STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155427	A. BUILDING 00 B. WING	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT MADISON	1945 CRAGMONT ST MADISON, IN 47250

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00429833. Complaint IN00429833 - Federal/State deficiency related to the allegations is cited at F684. Survey date: March 15, 2024 Facility number: 000348 Provider number: 155427 AIM number: 100288390 Census Bed Type: SNF: 10 NF: 1 SNF/NF: 25 Total: 36 Census Payor Type: Medicare: 7 Medicaid: 20 Other: 9 Total: 36 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 24, 2024.	F 0000	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. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive			

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

Markietta Burns | Administrator | 04/15/2024

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

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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to document a resident's skin assessment for the skin under the mepilexes dressing or the implementation of a treatment order for a skin tear, upon re-admission for 1 of 3 residents reviewed for quality of care. (Resident B) Findings include: The clinical record for Resident B was reviewed on 3/15/24 at 10:34 a.m. The diagnoses included, but were not limited to, multiple myeloma, diabetes and anorexia. The care plan, dated 10/19/23, indicated the resident was at risk for skin breakdown and staff were to assess the resident's skin condition weekly, as needed and; staff were to provid treatments as ordered. The admission note, dated 2/9/24 at 4:29 p.m., indicated the resident re-admitted with a 1 cm (centimeter) abrasion to the left shin and an open area just below the coccyx. The wound note, dated 2/13/24 at 10:07 a.m., indicated upon re-admission, the resident's left arm was covered with multiple mepilexes (bandages). Upon removal, a new skin tear was noted from the adhesive of the mepilex. The area measured 0.8 cm in length, 0.5 cm in width with a depth of 0.1 cm. The treatment recommendation was to clean the area with wound cleanser, apply Bacitracin ointment to the base of the wound and to secure with non-adherent pad and rolled gauze every other day.	F 0684	**F 684** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B's skin assessment has been completed and documented. Implementation of a treatment order for the skin tear has been completed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Up to 3 residents who receive treatments have the potential to be affected by the alleged deficient practice. All residents with treatments in the last 30 days were audited to ensure appropriate skin assessments were completed and implementation of treatments were applied. All nurses will be in-serviced on skin assessments and applying treatments by the DNS or designee on or before 4/4/24 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All nurses will be in-serviced on	04/04/2024

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	The clinical record lacked documentation of an assessment of the skin under the mepilexes or the implementation of a treatment order for the skin tear on 2/13/24. The hospital records lacked documentation of any orders to not remove the mepilexes. During an interview on 3/15/24 at 3:16 p.m., the Director of Nursing indicated the resident returned from the hospital with the mepilexes to her left arm. She believed the mepilexes were in place for protection due to fragile skin. Their protocol would be to remove the mepilex to see what was under them unless there was an order for them not to remove. When the mepilex were removed, the resident acquired a skin tear due to the adhesive of the bandage. There should have been an order implemented for the skin tear on 2/13/24 and there was not. On 3/15/24 at 3:15 p.m., the Executive Director provided a current copy of the document titled "Skin Management Program" dated 5/2022. It included, but was not limited to, "Policy...It is the policy...to ensure each resident receives care, consistent with professional standards of practice...." This Citation relates to Complaint IN00429833 3.1-37		skin assessments and applying treatments by the DNS or designee on or before 4/4/24 When a resident has a order for a treatment the responsible nurse will review the order and provide the treatment as ordered by the Physician. The nurse will then document on the TAR (Treatment Administration Record). The Director of Nursing/Designee will review the Administration Compliance Report daily during the Clinical Morning meeting held 5 times a week. The charge nurse on weekend will review the Administration Compliance Report to ensure treatments are completed. If there is documentation to reflect the treatment was not done, the DNS will educate/re-train the nursing staff involved regarding the facility policy for treatments. Written counseling will be rendered for continued noncompliance. **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 will complete a treatment CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months. The treatment CQI audit tool will be reviewed bi-monthly	

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			during QAPI for six months. If a 95% threshold is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. Compliance Date: 4/4/24	