STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SUNSET	1109 S INDIANA STREET GREENCASTLE, IN 46135

(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 the Investigation of Complaints IN00435710, IN00436109, IN00436745, and IN00437354. Complaint IN00436745 - No deficiencies related to the allegations are cited. Complaint IN00437354 - No deficiencies related to the allegations are cited. Complaint IN00436109 - No deficiencies related to the allegations are cited. Complaint IN00435710 - Federal/state deficiencies related to the allegations are cited at F742, F778, and F806. Survey dates: June 27 and 28, 2024 Facility number: 000418 Provider number: 155565 AIM number: 100274870 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 0 Medicaid: 31 Other: 21 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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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	Quality review completed on July 5, 2024.			
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview, and record review, the facility failed to ensure a resident with a history of post-traumatic stress disorder and anxiety, received appropriate services to attain the highest practicable mental and psychosocial well-being resulting in psychosocial distress for 1 of 2 residents reviewed for psychosocial wellbeing (Resident G). Findings include: On 6/27/24 at 12:27 p.m., during a routine observation and interview with the resident, he was sitting up in his wheelchair in his room. The resident was alert and meticulous in his note taking and record keeping. He indicated he had notes, recordings of conversations, and text messages when he had voiced and written his concerns to the Administrator, facility staff, and the Director of Nursing. He was pleasant but emotional during the interview.	F 0742	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Revisit. **F tag**: **742- Treatment/Services Mental/Psychosocial Concerns** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Resident G is no longer a**	07/24/2024

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	The resident indicated he has severe abandonment anxiety. He had suffered from this since his accident when his wife tried to kill him resulting in trauma. The resident indicated he had been seeing psychiatric (psych) services since his accident but did not use the services through the facility. The resident indicated the facility staff were aware of this. When he was admitted he was in a room on the East side of the building and used the shower room on that side. The resident indicated he was placed in the shower room and the call light cord would not reach him where he was sitting. The staff tied a string to the cord to enable him to call for assistance. The resident indicated the facility staff told him they could not tie a string to the cord due to it being a choking hazard. The resident indicated the string was removed and he was provided a bell to ring for assistance. He was unsure of the exact date of the occurrence. The resident indicated he was placed in the shower room on a bedside commode to use the restroom. He rang the bell, and no one answered or came to assist him. The resident indicated he became increasingly upset and fearful. He indicated he started yelling and throwing things that were within his reach. The Administrator came to the door and obtained assistance for him. The resident indicated he told the Administrator he had been left for around 1.5 hours. He was moved to another room in the west hall and was advised the shower room had a call system which would reach him. The resident indicated he had been left several times in the shower room since being moved. On 5/28/24 the resident indicated he had an appointment to have an MRI at the hospital and he needed to complete his bowel regiment prior to leaving for his		**resident in the facility** 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 **Other residents have potential to be affected, specifically those reflective of psychosocial distress.** **A full audit of all residents was conducted by SS on 7/11, to ensure they are receiving appropriate services for their psycho-social well-being. Any concerns identified were corrected** **Leadership will be in-serviced on maintaining psychosocial well being, and follow up on psychosocial distress by regional social wellness & enrichment support on or before 7/24/24.** **Nursing staff will receive education on or before 7/24/24 from the DNS/designee regarding behavior documentation** **Facility staff will be educated on factors that can influence psychosocial wellbeing, including transportation and**	

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	appointment. The resident indicated he had asked several staff members to take him to the bathroom. One of the Certified Nurse Aides (CNA) took him to the shower room and left him there. He indicated he was left in the shower room for about 30 minutes. He pulled the light cord, and no one came, and he started yelling for help. He indicated after some time the staff came in to assist him, he was unsure of how long he had been left without assistance. The resident indicated he had been forgotten 4 or 5 different times in the shower room. The resident indicated another occasion when he had been forgotten in the shower room, he was unsure of the date of occurrence. The resident indicated he had to yell for assistance because no one answered the bell. The resident indicated a nurse opened the door and told him he had heard him yelling and would get an aide to assist him. During the interview the resident provided copies of dated text messages that had been sent to the Director of Nursing regarding being forgotten in the shower room, asking for help and indicated he had mental health issues related to problems in his past. The resident became emotional when retelling of the incidents and had to stop several times. He indicated this had caused him a great deal of anxiety and he had felt abandoned by the staff. The resident indicated on 5/28/24 he was sent to the hospital for an MRI and was told by the nurse his transportation was taken care of. The resident indicated he was not given any information about who was taking him or picking him up. The resident indicated he was left outside the hospital to wait to be picked up. The transportation van		**call lights by the Executive Director/designee on or before 7/24/24** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Leadership will be in-serviced on maintaining psychosocial well being, and follow up on psychosocial distress by regional social wellness & enrichment support on or before 7/24/24.** **Nursing staff will receive education on or before 7/24/24 from the DNS/designee regarding behavior documentation** **Facility staff will be educated on factors that can influence psychosocial wellbeing, including transportation and call lights by the Executive Director/designee on or before 7/24/24** **The IDT team, through customer care rounding, will communicate in morning meeting changes in condition of their residents. IDT team will review all newly admitted residents to ensure proper diagnosis and proper**	

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	did not show up. The resident indicated he attempted to call the facility for about 30 minutes. No one answered the phone. An off duty employee from the facility saw him at the hospital and took him back to the facility. He indicated he was very fearful and anxious at the time and felt abandoned by the staff. On 6/27/24 at 12:46 p.m., during an interview, CNA 4 indicated on 5/31/24 she had placed the resident in the shower room because he was needing to go to the bathroom before leaving to have an MRI done at the hospital. She acknowledged she did not tell anyone she had placed the resident in the shower room. She gave him a call light to call for assistance and left to do other things. The CNA indicated she was working on appointments and she and another CNA heard someone yelling for help. The other CNA asked who was in the shower room. She told the CNA she put the resident in the shower room to use the bathroom. The CNA then removed the resident from the shower room. On 6/28/24 at 9:00 a.m., the medical record of Resident G was reviewed. The resident was admitted to the facility with diagnosis which included, but not limited to, burn of unspecified degree of right foot, paraplegia (paralysis that occurs in the lower half of the body), generalized anxiety disorder (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat), and major depressive disorder (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks). Most recent MRI assessment indicated the		**corresponding interventions are care planned and services provided for those dealing with psycho-social concerns, including trauma-related and or anxiety diagnoses.** 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; **The SSD/designee will complete the CQI tool entitled "Trauma Informed Care" weekly for 4 weeks, monthly for 5 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance**. by what date the systemic changes will be completed. **7/24/24**	

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	resident was minimal assist of one for activities of daily living (ADL). A care plan, dated 4/11/2024, indicated the resident was at risk for signs and symptoms of anxiety (worried facial expressions, repetitive movements, shortness of breath, nausea, sweating, tremors, irritability, insomnia, reports of anxiety). Resident had a diagnosis of anxiety. Interventions included, but were not limited to, encourage resident to verbalize fears and anxiety; offer validation and reassurance, maintain a calm environment, observe for increase in signs and symptoms of anxiety; and obtain psych services as appropriate. A care plan, dated 2/29/2024, indicated the resident was a new admission to the facility and requires implementation of services to promote physical, emotional, and psychosocial well-being. Interventions included, but were not limited to, assist with transfers, ambulation, bed mobility, toileting and/or incontinent care, and honor resident wishes. A care plan, dated 3/11/2024, indicated resident was at risk for signs and symptoms of depression, expresses feeling depressed, feeling tired, trouble concentrating, feeling nervous, and/or fidgety. Resident had a diagnosis of depression. Resident reported feeling down, trouble concentrating, feeling tired and moving slowly on recent PHQ-9. Interventions included, but were not limited to, allow resident to express feelings and frustrations; offer validation and support; and emphasize and promote independence and feelings of control and choice. The medical record lacked evidence of a trauma assessment being completed after the resident			

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	informed the Director of Nursing and Administrator, he had a diagnosis of PTSD. The record lacked documentation for offering of additional behavior health services. The record lacked evidence of a care plan for trauma-based care. On 6/28/2024 at 2:00 p.m., the Administrator provided a document, titled, "Trauma Informed Cre," dated 2/20, and indicated it was the policy currently being used by the facility. The policy indicated, "...It is the policy of this facility to ensure that residents who are trauma survivors receive culturally competent trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident ...Trauma informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma ...Procedure ...2. Residents who screen positive for a history of trauma will be referred to behavioral health services for further screening. 3. Behavioral health services will assist the resident and interdisciplinary team in developing a plan of care which will be added to the medical record. This plan of care will incorporate individual experiences ...4. The plan of care will routinely be evaluated whether the interventions have been able to mitigate(or reduce) the impact of identified triggers on the resident that may cause re-traumatization ...." On 6/27/2024 at 2:00 p.m., the Administrator provided a document, titled, "Resident Rights," dated 3/15/17, and indicated it was the policy currently being used by the facility. The policy indicated, "...Resident Rights ...Safe Environment ...You have the right to a safe, clean comfortable			

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	and homelike environment, including but not limited to receiving treatment and supports for daily living safety ...." This citation relates to Complaint IN00435710. 3.1-43(a)(1)			
F 0778 SS=D Bldg. 00	483.50(b)(2)(iii) Assist w/ Transport Arrangements to Radiology §483.50(b)(2)(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance. Based on observation and interview, the facility failed to assist the resident in obtaining transportation from a hospital appointment for 1 of 1 residents reviewed for transportation (Resident G). Findings include: On 6/27/24 at 12:27 p.m., during a routine observation and interview with Resident G, he was sitting up in his wheelchair in his room. Resident G was very alert and meticulous in his note taking and record keeping. He indicated he had notes and recordings of conversations and text messages when he had voiced and written his concerns to the Administrator, facility staff and the Director of Nursing about being left at the hospital without transportation back to the facility. The resident indicated on 5/28/24 he was sent to the hospital for an MRI. He was told by the nurse his transportation was taken care of, but he was not given any information about who was taking	F 0778	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Revisit. **F tag: 778 Assist W/Transport Arrangements** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Resident G is no longer a resident in the facility** how other residents having	07/24/2024

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	him. When he completed the MRI approximately an hour and a half later, he was left outside. His transportation van did not show up. The resident indicated he had attempted to call the facility for about 30 minutes. No one answered the phone. When the transportation van did not come to the hospital an off duty employee of the facility brought him back to the facility after randomly seeing him outside the hospital. On 6/28/24 at 9:57a.m., during a confidential interview Employee 3 indicated on 5/28/24 they were leaving the hospital where Resident G had been. The resident was sitting outside in the front of the hospital and indicated he was waiting for the van. He had been there for an MRI and was told by the driver he was not on his list to pick up. While the employee observed the resident call the facility at least six times with no answer. The employee called the facility and talked to the supervisor. The employee explained the situation and asked who was picking up the resident. The supervisor indicated no one knew what was going on. The employee agreed to bring him back to the facility. The employee indicated the same day just prior to the resident going to the hospital he had been left in the shower room and he was very upset and feeling abandoned. On 6/28/24 at 10:05a.m., during a confidential interview Employee 5 indicated Employee 3 called on 5/28/24 about Resident G being left at the hospital. The employee spoke to several staff members regarding who was picking him up and asked for the transportation phone number. The staff indicated they did not have a number. No one knew who to call. On 6/28/24 at 9:00 a.m., the medical record of Resident G was reviewed. Resident G was		the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **Alert and Oriented Residents using third party transport have potential to be affected** **Staff will receive education on or before 7/24/24 from the ED/designee on transportation policy and location of daily residents transportation information which will include time, and phone number of transport vendor.** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Staff will receive education on or before 7/24/24 from the ED/designee on transportation policy and location of daily residents transportation information which will include time, and phone number of transport vendor.** **Facility will provide in the appointment packet to the resident a form with the information on transport vendor / phone number and**	

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	admitted to the facility with diagnoses which included, but not limited to, burn of unspecified degree of right foot, paraplegia (paralysis that occurs in the lower half of the body), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), generalized anxiety disorder (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat), and major depressive disorder (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks). On 6/28/2024 at 2:33 p.m., the Administrator provided an undated document, titled, "ASC Facility Bus/Van Transportation Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "...Transportation will be provided by the facility bus/van for residents participating in activities outside of the facility ...Outside transport should be the chosen option prior to utilizing facility van for physician and or other medical related appointments ..." On 6/27/2024 at 2:00 p.m., the Administrator provided a document, titled, "Resident Rights," dated 3/15/17, and indicated it was the policy currently being used by the facility. The policy indicated, "...Resident Rights ...Safe Environment ...You have the right to a safe, clean comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety ...." This citation relates to Complaint IN00435710. 3.1-49(j)(3)		**facility name/phone number when using third party transport.** **Information of daily appointments will be available to staff at the nurse's station** 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 is responsible for the completion of the Transportation CQI tool weekly times 4 weeks, monthly times 5 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance**. by what date the systemic changes will be completed. **7/24/24**	

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F 0806 SS=D Bldg. 00	483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; Based on observation, interview, and medical record review, the facility failed to honor a resident's dietary dislikes and food preferences 1 of 3 residents reviewed for food preferences (Resident G). Findings include: On 6/27/24 at 12:27 p.m., during observation and interview Resident G indicated he can't have gassy foods, spicy foods, or greasy food due to an issue with his digestion related to his paralysis. He indicated he had met with the dietitian when he was admitted, and he had told the staff several times of his food preferences. He understood he had a regular diet ordered but the staff did not provide his preferences as requested. The resident indicated he continued to receive foods he can't tolerate. He indicated at times he must eat it because there was only grilled cheese or cold cuts sandwich offered as an alternate. He was given sausage and eggs every day though he had told them he can't eat greasy food. On 6/27/24 at 1:05 p.m., observed the resident	F 0806	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Revisit. F tag: **806 Resident Allergies, Preferences, Substitutes** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Resident G is no longer a resident in the facility**	07/24/2024

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	being served the noon meal. The diet slip indicated a regular diet. He was served sausage pizza for lunch. His preferences and dislikes were not listed on the diet slip. The resident indicated he has told the staff many times of his dislikes. He had only met once with a dietitian but had voiced complaints to the Administrator and the Director of Nursing. He indicated he had continued to be served foods that he did not like or tolerate. On 6/28/24 at 2:00 p.m., during an interview with the Administrator, she indicated she had offered numerous alternates to the resident. She indicated the diet ticket would not indicate the resident's dietary dislikes because the resident changed his mind all the time. She indicated he would not be served foods that were on a dislike list if a list had been provided. A food preference list had not been created for Resident G. She indicated she had been aware of different preferences the resident had communicated to her. She indicated she had not tried alternate ways of communication for the resident to express his dislikes and preferences. On 6/28/24 at 9:00 a.m., the medical record of resident G was reviewed. Resident was admitted to the facility with diagnoses which included, but not limited to, paraplegia (paralysis that occurs in the lower half of the body), gastro-esophageal reflux disease (a common condition in which the stomach contents move up into the esophagus), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), generalized anxiety disorder (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat), and major depressive disorder (an illness characterized by persistent sadness and a loss of interest in activities that you normally		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 **All residents with preferences and dislikes have potential to be affected** **All residents will be interviewed and preferences and dislikes will be updated to ensure accurate information is in the meal tracker system for culinary staff.** **Staff will be educated by the ED/designee on communicating with culinary manager on residents preferences and dislikes on or before 7/24/24.** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Staff will be educated by the ED/designee on communicating with culinary manager on residents' preferences and dislikes on or before 7/24/24.** **Residents will have their preferences established by Culinary manager upon admission. Residents will be offered alternatives when resident voices a desire for**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SUNSET	1109 S INDIANA STREET GREENCASTLE, IN 46135

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	enjoy, accompanied by an inability to carry out daily activities, for at least two weeks). The medical record lacked documentation of care plan addressing dietary food preferences. On 6/27/2024 at 2:00 p.m., the Administrator provided a document, titled, "Residents Rights," dated 3/15/17, and indicated it was the policy currently being used by the facility. The policy indicated, "...Residents Rights ...Respect and Dignity ...The right to reside and receive services in the facility with reasonable accommodation of your needs and preferences ...Self Determination ...You have the right to make choices about aspects of your life in the facility that are significant to you ...." This citation relates to Complaint IN00435710. 3.1-21(d)(4) 3.1-21(d)(5)		**something else during meals.** 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 Culinary manager is responsible for the completion of the Meal Preferences CQI tool weekly times 4 weeks, monthly times 5 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance**. by what date the systemic changes will be completed. **7/24/24**	