optifoam dressing.<br><br>The May 2023 ETAR (Electronic Treatment Administration Record) was provided by the DON (Director of Nursing) on 06/12/23 at 1:03 P.M. The record indicated the following physician ordered | | **action(s) will be taken:**<br>·All residents have the potential to be affected by the alleged deficient practice.<br>·All residents with potential to develop pressure wounds will have IDT review of Weekly Skin Assessments for completion and accuracy to identify and prevent development of pressure ulcers.<br>·100% audit of skin sweeps was completed to ensure any resident with the risk for development of pressure ulcers have Weekly Skin Assessments to identify and prevent the development or worsening of a pressure ulcer.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br>· All Licensed nurses will be in-serviced by the DNS/Designee to ensure that residents have Weekly Skin and Vital Sign Assessment to identify and prevent the development or worsening of a pressure ulcer.<br>· DNS/Designee will complete daily audits per the schedule for Weekly Skin and Vital Sign Assessment completion and accuracy<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie. what quality assurance program will be put** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155424 | A. BUILDING 00<br>B. WING | 06/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HICKORY CREEK AT COLUMBUS | 5480 E 25TH STREET<br>COLUMBUS, IN 47203 |

| (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 |
|---|---|---|---|---|
| | treatments were administered:<br><br>- The Santyl and Optifoam dressing treatment was administered daily to the left buttock from 05/10/23 until it was discontinued on 05/26.23, and<br><br>- The Medihoney and Optifoam dressing treatment was administered daily to the left buttock from 05/26/23 until it was discontinued on 05/30/23.<br><br>- A treatment listed on the May 2023 ETAR indicated nursing staff were to apply Skin Prep (a liquid, film forming dressing) to the dry area on the right buttock every shift from 05/10/23 until the treatment was discontinued on 05/30/23.<br><br>The record lacked documentation of any other treatment to the wound on the resident's right buttock.<br><br>Both wounds were documented as resolved on 05/30/23 in the Wound Management Detail Report.<br><br>During an interview on 06/12/23 at 11:25 A.M., the DON indicated the wounds on the resident's buttocks should have been identified before they were unstageable wounds. The wound on the resident's right buttock was identified one day and gone a few days later.<br><br>During an interview on 06/12/23 at 2:35 P.M., CNA (Certified Nurse Aide) 3 indicated staff were to look out for skin impairments. They would observe the residents' skin while assisting a resident with toileting, bathing, dressing, and undressing. If they found a wound, they would notify the nurse. They also filled out shower sheets on shower days and would note any skin | | **into place:**<br>DNS/designee will conduct audits using Skin Management Program: Weekly Skin Assessment weekly x 4 weeks, monthly x 6 months and quarterly x 2 quarters. Audit tool results to be reviewed Monthly at QAPI meeting. If 95% compliance is not achieved, an action plan will be implemented.<br>**By what date the systemic changes will be completed:**<br>**7/7/2023202** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155424 | A. BUILDING 00<br>B. WING | 06/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HICKORY CREEK AT COLUMBUS | 5480 E 25TH STREET<br>COLUMBUS, IN 47203 |

| (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 |
|---|---|---|---|---|
| | impairments there. Resident 1 required enough assistance with ADLs (Activities of Daily Living) that her skin would be observed at least daily.<br><br>The current facility policy, titled "Skin Management Program", with a most recent revision date of 05/22, was provided by the DON on 06/12/23 at 1:03 P.M. The policy indicated, "...It is the policy...to ensure that each 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...a resident with pressure ulcers receives necessary care and treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing...Interventions to prevent wounds from developing and/or promote healing will be initiated..."<br><br>3.1-40(a)(1)<br>3.1-40(a)(2) | | | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155424 | A. BUILDING 00<br>B. WING | 06/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HICKORY CREEK AT COLUMBUS | 5480 E 25TH STREET<br>COLUMBUS, IN 47203 |

| (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 |
|---|---|---|---|---|
| | under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs 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.<br>Based on observation, interview, and record review, the facility failed to store medications appropriately related to insulin pens for 1 of 2 medication carts reviewed. (Back Hall medication cart)<br><br>Findings include:<br><br>On 06/12/23 at 10:55 A.M., the Back Hall medication cart was observed with RN 2, and contained the following:<br><br>- A Lispro insulin pen for Resident 5, with an open date of 05/14/23. The nurse verified the open date. The pen was 1/4 full. The resident had received the insulin that morning.<br><br>- A Lispro insulin pen for Resident 7, with an open date of 05/14/23. The nurse verified the open date. The pen was 1/4 full. The resident had received the insulin that morning.<br><br>During an interview on 5/14/23 at 10:58 A.M., RN 2 indicated the Lispro insulin pens were good for 30 days after the open date. | F 0761 | **F 761 Labels/Storage of Drugs and Biologicals: The facility failed to ensure appropriate labelling and storage of medications**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>· Resident #5 did not have ill effects related to this alleged deficient practice.<br>· Medications were immediately removed or discarded<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br>·All residents have the potential to be affected by the alleged deficient practice.<br>· DNS audited medication carts and medication rooms on for | 07/07/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155424 | A. BUILDING 00<br>B. WING | 06/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HICKORY CREEK AT COLUMBUS | 5480 E 25TH STREET<br>COLUMBUS, IN 47203 |

| (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 06/12/23 at 2:00 P.M., the Administrator indicated the facility did not have a specific medication storage policy, they followed the pharmacy recommendations.<br><br>The current facility pharmacy manual, with a revised date of 01/01/22, was provided by the DON on 06/12/23 at 11:45 A.M. The manual indicated, "...Insulin Lispro pen once opened is good for 28 days..." The pens should have been taken out of use after 06/10/23.<br><br>3.1-25(j)<br>3.1-25(o) | | appropriate labelling and storage of medications, with no identified expired medications noted.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br>· All Licensed nurses in-serviced by the DNS/Designee to ensure that appropriate storage of medications is per policy, including discarding any expired medications.<br>· DNS/Designee will conduct rounds each shift to ensure accurate storage of medications per policy, including discarding any expired medications.<br>· Medication Storage Stickers with open & discard dates are to be placed on insulins upon opening, dated appropriately per policy & being checked every shift by DNS/designee.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie. what quality assurance program will be put into place:**<br>DNS/designee will conduct audits using Medication, Labelling and Storage Review QA audit tool daily x 4 weeks, weekly x 4 weeks, monthly x 6 months and quarterly x 2 quarters. Audit tool results to be reviewed Monthly at the QAPI meeting. If 95% compliance is not achieved an action plan will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155424 | A. BUILDING 00<br>B. WING | 06/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HICKORY CREEK AT COLUMBUS | 5480 E 25TH STREET<br>COLUMBUS, IN 47203 |

| (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 |
|---|---|---|---|---|
| | | | developed.<br>**By what date the systemic changes will be completed: 7/7/2023** | |