STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN 47170

(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. Survey dates: April 23, 24, 25, and 28, 2025. Facility number: 000421 Provider number: 155417 AIM number: 100288340 Census Bed Type: SNF: N/A NF: N/A SNF/NF 31 Total: 31 Census Payor Type: Medicare: 2 Medicaid: 28 Private: 1 Other: N/A Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 30, 2025.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to ensure the physician was notified in a timely manner for 1 of 3 residents reviewed for a change in condition. (Resident 1) Findings include:	F 0580	This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited. The submission of the Plan of Correction is not an admission of or agreement with the	05/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Colwell	Administrator	05/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN 47170

(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 record for Resident 1 was reviewed on 4/24/25 at 1:37 p.m. The resident's diagnoses included but were not limited to chronic iron deficiency anemia secondary to blood loss, type 2 diabetes mellitus, schizoaffective disorder, bipolar disorder, epilepsy, functional dyspepsia, constipation, personal history of diseases of the digestive system, and atherosclerotic heart disease. The care plan, dated 8/17/20 and revised 4/24/25, indicated the resident was diabetic and at risk for hypoglycemic, hyperglycemic episodes related to the diagnosis. Possible negative outcomes of not following the prescribed diet. Consumes sugary snacks, ice cream, shakes, Pepsi and other items not on the resident's diet. Per the resident's preference, the resident kept these at her bedside and consumed through the day. The resident had a new diagnosis of a hernia with a recommendation to start 5 smaller meals starting November 2024. The interventions, dated 4/30/21, included, but were not limited to a diet per the medical doctor (MD) order for a regular diet of 3 small portion meals and 2 snacks, to honor preferences, and lab work as ordered with the results reported to the MD. Monitor blood sugars as needed for signs and symptoms of hypoglycemia or hyperglycemia. Nursing would notify the MD as needed, and provide medications as ordered. The physician's order, dated 9/21/23, indicated staff were to administer to the resident, 1 gram of carafate three times daily. The order was discontinued on 6/17/24. The physician's order, dated 9/25/23, indicated staff were to administer to the resident, 81 milligrams (mg) of chewable aspirin daily. The		deficiencies or conclusions contained in the Department's inspection report. Hickory Creek of Scottsburg would like to request a desk review. Please feel free to contact Rachel Colwell if you need any additional information to support the desk review at 812-595-6125. Thank you for your consideration. **F 580** **It is the standard of this facility to ensure that the physician is notified of changes.** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 was sent to ER, NP was notified and resident returned to facility the same day. Resident returned with new orders which have been implemented. 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by this alleged deficient practice. All clinical staff will be in serviced on the facility s Notification of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN 47170

(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
	order was discontinued on 11/14/24. The nurse's note, dated 11/11/24 at 8:35 a.m., indicated Certified Nurse Aides (CNAs) reported the resident's vomiting to the Licensed Practical Nurse (LPN). Upon arriving to the resident's room, the resident had large brownish black emesis with little black spots in it. The resident complained of feeling bad, feeling sick and tired. The resident's vital signs were stable, however due to the appearance of possible blood in the emesis, the Nurse Practitioner (NP) gave an order to send the resident to a local hospital for evaluation and treatment. The physician's evaluation, dated 11/15/24 at 10:46 a.m., indicated an order to increase the protonix to twice daily and to add carafate. The resident had an upper endoscopy, which showed grade 4 esophagitis with a hiatal hernia. The resident had been on aspirin since 2023. The same thing happened 1 year ago, and the resident remained on aspirin. The physician took the resident off her carafate one month ago. For the future, the resident should stay off of aspirin without documented cerebrovascular or coronary artery disease. Nursing could try to take the resident off carafate again in a year, if the resident did not have any further bleeding. The resident was complaining of abdominal pain and nausea at that time. A recent upper gastrointestinal (GI) bleed appeared to be stabilized. The nurse's note, dated 11/27/24 at 10:02 p.m., indicated the resident had reported not feeling well and vomiting throughout the day after drinking ordered boost. The vomit was dark in color as if the resident had been eating and drinking something dark. The NP and Director of Nursing (DON) were made aware. The resident		Resident Change of Condition policy on DNS/Designee reviewed all resident medical records and to ensure residents MD have been notified for a change of condition. On 05/8/25 an audit of the past 30 days was completed for all residents to ensure proper notification was made for all residents who may have had a change in condition. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS OR DESIGNEE will review facility activity report during morning meeting and during Gemba rounds with the clinical IDT team. The DNS/Designee will verify if the physician has been notified of any medical status changes. 4. How the corrective action will be monitored to ensure that the deficient practice will not recur, i.e. what quality assurance program will be put into place? To ensure compliance the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN 47170

(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
	requested to be sent to the hospital at that time. The resident was not sent out to the hospital. The nurse's note, dated 11/28/24 at 12:07 a.m., indicated the resident requested to drink soda to attempt to settle her stomach and to prevent being sent out to the hospital. There were no signs or symptoms of vomiting for several hours. The resident was educated not to drink too many Boost protein drinks. Drinking too many Boost drinks caused the resident to not eat anything throughout the day. The resident was educated to let staff know if she vomited again. An order was given by the NP to send the resident out to the emergency room (ER) if needed. The physician's order, dated 11/15/24, indicated to provide small portions with regular meals and 2 snacks between meals. The order was discontinued on 12/20/24. The physician's order, dated 12/10/24, indicated staff were to administer to the resident, 100 milligrams (mg) iron-250 mg/5 milliliters (mL) 325 mg twice daily of Protect iron liquid (iron polysaccharide-vitamins C and B 12 complex). The order was discontinued on 12/17/24. The laboratory results, dated 12/18/24, indicated the resident had a Hemoglobin of 11.0 grams per deciliter (g/dL) and a Hematocrit of 34.6%. The normal range of Hemoglobin was 12.0 to 15.5 g/dl and the normal range of Hematocrit was 36 % to 48%) The nurse's note, dated 1/26/25 at 2:02 a.m., the resident reported pain that started in the stomach and radiated to her chest. The resident had requested as needed (PRN) pain medication at the medication pass. The resident was able to rest for		DNS/Designee will complete Change of condition QAPI tool weekly x 4weeks, monthly x 6 months and quarterly x 3. The QAPI committee will determine the need for further review. If 100% is not achieved an action plan will be developed. Date of compliance: 05-28-25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN 47170

(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 few hours after receiving the medication. The resident pressed her call light to notify staff she had vomited a large amount of emesis. The resident's blood pressure was 91/62 millimeters of mercury (mm Hg), a heart rate of 103 beats per minute (bpm), oxygen (O2) saturation at 93%, a temperature of 97.8 degrees Fahrenheit (F), and a respiratory rate (RR) of 18 breaths per minute. The resident requested to go to the ER. The NP, DON and Executive Director (ED) were notified. The resident continued to vomit. The vomit was dark with almost a look of coffee grounds to it. The resident then proceeded to demand to go to the ER related to feeling weak and continued vomiting. The NP, DON, and ED were notified, and the resident was sent to a local hospital. The nurse's note, dated 2/4/25 at 1:56 a.m., indicated the resident had an episode of vomiting, which was brown in color. The resident was on iron supplements, two times daily and had no history of ulcers or GI bleeds. The resident's vital signs were stable and within normal limits and the resident was alert and oriented. The resident denied the need for pain medication or any PRN medication. The record indicated the resident had a history of GI bleeding in November of 2024. The record lacked documentation of notification to the NP, DON, or ED of the resident's episode of dark brown emesis (vomiting) on 2/4/25 at 1:56 a.m. The NP, DON, or ED was not notified until 8:28 a.m. (6 hours and 24 minutes after the initial change in condition). The nurse's note, dated 2/4/25 at 8:28 a.m., indicated the resident had an elevated heart rate of 120 bpm and dark brown emesis. The resident refused her morning medications. The NP was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN 47170

(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
	notified, and a new order was received to send the resident to the ER for evaluation and treatment. The nurse's note, dated 2/4/25 at 8:50 a.m., indicated Emergency Medical Services (EMS) took the resident to a local hospital and left the building at 8:50 a.m. The nurse's note, dated 2/4/25 at 4:40 p.m., indicated the resident arrived back from the local hospital with diagnoses of gastroenteritis and acute cystitis without hematuria. A new order was placed in the computer for an antibiotic and antiemetic. The nurse's note, dated 2/4/25 at 5:24 p.m., indicated an order for Keflex from the ER was verified with the NP. The resident was currently on Augmentin for a UTI. The NP indicated to keep the Augmentin order and discontinue the Keflex order. The Minimum Data Set (MDS) Significant Change in Status assessment, dated 3/14/25, indicated the resident was cognitively intact. During an interview, on 4/28/25 at 9:53 a.m., RN 1 indicated the resident had been hospitalized on 2/4/25 for a gastrointestinal (GI) issue and was diagnosed with gastroenteritis and acute cystitis without hematuria. She was vomiting and had abdominal pain prior to hospitalization. The resident was vomiting brown emesis. She had complained of stomach pain at times in the past. It was one o'clock in the morning when the resident began vomiting and at 8:24 a.m., the same day, the resident was still vomiting and had an increased heart rate. The NP was notified and gave the order to send the resident to the ER. LPN 2 should have reached out to the Director of Nursing (DON), but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN 47170

(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
	LPN 2's note didn't reflect that he did that. During an interview, on 4/28/25 at 9:56 a.m., the DON indicated she was not contacted by the LPN on 2/4/25 about the resident vomiting brown emesis. The current Resident Change of Condition Policy, included, but was not limited to, "... It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place..." 3.1-5(a)(2)			