STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155424	A. BUILDING 00 B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT COLUMBUS	5480 E 25TH STREET COLUMBUS, IN 47203

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 22, 23, 27, 28, and 29, 2024. Facility number: 000284 Provider number: 155424 AIM number: 100290690 Census Bed Type: SNF/NF: 29 Total: 29 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.	F 0000	The creation and submission of this plan correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulations.	
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 notify the physician of blood glucose levels per the physician's order for 1 of 14 residents reviewed for notification of change. (Resident 8) Findings include: The clinical record for Resident 8 was reviewed on 08/28/24 at 2:25 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/21/24, indicated	F 0580	POC F-580 What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice? · Staff educated on MD notification of resident condition change concerns ensuring that MD notification is completed for resident condition change. · Resident blood glucose levels for	09/21/2024

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

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	the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, hypertension, diabetes, anxiety, and depression. A current physician's order, with a start date of 03/20/24, indicated the resident was to be administered insulin lispro per a sliding scale. The physician was to be notified if the resident's blood glucose level was greater than 350. The June, July, and August 2024, EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident's blood glucose levels were greater than 350 on the following dates and times: - On 06/10/24 at 11:00 A.M., the resident's blood glucose level was 368, - On 06/20/24 at 11:00 A.M., the resident's blood glucose level was 355, - On 06/25/24 at 11:00 A.M., the resident's blood glucose level was 367, - On 07/08/24 at 11:00 A.M., the resident's blood glucose level was 399, - On 07/21/24 at 11:00 A.M., the resident's blood glucose level was 389, - On 08/19/24 at 7:00 A.M., the resident's blood glucose level was 358, and - On 08/19/24 at 11:00 A.M., the resident's blood glucose level was 394. The resident's clinical record lacked any documentation the physician was notified of the blood glucose levels. During an interview on 08/29/24 at 2:09 P.M., LPN (Licensed Practical Nurse) 2 indicated the resident's blood glucose levels were documented		resident 8 reviewed for all levels out of range with MD, no other concerns noted 9/6/24. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? · DNS/designee to review facility activity report for all residents with sliding scale parameters to ensure MD is notified per order and documented in resident clinical record · All diabetics with sliding scale parameters have the potential risk of alleged deficient practice. · DNS/designee audited to ensure any resident identified with sliding scale parameter was to notify MD was completed, no other residents identified 9/6/24. What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? · An audit tool of all diabetics completed on 9/6/24 identifying all diabetics in facility for potential change in condition and need to notify MD, no other discrepancies noted. · All licensed nurses educated on appropriate policy and procedure for change in condition and MD notification. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	

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	on the EMAR/ETAR. If the blood glucose was out of the parameter and if the nurse was required to call the physician it would be documented on the EMAR/ETAR and in a progress note. They would document if there were any new orders in a progress note. During an interview on 08/29/24 at 2:55 P.M., the DON (Director of Nursing) indicated the resident did not suffer any ill effects related to the physician not being notified of the blood glucose levels. The current facility policy titled, "Blood Glucose Monitoring", with a revision date of 2/2015, was provided by the DON on 08/29/24 at 2:45 P.M. The policy indicated, "...The physician will be notified when the resident's blood glucose is outside the physician stated parameters..." 3.1-5(a)(2)		put into place? · DNS/designee will be responsible for change of condition QAPI tool completion weekly x 4 weeks, monthly x 3 months, and quarterly for one year, with results reported to QAPI committee, overseen by ED. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance By what date will the systemic changes be completed? · 9/21/2025 We are requesting paper compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to monitor a resident's blood pressure as ordered by the physician's for 1 of 14 residents reviewed for quality of care. (Resident 7) Findings include: The clinical record for Resident 7 was reviewed on 08/27/24. A Quarterly MDS (Minimum Data Set) assessment, dated 08/05/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, depression, and insomnia.	F 0684	POC F-684 What corrective action(s) will be implemented for those residents found to have been affected by deficient practice? · Resident 7 blood pressure being taken daily and documented in clinical record. MD is being notified if systolic is less than 100. · All orders of resident 7 audited and corrected if not in appropriately 9/6/24. How other residents having potential to be affected by the same deficient practice will be	09/21/2024

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	A current physician's order, with a start date of 06/13/24, indicated the staff were to obtain the 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 be taken to the next appointment on 12/13/24. The June, July, and August 2024, EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked any documented blood pressures. The Vitals Report for June, July, and August 2024, lacked documented blood pressures for Resident 7 on the following dates: 06/15/24, 06/16/24, 06/18/24, 06/20/24, 06/21/24, 06/24/24, 06/25/24, 06/29/24, 06/30/24, 07/27/24, 07/28/24, 07/31/24, 08/01/24, 08/02/24, 08/05/24, 08/06/24, 08/10/24, 08/11/24, 08/15/24, 08/16/24, 08/19/24, 08/20/24, and 08/22/24. During an interview on 08/29/24 at 11:05 A.M., LPN (Licensed Practical Nurse) 2 indicated when a resident had an order to monitor their blood pressure it would be documented on the EMAR/ETAR. During an interview on 08/29/24 at 11:08 A.M., the DON (Director of Nursing) indicated the resident's blood pressure should have been monitored daily per the physician's order. The current facility policy titled, "Documenting Guidelines for Nursing" with a revision date of 7/24, was provided by the DON on 08/29/24 at 2:45 P.M. The policy indicated, "...To accurately document in an organized manner all information related to the resident in the medical record..." 3.1-37(a)		identified and what corrective action(s) will be taken? · An audit of all residents for monitor for orders to ensure orders are in accurately and corrections made if needed 9/6/24. · All residents whose blood pressure is to be monitored have the potential to be affected by the alleged deficient practice. What measures will put into place to and what systemic changes will be made to ensure that the deficient practice will not recur? · An audit tool for all residents with monitor vitals orders will be checked that orders are in for accuracy and vitals are being monitored appropriately 9/6/24. · All licensed nurses educated 9/6/24 on policy for monitor vitals, appropriately entering orders and documentation. · DNS/designee will review facility activity report for all residents with an order for vitals to be monitored and notification of MD is completed per order. 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 for prevention? · DNS/designee will be responsible for vitals monitoring QAPI tool to be completed weekly x 4, monthly x 3, and quarterly for one year, with results reported to QAPI committee, overseen by ED. If a threshold of 95% is not	

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			achieved, an action plan will be developed. · DNS/designee will review 5 days/week in clinical meeting with the team. By what date will systemic changes be competed on 9/21/2025 We are requesting Paper compliance for this plan of correction.	