PRINTED: 12/20/2024
FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2024	
	PROVIDER OR SUPPLIE		5480 E	ADDRESS, CITY, STATE, ZIP COD E 25TH STREET MBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
F 0000						
Bldg. 00	Licensure Survey.	55424	F 0000	The creation and submission this plan correction does not constitute an admission by th provider of any conclusion se in the statement of deficiencie any violation of regulations.	is t forth	
F 0580 SS=D Bldg. 00	Census Payor Type: Medicaid: 27 Other: 2 Total: 29 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 4, 2024. 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.)		F 0580	POC F-580 What corrective action(s) will accomplished for those reside found to be affected by the deficient practice? • Staff educated on MD notific of resident condition change concerns ensuring that MD notification is completed for resident condition change. • Resident blood glucose level	ents	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 00 COMPLETED B. WING 08/29/2024 155424 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5480 E 25TH STREET HICKORY CREEK AT COLUMBUS COLUMBUS, IN 47203 (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 the resident was moderately cognitively impaired. resident 8 reviewed for all levels The resident's diagnoses included, but were not out of range with MD, no other limited to, heart failure, hypertension, diabetes, concerns noted 9/6/24. anxiety, and depression. How other residents having potential to be affected by the A current physician's order, with a start date of same deficient practice will be 03/20/24, indicated the resident was to be identified and what corrective administered insulin lispro per a sliding scale. The action(s) will be taken? physician was to be notified if the resident's blood · DNS/designee to review facility glucose level was greater than 350. activity report for all residents with sliding scale parameters to ensure The June, July, and August 2024, EMAR/ETAR MD is notified per order and (Electronic Medication Administration documented in resident clinical Record/Electronic Treatment Administration record Record) indicated the resident's blood glucose · All diabetics with sliding scale levels were greater than 350 on the following parameters have the potential risk dates and times: of alleged deficient practice. · DNS/designee audited to ensure - On 06/10/24 at 11:00 A.M., the resident's blood any resident identified with sliding glucose level was 368, scale parameter was to notify MD - On 06/20/24 at 11:00 A.M., the resident's blood was completed, no other residents glucose level was 355. identified 9/6/24. - On 06/25/24 at 11:00 A.M., the resident's blood What Measures will be put into glucose level was 367, place and what systemic changes - On 07/08/24 at 11:00 A.M., the resident's blood will be made to ensure that the glucose level was 399. deficient practice does not recur? - On 07/21/24 at 11:00 A.M., the resident's blood · An audit tool of all diabetics glucose level was 389, completed on 9/6/24 identifying all - On 08/19/24 at 7:00 A.M., the resident's blood diabetics in facility for potential glucose level was 358, and change in condition and need to - On 08/19/24 at 11:00 A.M., the resident's blood notify MD, no other discrepancies glucose level was 394. noted. · All licensed nurses educated on The resident's clinical record lacked any appropriate policy and procedure documentation the physician was notified of the for change in condition and MD blood glucose levels. notification.

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During an interview on 08/29/24 at 2:09 P.M., LPN

resident's blood glucose levels were documented

(Licensed Practical Nurse) 2 indicated the

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How the corrective action(s) will be

monitored to ensure the deficient

quality assurance program will be

practice will not recur, i.e., what

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155424	B. WING		08/29/2024	
	PROVIDER OR SUPPLIEF		5480 E	ADDRESS, CITY, STATE, ZIP COD 25TH STREET MBUS, IN 47203		
ПСКОК	- CREEK AT COLO	JIVIBUS	COLON	WIBOS, IN 47203		
(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)	COMPLETION	
TAG	 	R LSC IDENTIFYING INFORMATION R. If the blood glucose was	TAG		DATE	
	out of the paramete to call the physician the EMAR/ETAR a would document if progress note. During an interview DON (Director of N did not suffer any il physician not being levels. The current facility Monitoring", with a provided by the DO policy indicated, "	r and if the nurse was required it would be documented on and in a progress note. They there were any new orders in a v on 08/29/24 at 2:55 P.M., the Jursing) indicated the resident 1 effects related to the notified of the blood glucose policy titled, "Blood Glucose revision date of 2/2015, was 0N on 08/29/24 at 2:45 P.M. The .The physician will be notified blood glucose is outside the		put into place? DNS/designee will be responsible for change of cond QAPI tool completion weekly weeks, monthly x 3 months, a quarterly for one year, with responsed to QAPI committee, overseen by ED. If a threshold 95% is not achieved, an action plan will be developed to ensurompliance By what date will the systemic changes be completed? 9/21/2025 We are requesting paper compliance.	x 4 nd sults d of n ure	
F 0684 SS=D	3.1-5(a)(2) 483.25 Quality of Care					
Bldg. 00	failed to monitor as ordered by the phys reviewed for quality. Findings include: The clinical record 08/27/24. A Quarte assessment, dated 0 was moderately cogresident's diagnoses	view and interview, the facility resident's blood pressure as sician's for 1 of 14 residents y of care. (Resident 7) for Resident 7 was reviewed on rly MDS (Minimum Data Set) 8/05/24, indicated the resident entitively impaired. The sincluded, but were not sion, diabetes, depression, and	F 0684	POC F-684 What corrective action(s) will be implemented for those resider found to have been affected be deficient practice? Resident 7 blood pressure be taken daily and documented in clinical record. MD is being notified if systolic is less than All orders of resident 7 audite and corrected if not in appropriately 9/6/24. How other residents having potential to be affected by the same deficient practice will be	nts Py eing n 100. ed	

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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 <u>00</u>		COMPLETED	
		155424	B. WING		08/29/2024	
			CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER				25TH STREET		
HICKORY CREEK AT COLLIMPLIS				MBUS, IN 47203		
HICKORY CREEK AT COLUMBUS			COLUN	MDO3, IN 47203		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			DEFICIENCY)	DATE	
	A current physician's order, with a start date of			identified and what corrective		
	· ·	the staff were to obtain the		action(s) will be taken?		
	resident's blood pressure daily and to notify the physician's office if the systolic (top number) was less than 100. The blood pressure record was to			· An audit of all residents for		
				monitor for orders to ensure of	ensure orders	
				are in accurately and correction		
	be taken to the next appointment on 12/13/24.			made if needed 9/6/24.		
				· All residents whose blood		
	The June, July, and August 2024, EMAR/ETAR			pressure is to be monitored ha		
	(Electronic Medication Administration			the potential to be affected by the		
	Record/Electronic Treatment Administration			alleged deficient practice.		
	Record) lacked any documented blood pressures.			What measures will put into p	lace	
				to and what systemic changes will		
	The Vitals Report for June, July, and August 2024,			be made to ensure that the		
	lacked documented blood pressures for Resident			deficient practice will not recur?		
	7 on the following dates: 06/15/24, 06/16/24,			· An audit tool for all residents	s with	
	06/18/24, 06/20/24, 06/21/24, 06/24/24, 06/25/24,			monitor vitals orders will be		
	06/29/24, 06/30/24, 07/27/24, 07/28/24, 07/31/24,			checked that orders are in for		
	08/01/24, 08/02/24, 08/05/24, 08/06/24, 08/10/24,			accuracy and vitals are being		
	08/11/24, 08/15/24, 08/16/24, 08/19/24, 08/20/24,			monitored appropriately 9/6/2	4.	
	and 08/22/24.			· All licensed nurses educated	d l	
				9/6/24 on policy for monitor vi	tals,	
	During an interview	v on 08/29/24 at 11:05 A.M.,		appropriately entering orders	and	
	LPN (Licensed Practice)	ctical Nurse) 2 indicated when a		documentation.		
	resident had an orde	er to monitor their blood		· DNS/designee will review fa	cility	
	pressure it would be	e documented on the		activity report for all residents	with	
	EMAR/ETAR.			an order for vitals to be monit	ored	
	During an interview on 08/29/24 at 11:08 A.M., the			and notification of MD is		
				completed per order.		
	DON (Director of Nursing) indicated the resident's			How the corrective action(s) v	vill be	
	blood pressure should have been monitored daily			monitored to ensure the defic	nsure the deficient	
	per the physician's order.			practice will not recur, i.e. what		
				quality assurance program wi	ll be	
	The current facility policy titled, "Documenting		put into place for prevention?			
	Guidelines for Nursing" with a revision date of			· DNS/designee will be		
	7/24, was provided by the DON on 08/29/24 at 2:45 P.M. The policy indicated, "To accurately			responsible for vitals monitori	ng	
				QAPI tool to be completed we	eekly	
	document in an org	anized manner all information		x 4, monthly x 3, and quarterly	•	
	related to the reside	ent in the medical record"		one year, with results reported	•	
	3 1-37(2)			/ ED.		
				If a threshold of 95% is not		

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP COD 5480 E 25TH STREET COLUMBUS, IN 47203				
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
					achieved, an action plan will be developed. DNS/designee will review 5 days/week in clinical meeting the team. By what date will systemic changes be competed on 9/21/2025 We are requesting Paper compliance for this plan of correction.		

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