STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155417		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/06/2024	
	PROVIDER OR SUPPLIER Y CREEK AT SCO		1100 N	ADDRESS, CITY, STATE, ZIP COD I GARDNER AVE TSBURG, IN 47170	
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	IN00447152 and IN Complaint IN00447 related to the allegal and F880. Complaint IN00447 related to the allegal and F880. Survey dates: Decorate De	7152 - Federal/State deficiencies ations are cited at F755, F842 7339 - Federal/State deficiencies ations are cited at F755, F842 ember 5 and 6, 2024 00421 155417 288340 :: reflect State Findings cited in 0 IAC 16.2-3.1. appleted on December 11, 2024.	F 0000	This plan of correction constitute the facility's written allegation of compliance for the deficiencies cited. The submission of the Pl of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. Hickory Crees Scottsburg would like to request desk review. Please feel free to contact Rachel Colwell, if you need any additional information support the desk review at 812-595-6125. Thank you for you consideration.	of s dan on ek of st a o
Bldg. 00	Based on observation	/Pharmacist/Records on, interview and record failed to ensure physician	F 0755	F755 It is the policy of Hickory Creek	01/06/2025
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

(X6) DATE

Rachel Colwell Administrator 12/23/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MTKH11 Facility ID: 000421 If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155417	B. W	ING		12/06/	2024
				CTD DET	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
LUOKOD	V ODEEK AT 000	TTODUDO			GARDNER AVE		
HICKOR	Y CREEK AT SCO	I I SBUKG		SCOTT	SBURG, IN 47170		
(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
	orders were followe	ed for residents during			Scottsburg to follow the policie	es	
	medication administration for 3 of 5 residents				and procedures in place for		
	reviewed for pharmacy services. (Resident's B, C,				pharmacy services procedure	S.	
	F and G)				#1 What corrective action wi	<u>II_</u>	
					be accomplished for those		
	Findings included:				residents found to be affected	<u>ed</u>	
					by the deficient practice?		
		rd for Resident B was reviewed			QMA 4 and all other QMA's ar	nd	
		p.m. The resident's diagnoses			nurses will be in-serviced by the	he	
	· ·	not limited to, chronic			DON/Designee on 12/23/24		
	obstructive pulmonary disease, chronic				regarding the facilities policy f	or	
	respiratory failure and gastroesophageal reflux				Medication Administration		
	disease.				including following physician's	}	
					orders.		
		4 physician's orders indicated			Resident B, is offered medicat	tions	
		receive the following morning			per MD order		
	medications:				Resident C and G are offered	to	
					rinse mouth and spit after		
		e (TUMS), 500 mg tablets, give			inhalation per MD order		
	2 1/2 tabs to equal	1,250 mg			<u>-</u>	_	
		0.000			#2 How will the facility identi	fy	
	- Advair Diskus (Co				other residents having the		
		one puff via inhalation. Special			potential to be affected by th	<u>ie</u>	
	instructions "rinse r	mouth after use.			same deficient practice?		
	Duning a great diagram	n administration abti			All residents have the potentia	ai to	
	_	n administration observation a.m., QMA (Qualified			be affected by this practice;		
					however, no residents were		
	· ·	was observed to remove 2 ttle of calcium carbonate rather			affected by this deficiency.		
					All residents who receive medication via inhalation from		
		the QMA did not take the the resident's room during the					
		stration observation.			QMAs and nursing staff were	0	
	incurcation auminis	manon ooservanon.			observed by DNS/Designee t ensure MD orders were follow		
	During an interview	v on 12/6/24 at 9:55 a.m., the			ensure MD orders were follow	c u.	
		g indicated the resident			All QMA's and nurses will be		
	1	e Advair Diskus, however,			in-serviced by the DON/Desig	nee	
		e taken the medication to the			on 12/23/24 regarding the faci		
		medication pass and offered			policy for Medication	เแนธอ	
	the medication to the				1	ina	
	are medication to tr	ic restuent.	1		Administration including follow physician's orders.	nig	
	1		1		I DIIVSICIALIS CIUEIS.		i

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155417	B. W	ING		12/06/	2024
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			GARDNER AVE		
HICKOR'	Y CREEK AT SCO	TTSBURG			SBURG, IN 47170		
	T		1		I	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCI)		DATE
	_	w on 12/6/24 at 11:26 a.m., LPN					
	(Licensed Practical Nurse) 5 indicated all physician orders were to be followed. 2. The clinical record for Resident C was reviewed				#2 What magazines will be no	.4	
					#3 What measures will be pu		
					into place and what systemic changes will be made to	<u>. </u>	
		p.m. The resident's diagnoses			ensure that the deficient		
		not limited to, chronic			practice does not reoccur?		
	obstructive pulmonary disease and diabetes.				The DON/Designee will obser	ve	
	pamon				medication administration by		
	The December 202	4 physician's orders indicated			licensed staff member to ensu		
		receive the following morning			medication administration is	-	
	medications:				conducted per MD order.		
					·		
	- Breo Ellipta (inhaled medication for COPD)				#4 How will the facility monit	tor	
	200-25 mcg/dose, o	one puff via inhalation. Special			its corrective actions to ensu		
	instructions: After t	use rinse mouth and spit.			that the deficient practice wi	<u>II</u>	
					not reoccur?		
		OPD) 62.5 mcg, one puff via			The DON/Designee will obser	ve	
	inhalation. Special	Instructions: Rinse mouth after			medication administration wee	ekly	
	use.				x 4, monthly x 6, then quarterl	-	
					thereafter. Observations will I		
		a.m., during the medication			documented on an audit tool.		
		ervation, QMA 4 did not have			DON/Designee will review the		
		ut her mouth after the use of			outcomes of the audits with th		
	both inhalers.				QA committee, monthly. IF 10		
	2 The elimination	ord for Resident G was reviewed			is not achieved an action plan		
	_	ord for Resident G was reviewed a.m. The resident's diagnoses			be developed and monitoring	WIII	
		not limited to, chronic			continue for 6 months		
		not limited to, chronic hary disease and iron			Date of compliance: 01/06/25		
	deficiency anemia.				Date of compliance, 01/06/25		
	deficiency affeitifa.				-		
	- Advair HFA aeros	sol inhaler (COPD) 115-21					
		affs via inhalation: Special					
	instructions: Rinse	_					
		1					
	On 12/6/24 at 7:42	a.m., during the medication					
		ervation, QMA 4 did not have					
		nd spit after the administration					
	of the Advair Disku	-					

ľ		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155417	A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 00 COMPLETE B. WING 12/06/202			ETED
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1100 N GARDNER AVE SCOTTSBURG, IN 47170			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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 0842 SS=D Bldg. 00	provided a current of "General Dose Prep Administration" dat was not limited to, 'AdministrationFameasures required by applicable lawVer administered that is manufacturer medic guidelines" This Citation relates and IN00447339. 3.1-25(b) 483.20(f)(5), 483.7 Resident Records Based on interview failed to ensure a remedication administration of na residents reviewed to the clinical record on 12/5/24 at 1:29 pincluded, but were a syndrome, anxiety at The physician's orderesident was to receantianxiety medicat daily for anxiety at the clinical record and the clinical record and the clinical record and the clinical record on 12/5/24 at 1:29 pincluded, but were a syndrome, anxiety at the clinical record and the	- Identifiable Information and record review, the facility sident's (Resident D) tration record reflected the proof of 3 for medical records. for Resident D was reviewed a.m. The resident's diagnoses not limited to, irritable bowel	F 08	342	F842 It is the policy of Hickory Cree Scottsburg to follow the policie and procedures in place for medication administration records. #1 What corrective action wil be accomplished for those residents found to be affecte by the deficient practice? Resident D no longer resides a this facility. #2 How will the facility identi- other residents having the potential to be affected by th same deficient practice? All residents who receive medication have the potential	es II d at fy e	01/06/2025

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

Event ID:

MTKH11 Facility ID: 000421

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PRINTED: 01/02/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 12/06/2024		
	PROVIDER OR SUPPLIER		1100 N	ADDRESS, CITY, STATE, ZIP COD I GARDNER AVE ISBURG, IN 47170		
	SUMMARY: (EACH DEFICIEN REGULATORY OR record indicated the medication on the form of the second indicated the medication on the form of the second indicated the medication on the form of the second indicated the administration record indicated the medication on the form of the second indicated the medication on the second indicated the sec	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ALSC IDENTIFYING INFORMATION The resident received the following dates and times: June June June June June June June Jun	1100 N	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) be affected. The DON/Designee audited the medication administration recording for the past 10 days for all residents by running the medication administration reportant reviewing for deficiencies. Any concerns identified were immediately addressed by the DON/Designee #3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? The DON/Designee will reeduct staff regarding the facilities Medication Administration policifor documentation of medicatic as outlined in the facility policy Medication Administration (Me pass procedure). The DON/Designee will audit to medication administration recording for all residents by runnin the medication administration	e pord t cate cy pons d he pord g	(X5) COMPLETION DATE
		.m. ber 2024 Medication ord lacked documentation of		report and reviewing for deficiencies. #4 How will the facility monitorits corrective actions to ensure that the deficient practice will not reoccur?	or re	
	resident was to rece hydrocodone-acetar	er, dated 4/23/24, indicated the vive minophen (narcotic) 5-325 mg at 9:00 a.m. and 9:00 p.m.		An audit titled "Medication Administration Record Audit To will be conducted by the DON/Designee 5x week x 4 weeks, 2x week x 4 weeks,	ool"	

Review of the October 2024 Controlled Substance

weekly x 4 weeks, and monthly for

6 months. If 100% is not achieved

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

PRINTED: 01/02/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155417		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/06/2024	
	PROVIDER OR SUPPLIER		1100 N	ADDRESS, CITY, STATE, ZIP COD I GARDNER AVE ISBURG, IN 47170	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	medication on the final medication on the medication of the medication o	o.m. o.m. o.m. o.m. o.m. o.m. o.m. o.m.		an action plan will be develop The DON/Designee will bring results of the medication administration audits to the monthly QA committee meetir for further review and recommendations. Date of compliance: 01/06/25	the ng
	measures required b	lity staff should take all by facility policy and uding, but not limited ssary medication			
	and IN00447339	s to Complaints IN00447152			
	3.1-50(a)(2)				
F 0880 SS=E	483.80(a)(1)(2)(4) Infection Prevention				

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

Event ID:

MTKH11 Facility ID: 000421

If continuation sheet Page 6 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(7/2) 7.5	III TEIDE D CC	NCTRICTION	(V2) D + 777	CLIDA/EX/	
		X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ЛLDING	00	COMPLETED	
		155417	B. W	ING		12/06/	2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					GARDNER AVE		
HICKOR'	Y CREEK AT SCOT	rtsburg		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00							
	Based on observation	on, interview and record	F 0	380	F880		01/06/2025
	review, the facility	failed to ensure staff hand			It is the policy of Hickory Cree	ek at	
	sanitized during a n	nedication pass and failed to			Scottsburg to follow the policie	es	
	ensure staff did not	touch medications prior to			and procedures in place for		
		tration for 6 of 6 residents			infection control, to provide a	safe.	
	reviewed for infecti	on control. (Resident's B, C, E,			sanitary and comfortable	,	
	F, G and H)	, , , ,			environment and help prevent	the	
					development and transmission		
	Findings include:				communicable diseases and	. 0.	
	i mamga maraati				infections.		
	The clinical record for Resident B was reviewed				#1 How will corrective action		
	on 12/5/24 at 12:12 p.m. The resident's diagnoses				be accomplished for those	<u> </u>	
	included, but were not limited to, chronic				residents found to have been	•	
	obstructive pulmonary disease (COPD), chronic					<u> </u>	
	-	ary disease (COTD), chrome and gastroesophageal reflux			affected by the deficient		
		ild gastroesophagear remux			practice?		
	disease (GERD).				QMA 4 and all other QMA's a		
	TI D 1 202	4 1			nurses will be in-serviced by the	ne	
		4 physician's orders indicated			DON/Designee on 12/23/24		
		receive the following morning			regarding the facilities policy f	or	
		trozole (cancer medication),			Infection Control, medication		
	Propranolol (hypert				administration including hand		
	(supplement), Isoso				sanitizing and handwashing.		
		iidone (tremors), Eliquis (blood			Residents B, C, E, F, G and H		
		arbonate (TUMS), Advair			receiving medications per pro-		
		neprazole (GERD), Claritin			#2 How will the facility identi	fy	
	` ` ` ' '	m (atrial fibrillation),			other residents having the		
		itamin), Zoloft (depression),			potential to be affected by the	<u>ıe</u>	
	and Magnesium oxi	ide (supplement).			same deficient practice?		
					All residents who receive		
		s medication administration			medication have the potential	to	
	observation on 12/6	5/24 at 9:17 a.m., QMA			be affected, however, no resid	lents	
	(Qualified Medicati	on Aide) 4 was observed to			were affected by this deficiend	cy.	
	remove 2 tablets fro	om the bottle of calcium			All QMA's and nurses will be		
	carbonate into her b	pare left hand and place in the			in-serviced by the DON/Desig	nee	
		AA 4 then removed the 2			on 12/23/24 regarding the faci		
		dication cup and placed in			policy for Infection Control,		
		cup with her bare fingers. Prior			medication administration		
		removed her medication cart			including hand sanitizing and		
		et and unlocked the medication			handwashing.		
	. J I men poem		1		ı		i

01/02/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/06/2024 155417 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1100 N GARDNER AVE HICKORY CREEK AT SCOTTSBURG SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE cart. She then opened the medication cart drawer with her right hand. She removed the medications from individualized package cards and touched #3 What measures will be put her computer mouse after the removal of each into place and what systemic medication from the cart. QMA 4 did not hand changes will be made to sanitize prior to or after the medication ensure that the deficient administration to the resident. practice does not reoccur? The DON/Designee will observe On 12/6/24 at 9:25 a.m., QMA 4 indicated when QMA/nurse medication passing medications staff were not suppose to administration including hand touch the medications with their bare hands. sanitizing/handwashing, to ensure all staff are following the Infection During an interview on 12/6/24 at 11:26 a.m., LPN Control policy. Licensed Practical Nurse) 5 indicated during a medication pass, hands should be sanitized before #4 How will the facility monitor and after each resident. its corrective actions to ensure that the deficient practice will 2. The clinical record for Resident C was reviewed not reoccur? on 12/5/24 at 12:39 p.m. The resident's diagnoses Ongoing compliance with this included, but were not limited to, chronic corrective action will be monitored obstructive pulmonary disease and diabetes. through the facility----- QAPI tool. The DNS/designee will be The December 2024 physician's orders indicated responsible for completing the the resident was to receive the following morning QAPI Audit tool weekly for 4 medications: Myrbetriq (overactive bladder), Breo weeks, monthly for 6 months and Ellipta (inhaled medication for COPD), quarterly thereafter for at least 2 Acetaminophen (pain), Hydroxychloroquine quarters. If the threshold of 90% is (rheumatoid arthritis), Isosorbide mononitrate not met, an action plan will be (COPD), Levetiracetam (seizure medication), developed. Findings will be Spironolactone (heart failure), Cymbalta submitted to the QAPI Committee (depression), Paxil (depression), Clonazepam for review and follow up. (seizures), Morphine (pain), Incruse Ellipta (COPD), Depakote (schizoaffective disorder), Seroquel (schizoaffective disorder), and Date of Compliance: 01/06/2025 Oxybutynin chloride (overactive bladder). During a continuous medication administration observation on 12/6/24 at 8:55 a.m., QMA 4 was observed to remove her medication cart keys from her pocket and unlocked the medication cart. She

i f		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 12/06/2024				
		155417	B. W	ING		12/06	/2024
NAME OF P	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD		
				1	GARDNER AVE		
HICKOR	Y CREEK AT SCOT	I I 2ROKG		SCOTT	SBURG, IN 47170		
(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)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION dication cart drawer with her	+	TAG	DEFICIENCE		DATE
	*	oved the medications from					
	_	age cards and touched her					
	_	ter the removal of each					
	1 -	e cart. QMA 4 did not hand					
	sanitize prior to or a	after the medication					
	administration to th	e resident.					
	3. The clinical recor	rd for Resident E was reviewed					
		a.m. The resident's diagnoses					
		not limited to, malignant					
		arynx and chronic obstructive					
	pulmonary disease.						
		4 physician's orders indicated					
		receive the following morning					
	_	s (blood thinner), Ondansetron Sodium (constipation),					
	Sodium Chloride (h						
	· ·	antihistamine), and Tramadol					
	(pain medication).	unumoumne), una Tramacor					
	_	s medication administration					
		5/24 at 7:29 a.m., QMA 4 was					
		her medication cart keys from					
	_	cked the medication cart. She					
	_	dication cart drawer with her oved the medications from					
		age cards and touched her					
	_	ter the removal of each					
		e cart. QMA 4 did not hand					
		edication administration to the					
	resident.						
		rd for Resident F was reviewed					
		a.m. The resident's diagnoses					
		not limited to, mild dementia					
	kidney disease.	nce, endometriosis and stage 3					
	Kidney disease.						
	I						1

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				ETED
		155417	B. WING			12/06/	/2024
		<u> </u>	STF	EET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			GARDNER AVE		
HICKOR'	Y CREEK AT SCOT	TTSBURG			SBURG, IN 47170		
(X4) ID	SHMMARV	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	ıχ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		4 physician's orders indicated					
		receive the following morning					
		nin B12 (supplement),					
	Carvedilol (hyperte	nsion), Potassium Chloride					
	(supplement), Omeprazole (GERD), and						
	Alprazolam (anxiet	y).					
	During the continuo						
		6/24 at 7:35 a.m., QMA 4					
		's room and obtained the ssure. QMA 4 then walked					
	•	ion cart had removed her					
		s from her pocket and					
		ation cart. She then opened					
		drawer with her right hand.					
		edications from individualized					
		couched her computer mouse					
	after the removal of	f each medication from the cart.					
	QMA 4 did not san	itize her hands after she					
	obtained the blood	pressure or prior to or after the					
	administration of th	e resident's medications.					
	5 The clinical reco	ord for Resident G was reviewed					
		a.m. The resident's diagnoses					
		not limited to, chronic					
	· ·	ary disease and iron					
	deficiency anemia.						
	_						
		4 physician's orders indicated					
		receive the following morning					
		ir HFA aerosol inhaler (COPD),					
		osy), Fluoxetine (depression),					
		ffective disorder), Polyethylene					
	• • •	n), Ferrous Sulfate (anemia),					
	` *	epsy), Xanax (anxiety),					
	Gemfibrozil (hyper						
		operidol (schizoaffective					
		n Chloride (supplement),					
		ia), Tylenol Extra Strength					
	(pain), and Saime N	Vasal mist (allergies).					

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DENTIFICATION NUMBER 155417 B. WING	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG IXMARY STATEMENT OF DEFICIENCE PREFIX GEACH DEFICIENCY MUST BE PRECEDED BY BULL TAG REGULATORY OR LSC IDENTIFYING BRORMATION During the continuous medication administration observation on 12/6/24 at 17-42 a.m., QMA 4 had removed her medication cart drawer with her right hand. She removed the medications from individualized package cards and touched her computer mouse after the removal of each medication for a state of the resident was to recisient successful. The December 2024 physician's orders indicated the resident was to recisient's medication. For indicated the resident's action of the resident's	AND PLAN	OF CORRECTION						
HICKORY CREEK AT SCOTTSBURG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG During the continuous medication administration observation on 12/6/24 at 7.42 a.m., QMA 4 had removed her medications from individualized package cards and touched her essident's materials and present the medications. 6. The clinical record for Resident H was reviewed on 12/6/24 at 11-03 a.m. The resident's diagnoses included, but were not limited to, end stage liver disease and depression. The December 2024 physician's orders indicated the resident was to receive the following morning medications: Escitalopram oxaliate (depression), Folic acid (supplement), Srinoatcone (directic), Thiamine (supplement), Arinoatcone (directic), Thiamine (supplement), and Omeprazole (GERD). During a continuous medication administration observation on 12/6/24 at 8:50 a.m., QMA 4 was observed to remove the medication cart drawer with her right thand. She removed the medication cart for the administration observation on 12/6/24 at 8:50 a.m., QMA 4 was observed to remove the medication cart for the cart. She then opened the medication cart for the removal the medication is administration observation on 12/6/24 at 8:50 a.m., QMA 4 was observed to remove the medication cart keys from her pocket and unlocked the medication cart keys from her pocket and unlocked the removal the medications from individualized package cards and touched her computer mouse after the removal the medications from individualized package cards and touched her computer mouse after the removal the medications from individualized package cards and touched her computer mouse after the removal the medications from individualized package cards and touched her computer mouse after the removal the medications from individualized package cards and touched her computer mouse after the removal the medications from individualized package cards and touched her computer mouse after the removal the medications from individualized package cards and touched her computer mouse after the removal the me			155417	B. WI	NG	_	12/06	/2024
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION During the continuous medication administration observation on 12/6/24 at 7:42 a.m., QMA 4 had removed her medication cart. She then opened the medication cart drawer with her right hand. She removed the medication from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not sanitize her hands before or after the administration of the resident's medications. 6. The clinical record for Resident H was reviewed on 12/6/24 at 11:03 a.m. The resident's flagnoses included, but were not limited to, end stage liver disease and depression. The December 2024 physician's orders indicated the resident was to receive the following morning medications: Escitalopram oxalate (depression), Folic acid (supplement), Spironolactone (diuretic), Thiamine (supplement), Xifaxan (irritable bowel), Zine sulfate (supplement), Xifaxan (irritable bowel), Zine sulfate (supplement), Aifaxan (irritable bowel), Zine sulfate (supplement), Aifaxan (irritable bowel), Zine procession on 12/6/24 at 8:50 a.m., QMA 4 was observed to remove her medication cart. She then opened the medication cart drawer with her right hand. She removed the medication from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not hand					1100 N	GARDNER AVE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION During the continuous medication administration observation on 12/6/24 at 7:42 a.m., QMA 4 had removed her medication cart. She then opened the medication cart drawer with her right hand. She removed the medication from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not sanitize her hands before or after the administration of the resident's medications. 6. The clinical record for Resident H was reviewed on 12/6/24 at 11:03 a.m. The resident's flagnoses included, but were not limited to, end stage liver disease and depression. The December 2024 physician's orders indicated the resident was to receive the following morning medications: Escitalopram oxalate (depression), Folic acid (supplement), Spironolactone (diuretic), Thiamine (supplement), Xifaxan (irritable bowel), Zine sulfate (supplement), Xifaxan (irritable bowel), Zine sulfate (supplement), Aifaxan (irritable bowel), Zine sulfate (supplement), Aifaxan (irritable bowel), Zine procession on 12/6/24 at 8:50 a.m., QMA 4 was observed to remove her medication cart. She then opened the medication cart drawer with her right hand. She removed the medication from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not hand	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID			(X5)
During the continuous medication administration observation on 12/6/24 at 7:42 a.m., QMA 4 had removed her medication cart drawer with her right hand. She removed the medications from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not sanitize her hands before or after the administration of the resident's medications. 6. The clinical record for Resident H was reviewed on 12/6/24 at 11:03 a.m. The resident's diagnoses included, but were not limited to, end stage liver disease and depression. The December 2024 physician's orders indicated the resident was to receive the following morning medications: Escitalopram oxalate (depression), Folic acid (supplement), Spironolactone (diuretic), Thiamine (supplement), Xifaxan (irritable bowel), Zinc sulfate (supplement), and Omeprazole (GEED). During a continuous medication administration observation on 12/6/24 at 8:50 a.m., QMA 4 was observed to remove her medication cart drawer with her right hand. She removed the medication cart drawer with her right hand she removed the medication cart drawer with her right hand. She removed the medication from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not hand						(EACH CORRECTIVE ACTION SHOULD BE		
observation on 12/6/24 at 7:42 a.m., QMA 4 had removed her medication cart keys from her pocket and unlocked the medication cart. She then opened the medication cart she then opened the medication cart she then opened the medication from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not sanitize her hands before or after the administration of the resident's medications. 6. The clinical record for Resident H was reviewed on 12/6/24 at 11:03 a.m. The resident's diagnoses included, but were not limited to, end stage liver disease and depression. The December 2024 physician's orders indicated the resident was to receive the following morning medications: Escitalopram oxalate (depression), Folic acid (supplement), Spironolactone (diuretic), Thiamine (supplement), Spironolactone (diuretic), Thiamine (supplement), and Omeprazole (GERD). During a continuous medication administration observation on 12/6/24 at 8:50 a.m., QMA 4 was observed to remove her medication cart keys from her pocket and unlocked the medication cart. She then opened the medication card drawer with her right hand. She removed the medications from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not hand	TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
resident. On 12/6/24 at 9:55 a.m., the Director of Nursing provided a current copy of the document titled		observation on 12/6 removed her medication and unlocked the mopened the medication. She removed individualized pack computer mouse aff medication from the her hands before or resident's medication. 6. The clinical record on 12/6/24 at 11:03 included, but were redisease and depress. The December 2022 the resident was to a medications: Escita Folic acid (supplementations). Escita Folic acid (supplementations). During a continuous observation on 12/6 observed to remove her pocket and unlot then opened the meright hand. She remindividualized pack computer mouse aff medication from the sanitize after the meresident. On 12/6/24 at 9:55 and	6/24 at 7:42 a.m., QMA 4 had ation cart keys from her pocket edication cart. She then ion cart drawer with her right the medications from age cards and touched her ter the removal of each e cart. QMA 4 did not sanitize after the administration of the ons. Ord for Resident H was reviewed a.m. The resident's diagnoses not limited to, end stage liver ion. 4 physician's orders indicated receive the following morning alopram oxalate (depression), ent), Spironolactone (diuretic), ent), Xifaxan (irritable bowel), ement), and Omeprazole s medication administration 6/24 at 8:50 a.m., QMA 4 was be her medication cart keys from backed the medication cart. She dication cart drawer with her toved the medications from age cards and touched her ter the removal of each e cart. QMA 4 did not hand edication administration to the					

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

PRINTED: 01/02/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155417		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG		STREET ADDRESS, CITY, STATE, ZIP COD 1100 N GARDNER AVE SCOTTSBURG, IN 47170					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	ATE	(X5) COMPLETION DATE
	Administration" dat was not limited to, hygiene should be p direct resident contact come into contact w medication cupFa touching the medica	paration and Medication ted 4/30/24. It included, but "ProcedureAppropriate hand performed before and after actMedications should not with any surface except for the actility staff should avoid ation with bare hands" s to Complaints IN00447152					

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