STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2024		
	ROVIDER OR SUPPLIE		•	STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975			
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)		ATE	(X5) COMPLETION
TAG F 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG		DEFERRET		DATE
Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00435999. Complaint IN00435999 - No deficiencies related to the allegations are cited. Survey dates: June 4, 5, 6, 7 & 10, 2024 Facility number: 000326 Provider number: 155430 AIM number: 100290770		F 00	000			
	Census Bed Type: SNF/NF: 28 Total: 28						
	Census Payor Type Medicare: 1 Medicaid: 17 Other: 10 Total: 28	e:					
	accordance with 4	reflect State Findings cited in 10 IAC 16.2-3.1. mpleted on 6/16/2024					
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8 Notice Requiremon Transfer/Dischard	ents Before ge					
	failed to provide a	view and interview, the facility transfer/discharge form for 2 of ed for hospitalizations.	F 06	523	We respectfully request consideration for Paper compliance for this survey due the low number of tags and lo scope parity associated with t survey.	W	06/28/2024

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 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: UBLO11 Facility ID: 000326 If continuation sheet Page 1 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155430	B. WI	ING		06/10/	/2024
NAME OF I	DDOWNED OD CLIDDLIE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	K		340 E 1	18TH STREET		
HICKOR	Y CREEK AT ROC	HESTER		ROCHE	ESTER, IN 46975		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	l						
		for Resident 11 was completed			F 623		
		A.M. Diagnoses included, but			Notice Requirements Before		
		, sepsis, Alzheimer's disease,			Transfer/Discharge		
	and cerebral infarction (stroke).				What corrective action will be		
		1.5/00/0004			accomplished for those resid	ents	
		ted 5/28/2024 at 5:59 P.M.,			found to be affected by the		
		11 refused to eat or drink. She			deficient practice?		
		of pureed food, and refused to			Residents did not have a neg		
		owed food to run out of her			outcome related to the allege	ed	
	_	included: blood pressure 100/48			deficient practice.		
		s of mercury), pulse 102 beats			How other residents having t		
	-	tions 20 per minute, and			potential to be affected by the		
	_	ahrenheit. The physician was			same deficient practice will b		
	· ·	licated the resident's Power of			identified and what corrective	9	
		anted Resident 11 sent to the			actions will be taken?		
	hospital.				All residents have the potent		
	D	C/10/2024 + 10 10 A M			be affected by this practice.		
	_	v, on 6/10/2024 at 10:18 A.M.,			audit of all residents who have		
		rsing (DON) indicated the			a hospital – ER transfer and		
	_	form was part of the sfer Form" under the			discharge in the past 90day		
	_	of the electronic health record.			completed by the DNS/desig		
		orm should have been			to ensure proper notifications provided and the notice of	were	
		resident was transferred from			transfer/discharge as soon a	c	
	the facility.	resident was transferred from			practicable.	J	
	lic facility.				What measures will be put in	ıto.	
	The form "Hospits	al-ER Transfer Form" could not			place and what systemic cha		
		etronic medical record for			will be made to ensure that the	•	
	Resident 11.				deficient practice does not re		
					Licensed Nurses will be	oui .	
	2. A record review	for Resident 1 was completed			re-educated on or before		
		37 A.M. Diagnoses included, but			6/28/2024 by the DNS/design	nee	
		, nondisplaced intertrochanteric			on the transfer/discharge not		
		nur, hemiplegia and hemiparesis			How the corrective actions w		
	_	roke), and osteoporosis.			monitored to ensure the defic		
			practice will not recur?				
	A Nurse's Note. da	ted 4/13/2024 at 11:00 P.M.,		The DNS/designee will be			
		1 was helped with a transfer			responsible for the hospital		
		and spun around, falling on			re-admission/transfer QAPI t		

		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155430	B. WI	NG		06/10/	/2024
NAME OF D	DOWNER OF CURRINE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER			340 E 1	8TH STREET		
HICKOR'	Y CREEK AT ROCH	HESTER		ROCHESTER, IN 46975			
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ent 1 complained of right hip			weekly times 4 weeks, monthl	-	
	-	physician was notified, and an			times 4 and then quarterly unt	il	
		to send Resident 1 to the			continued compliance is		
	emergency departm	ent.			maintained for 2 consecutive		
	431 131 11	A Nurse's Note dated 4/14/2024 at 2:00 A M			quarters. The results of these		
	A Nurse's Note, dated 4/14/2024 at 2:00 A.M., indicated Resident 1 was admitted to the hospital.				audits will be reviewed by the		
	indicated Resident	i was admitted to the hospital.			QAPI committee overseen by		
	D	(/10/2024 -4 10.19 A M			ED. If threshold of 100% is no		
	_	y, on 6/10/2024 at 10:18 A.M., sing (DON) indicated that the			achieved, and action plan will	be	
	transfer/discharge for	- · · · · · ·			developed, Deficiency in this practice will result in disciplina	ur./	
		sfer Form" under the			action up to and including	пу	
	_	of the electronic health record.			termination of responsible		
		orm should be completed when			employee.		
		rred from the facility.			The DNS/designee is respons	ihle	
	a resident is transfer	irea from the facility.			for the implementation and	ibic	
	The form "Hospita	l-ER Transfer Form", dated			monitoring of this plan.		
	_	P.M., indicated the resident or			Date of compliance: June 28,	2024	
		ive was not provided the			Bate of compilarios cario 20,		
	transfer/discharge fo	-					
	S						
	A form titled, "Noti	ce of Transfer or Discharge"					
	was provided by the	e Regional Nurse Consultant					
	on 6/10/2024 at 12:	49 P.M. A policy was not					
	attached to the form	1.					
	3.1-12(a)(6)(A)						
F 0625	483.15(d)(1)(2)						
SS=D		d Policy Before/Upon Trnsfr					
Bldg. 00		2 · c, 2 c.c. c, c p c · · · · · · ·					
	Based on record rev	view and interview, the facility	F 06	525	We respectfully request		06/28/2024
		e bed hold policy for 2 of 2			consideration for Paper		00/20/2021
	-	for hospitalizations. (Residents			compliance for this survey due	e to	
	11 & 1)	- `			the low number of tags and lo		
					scope parity associated with t		
	Findings include:				survey.		
		6 D 11 11					
		for Resident 11 was completed			F 625		
	on 6/6/2024 at 9:49	A.M. Diagnoses included, but			Notice of Bed Hold Policy		

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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 06/10/2024 155430 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 340 E 18TH STREET HICKORY CREEK AT ROCHESTER ROCHESTER, IN 46975 (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 were not limited to, sepsis, Alzheimer's disease, Before/Upon Transfer and cerebral infarction. What corrective action will be accomplished for those residents A Nurse's Note, dated 5/28/2024 at 5:59 P.M.. found to be affected by the indicated Resident 11 refused to eat or drink. She deficient practice? had eaten one bite of pureed food and refused to Residents did not have a negative swallow, which allowed food to run out of the her outcome related to the alleged mouth. Vital signs included: blood pressure 100/48 deficient practice. mmHg (millimeters of mercury), pulse 102 beats How other residents having the per minute, respirations 20 per minute, and potential to be affected by the temperature 98.9 Fahrenheit. The physician was same deficient practice will be notified, and he indicated the Resident's Power of identified and what corrective Attorney (POA) wanted Resident 11 sent to the actions will be taken? hospital. All residents have the potential to be affected by this practice. An During an interview, on 6/10/2024 at 10:18 A.M., audit of all residents who have had the Director of Nursing (DON) indicated that the a hospital – ER transfer and or bed hold policy was part of the "Hospital-ER discharge in the past 90day was Transfer Form" under the "Observation" tab of completed by the DNS/designee the electronic health record. She indicated the to ensure proper notifications were policy should be completed when a resident is provided and the notice of transferred or discharged from the facility. transfer/discharge as soon as practicable. The form, "Hospital-ER Transfer Form" could not What measures will be put into be found in the electronic medical record for place and what systemic changes Resident 11. will be made to ensure that the deficient practice does not recur? 2. A record review for Resident 1 was completed Licensed Nurses will be on 6/5/2024 at 10:37 A.M. Diagnoses included, but re-educated on or before were not limited to, nondisplaced intertrochanteric 6/28/2024 by the DNS/designee fracture of right femur, hemiplegia and hemiparesis on the transfer/discharge notices. following CVA (stroke), and osteoporosis. How the corrective actions will be monitored to ensure the deficient A Nurse's Note, dated 4/13/2024 at 11:00 P.M., practice will not recur? indicated Resident 1 was helped with a transfer The DNS/designee will be when she stumbled and spun around, falling on responsible for the hospital her buttocks. Resident 1 complained of right hip re-admission/transfer QAPI tool and back pain. weekly times 4 weeks, monthly

The physician was notified, and an order was

obtained to send Resident 1 to the emergency

times 4 and then quarterly until

continued compliance is

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155430	B. W	ING		06/10/	2024
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				8TH STREET		
HICKOB	V CDEEK AT DOCL	JESTED			ESTER, IN 46975		
HICKOR	Y CREEK AT ROCH	HESTER		ROCHE	51 ER, IN 40975		
(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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	department.				maintained for 2 consecutive		
					quarters. The results of these		
	A Nurse's Note, dated 4/14/2024 at 2:00 A.M.,				audits will be reviewed by the		
	indicated Resident 1 was admitted to the hospital.				QAPI committee overseen by	the	
					ED. If threshold of 100% is no	ot	
		y, on 6/10/2024 at 10:18 A.M.,			achieved, and action plan will	be	
		sing (DON) indicated the bed			developed, Deficiency in this		
		t of the "Hospital-ER Transfer			practice will result in disciplina	ıry	
		bservation" tab of the			action up to and including		
		cord. She indicated the policy			termination of responsible		
	_	d when a resident was			employee.		
	transferred or disch	arged from the facility.			The DNS/designee is respons	ible	
					for the implementation and		
		l-ER Transfer Form", dated			monitoring of this plan.		
		P.M., indicated neither the			Date of compliance: June 28,	2024	
		dent's representative was					
	provided with a cop	by of the bed hold policy.					
	A maliary vysa mmaryi	dad on 6/10/2024 at 12:40 D.M.					
		ded on, 6/10/2024 at 12:49 P.M. rse Consultant. The policy					
		indicated, "If a private pay					
		facility for a temporary stay in					
		elsewhere for a medical					
	_	ne resident or resident's					
		ay request the facility to hold					
		bed during the absence by					
	_	y rate. If a Medicare/Medicaid					
	1	facility for a temporary stay in					
		elsewhere for a medical					
	_	ne bed will be held2. The					
	_	ovided the bed hold policy at					
	·	oital transfer or therapeutic					
	_	ent's Representative will be					
		hold policy at the time of					
	notification of the transfer. The Resident's						
		be provided a copy of the bed					
	hold policy. 4. The staff will document the						
		resident and resident					
		e bed hold policy on the					
		nt Transfer Form"					

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

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UBLO11 Facility ID: 000326

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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 155430 B. WING 06/10/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 340 E 18TH STREET HICKORY CREEK AT ROCHESTER ROCHESTER, IN 46975 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 3.1-12(a)(25)(A) F 0695 483.25(i) SS=D Respiratory/Tracheostomy Care and Bldg. 00 Suctioning Based on observation, record review, and F 0695 We respectfully request 06/28/2024 interview, the facility failed to properly store a consideration for Paper Bi-Pap (bi-level positive airway pressure) mask for compliance for this survey due to 1 of 1 resident reviewed for oxygen/respiratory the low number of tags and low equipment. (Resident 131) scope parity associated with the survey. Finding includes: F 695 A record review for Resident 131 was completed, Facility failed to properly store a on 6/5/2024 at 1:08 P.M. Diagnoses included, but Bi-Pap were not limited to, pulmonary hypertension, What corrective action will be chronic obstructive pulmonary disease (COPD), accomplished for those residents and obstructive sleep apnea. found to be affected by the deficient practice? During an observation, on 6/4/2024 at 9:35 A.M., Residents did not have a negative Resident 131's Bi-Pap mask was observed on the outcome related to the alleged floor under the bed. deficient practice. How other residents having the A Physician's Order, dated 5/31/2024, indicated potential to be affected by the Bi-Pap on at bedtime and off upon waking. same deficient practice will be identified and what corrective A Care Plan, dated 6/3/2024, indicated Resident actions will be taken? 131 had the potential for impaired gas exchange No other resident will be affected related to pulmonary hypertension and COPD. by this practice, resident 131 is The goal indicated Resident 131 would have the only one in the building with a adequate respiratory functions as evidenced by Bi-Pap decreased or absence of dyspnea, improved What measures will be put into breath sounds, decreased or absence of shortness place and what systemic changes of breath, and improved oxygen saturation results. will be made to ensure that the The care plan did not address the use of the deficient practice does not recur? Bi-Pap. All nurses will be re-educated on properly storing a Bi-Pap by During an interview, on 6/10/2024 at 10:17 A.M., DNS/designee by 6/28/2024

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the Director of Nursing (DON) indicated the

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How the corrective actions will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		155430	B. WING 06/10/2			2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				8TH STREET		
HICKORY	Y CREEK AT ROCH	HESTER			STER, IN 46975		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	Bi-Pap mask should be stored in a respiratory bag				monitored to ensure the deficie	ent	
	when not in use.				practice will not recur?		
		1 1 (/100004) 10 40 P.15			The DNS/designee will be		
		led on, 6/102024 at 12:49 P.M.			responsible for the completion	of	
by the Regional Nurse Consultant. The policy titled, "Bi-Level Therapy". The policy did not				the QAPI tool weekly times 4			
					weeks, monthly times 4 and th	en	
	address the storage	of the mask when not in use.			quarterly until continued	,	
	3.1-47(a)(6)				compliance is maintained for 2 consecutive quarters. The res		
	3.1-47(a)(0)				of these audits will be reviewed		
					the QAPI committee overseen	-	
					the ED. If threshold of 100% is	-	
					not achieved, and action plan		
					be developed to ensure		
					compliance and disciplinary ac	tion	
					taken as needed.		
					The DNS/designee is respons	ble	
					for the implementation and		
					monitoring of this plan.		
					Date of compliance: June 28,	2024	
F 0730	483.35(d)(7)						
SS=E	` ' ' '	n Review-12 hr/yr In-Service					
Bldg. 00							
	Based on interview	and record review the facility	F 07	730	We respectfully request		06/28/2024
	failed to ensure perf	Formance evaluations were			consideration for paper		
		for 4 of 4 employee files			compliance for this survey due	to	
	reviewed. (CNA 3,	CNA 4, CNA 7 & CNA 8)			the low number of tags and lov		
					scope parity associated with th	ne	
	Findings include:				survey.		
	1. During an intervi	ew on 6/10/2024 at 10:05 A.M.,			F730		
	•	ney (the facility) do not do			It is the policy of Hickory Creel	<	
		year or evaluations."			Rochester to do an annual		
					performance evaluation		
	2. During an intervi	ew on 6/10/2024 at 11:01 A.M.,			What corrective action will be		
		e had not received a			accomplished for those reside	nts	
		tion since she started working			found to be affected by the		
	here (at the facility)				deficient practice?		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/10/2024	
	PROVIDER OR SUPPLIER			340 E 18	DDRESS, CITY, STATE, ZIP COD 8TH STREET STER, IN 46975			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	P.M.,the Business C (the facility) used to evaluations) but whover they gave out to just didn't get done, again." 4. During an intervite the Administrator in of Nursing completed done every year. The but there was a lot of think they were all of the employee file for 6/10/2024 at 1:36 P 2/8/2023. No annual located in the file. The employee file for 6/10/2024 at 1:38 P 4/17/2023. No annual located in the file. The employee file for 6/10/2024 at 1:40 P 8/11/2017. No annual located in the file. The employee file for 6/10/2024 at 1:43 P 9/22/2019. No annual located in the file. During an interview Business Office Ma	for CNA 3 was reviewed on .M. CNA 3 was hired on .Il performance evaluation was .Il performan			No resident was affected by the deficient practice. The ED/designee will do monthly checks to see who needs their annual performance evaluation done. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential be affected by this practice. ED/designee will do regular in-service education. The fact will complete a performance of every nurse aide at least or every 12 months, and provide education based on the outcomous of the reviews. What measures will be put interplace and what systemic charm will be made to ensure that the deficient practice does not recompliant and the corrective actions with monitored to ensure the deficient practice will not recur? The ED/designee will bring the results of the audit tool to the monthly QAA Committee meeting for further review. The ED/designee is responsite for the implementation and monitoring of this plan. Date of compliance: June 28,	r in the second of the second		

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(x3) date survey completed 06/10/2024	
	PROVIDER OR SUPPLIER			340 E 1	ADDRESS, CITY, STATE, ZIP COD 18TH STREET ESTER, IN 46975		
	TORELINATION	ILOTEIX			1		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	CY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	on 6/10/2024 at 1:46 P.M., the ated she did not have a policy rmance evaluations.					
F 0812 SS=F Bldg. 00	Based on observation review, the facility	e/Prepare/Serve-Sanitary on, interview and record failed to ensure kitchen good working condition in 1 of	F 08	312	RE: IDR for F812 (F): We ag that the seals were cracked f freezer and refrigerators, due normal wear and tear over tin. The seals have been replace the freezer and refrigerators.	for the e to me. ed for	07/05/2024
	During a kitchen to on 6/4/2024 at 9:26 observed: -broken seals to bot -broken seals to bot During an interview	ur with the Dietary Manager A.M., the following was h doors of the freezer. h doors on 2 refrigerators. y on 6/4/2024 at 9:45 A.M., the			would argue that despite these seals being cracked, the food being stored in these areas we safe as the temperatures for freezer and refrigerators were always within range before a during the survey. We will attemperature logs for the free.	se d was the e nd tach zer	
	fixed. On 6/10/2024 at 1:3 Consultant provided Safety Guidelines", the policy was the ofacility. The policy will report defective condition, acts, or sa and/or the maintenamaintenance depart	dicated the seals needed to be 36 P.M., the Regional Nurse of the policy titled,"Kitchen dated 4/2024, and indicated one currently used by the indicated"2. All employees the equipment, unsafe the supervisor three department 13. The ment is responsible for routine air of fans, vents and			and refrigerators that will ver claim. The surveyor saw that temperatures were within rar the freezer and refrigerators, the temperatures were never question. The temperatures on the mentioned in 2567 verbia being a concern for this deficiency. As a result of the temperatures being within rar all times, there was no risk to residents since the food was frozen and/or stored in a safe acceptable temperature range.	the ange for and r in were age as ange at o any	

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3.1-21(i)(3)

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UBLO11

Facility ID: 000326

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all times. We respectfully request

that the scope and severity for

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/20/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION				OMB NO. 0938-039	
		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X:	3) DATE SURVEY COMPLETED 06/10/2024
			340 E	ADDRESS, CITY, STATE, ZIP COD 18TH STREET ESTER, IN 46975	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				F812 be reduced from the F leve to a D level scope and severity rating.	at,
				F812:	
				We respectfully request consideration for paper compliance for this survey due to the low number of tags and low scope parity associated with the survey.	
				It is the policy of Hickory Creek Rochester to ensure that food safety requirements are met such as food procurement store/prepare/serve. What corrective action will be accomplished for those residents found to be affected by the deficient practice? DM will conduct an in-service by 06/28/2024 for all staff to report defective equipment, unsafe condition, acts, or safety hazards to the supervisor and/ or the maintenance department. The Dietary Manager will perform safety audit weekly for 30 days and monthly thereafter. How other residents having the	S
				potential to be affected by the	

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identified and what corrective actions will be taken?

the broken seals on the

No residents were harmed due to

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

PRINTED: 08/20/2024 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 155430	A. BU B. W	JILDING NG	00	COMPL 06/10/	
		133430	D. W	_		00/10/	72024
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD 18TH STREET		
HICKOR	Y CREEK AT ROC	HESTER			ESTER, IN 46975		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	COMPLETION DATE
1710	REGUENTORTO	R ESC IDENTIFY THAT INTORMATION		mo	freezer/refrigerators, there are	 }	DATE
					daily checks to monitor		
					temperatures that are done, a	nd	
					they were always in range.		
					What measures will be put int		
					place and what systemic char	-	
					will be made to ensure that the		
					deficient practice does not rec		
					An audit will be completed by DM weekly for 4 weeks and the		
					monthly thereafter.	len	
					How the corrective actions wil	l be	
					monitored to ensure the defici		
					practice will not recur?		
					The DM will bring the results of	of the	
					audit tool to the monthly QAA		
					Committee meeting for review		
					The DM is responsible for the		
					implementation and monitorin	g of	
					this plan.	0004	
					Date of compliance: June 28,	2024	
F 0880	483.80(a)(1)(2)(4)(e)(f)					
SS=E	Infection Preventi	on & Control					
Bldg. 00	5 1 1						
		on, record review and	F 08	380	We respectfully request		06/28/2024
		ity failed to ensure proper ractices were implemented			consideration for Paper	- 4-	
	_	d Barrier Precautions (EBP) for			compliance for this survey due		
		iewed for EBP; failed to follow			the low number of tags and lo scope parity associated with t		
		ractices when completing a			survey.	iie	
	_	for 1 of 1 resident reviewed for			Saivoy.		
		nents and failed to complete			F 880		
	_	nd hand washing during			Facility failed to ensure prope	r	
		of 1 resident observed for			infection control		
		re. (Resident 28, QMA 2, CNA			What corrective action will be		
	5, Resident 23)				accomplished for those reside	nts	
					found to be affected by the		
	Findings include:				deficient practice?		

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155430	B. WING		06/10/2024
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIEI	R		18TH STREET	
HICKOR	Y CREEK AT ROC	HESTER		IESTER, IN 46975	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	` `	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				Residents did not have a nega	
	1 During an interv	iew on 6/5/2024 at 8:27 A.M.,		outcome related to the alleged	
	_	ted he went to dialysis 3 times a		deficient practice.	1
		o signage and or indication the		How other residents having th	100
	resident was to be i			_	
	resident was to be i	II EBI Isolation.		potential to be affected by the	
	The man and for Desi	ident 28 was reviewed on		same deficient practice will be	
				identified and what corrective	
		.M. Diagnoses included, but cellulitis to the right leg,		actions will be taken?	oility
		Ç Ç.		All residents residing in the fa	•
	diabetes type 2, and	d end stage renal disease.		have potential to be affected.	ine
	A	- 1-4-15/7/2024 -42.46 D.M		Infection Preventionist (IP) or	
	_	n, dated 5/7/2024 at 3:46 P.M.,		designee will educate all staff	
		ent was receiving hemodialysis		regarding Infection control pol	
		complications such as fluid		What measures will be put int	
		g or infection due to a right		place and what systemic char	_
	jugular perma catho	eter.		will be made to ensure that the	
	D	C/10/2024 + 10.05 + 15		deficient practice does not rec	cur?
		v on 6/10/2024 at 10:05 A.M.,		A root Cause Analysis was	
		hey had "3 residents on EBP".		conducted by the IP with input	
	Resident 28 was no	it named.		from the facility MD,ED,and D	INS
	D	(10/2024 + 10.27 + 3.5		to identify the root cause and	
	_	v on 6/10/2024 at 10:27 A.M.,		develop solutions/systemic	
		rsing indicted the "resident had		changes to address the root	
		anted port). The Regional		cause. The IP will provide	
		ndicated "yes that is an		education and training to the I	וטו
	indwelling catheter	·"		and all staff of changes.	
				How the corrective actions wil	
	2.5			monitored to ensure the defici	ient
	_	vation of a blood sugar check,		practice will not recur?	
		1 P.M.,with QMA 2, the		The IP/designee will complete	
	following was obse			daily observational rounds thr	-
		glucometer (a device for		the facility covering all shifts a	
	_	ugar level) on the bedside		days of the week to ensure sta	
	_	ng a barrier first. She then		are practicing appropriate infe	
	`	IA 2 wiped the residents'		control practices and complian	
	_	hol pad, then with an opened		The facility will review, update	e, and
		ea that had just been cleansed.		make changes as needed.	
		a blood sample. QMA 2 exited		The DNS/designee will be	
	the resident's room	with her gloves on, and went		responsible for the completion	n of

to the medication cart. She removed the gloves

the QAPI tool weekly times 4

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155430	B. W			06/10/	
				_	_		-
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					8TH STREET		
HICKOR	Y CREEK AT ROCI	HESTER		ROCHE	ESTER, IN 46975		
(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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.	DATE
	and threw away her	trash.			weeks, monthly times 4 and th	ien	
					quarterly until continued		
	During an interview	v on 6/6/2024 at 11:56 A.M.,			compliance is maintained for 2	<u>)</u>	
	QMA 2 indicated sl	he "should have used a barrier,			consecutive quarters. The res		
	not fanned the area, and removed her gloves prior				of these audits will be reviewe		
	to coming out of the room".				the QAPI committee overseen	-	
					the ED. If threshold of 100% i	•	
	3. During an interview on 6/4/2024 at 9:46 A.M.,				not achieved, and action plan	will	
	Resident 6 indicate	d she had 2 catheters.			be developed to ensure		
					compliance and disciplinary ad	ction	
	The record for Resi	dent 6 was reviewed on			taken as needed.		
	6/5/2024 at 10:43 A	A.M. Resident 6's diagnoses			The DNS/designee is respons	ible	
	included, but were	not limited to Multiple			for the implementation and		
	Sclerosis, pressure	ulcers stage 4 sacral region,			monitoring of this plan.		
	left buttocks, right l	outtocks, and neuromuscular			Date of compliance: June 28,	2024	
	dysfunction of blad	der.					
	A Quarterly MDS (Minimum Data Set)					
	Assessment, dated 3	3/28/2024, indicated the					
	_	tal assist of 2 staff for bed					
	mobility, transfers,	and toilet use.					
	Δ Care Plan dated	5/6/2024, indicated the resident					
		oic (SP) urinary catheter and					
		dwelling catheter due to:					
		nuscular dysfunction of					
	~	nt had an indwelling Foley					
		n return to the facility due to					
		atheter to keep urine off of her					
	wounds to her botto	-					
	On 6/7/2024 at 1:40	P.M., CNA 5 was observed to					
		re to Resident 6. The aide put					
	_	over-the-bed table. She then					
	* *	applied a gown and gloves					
		basins with water. She then					
		ning, rinsing and drying of the					
		te peri area. With the same					
		then rearranged the residents					
	_	w, used the bed controls and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155430	B. W	ING		06/10/	/2024
en en r			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	£		340 E 1	8TH STREET		
HICKOR'	Y CREEK AT ROCH	HESTER		ROCHE	STER, IN 46975		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	then rearranged the	sheet over the resident.					
	During an interview	v, on 6/7/2024 at 2:02 P.M.,					
	_	he knew she should have					
	washed her hands and changed her gloves after completing peri and catheter care.						
	_	vation on 6/4/2024 at 11:11					
		was observed to have an					
	•	inage tube with a large amount					
	of sediment in the t	ubing.					
	The record for Desi	dent 13 was reviewed on					
		M. Resident 13's diagnoses					
		not limited to: diabetes,					
		function of bladder, and					
	intellectual disabilit						
	A Quarterly MDS (Minimum Data Set)					
	Assessment, dated 3	3/22/2024, indicated the					
	-	tensive assist of 1 staff for bed					
	-	and extensive assist for 2 staff					
		ad an indwelling urinary					
	catheter.						
	A current Care Diam	dated 5/4/2023 indicated the					
		n, dated 5/4/2023, indicated the nindwelling urinary catheter					
	-	ar dysfunction of the bladder.					
		led,, but were not limited to:					
		bing or any part of the					
		touch the floor. Store the					
		e a protective dignity pouch.					
	During an observati	ion, on 6/6/2024 at 10:29 A.M.,					
		ter drainage bag was					
	uncovered with the	catheter tubing on the floor.					
		ion, on 6/6/2024 at 12: 15 P.M.,					
	Resident 13's cather	ter tubing was on the floor.					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
		155430	B. WING			06/10/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹			8TH STREET			
HICKORY CREEK AT ROCHESTER				ROCHESTER, IN 46975				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG	During an observation, on 06/6/2024 at 1:14 P.M.,			TAG	DEFICIENCY		DATE	
	_	ter tubing was on the floor.						
	Resident 13 s came	ter tubing was on the moor.						
	During an observat	During an observation, on 6/6/2024 at 3:16 P.M.,						
	Resident 13's catheter tubing was on the floor.							
	resident 13 3 eduleter tubing was on the 11001.							
	During an observation, on 6/7/2024 at 2:06 P.M.,							
	Resident 13's catheter tubing was on the floor.							
	D							
	During an interview, on 6/7/2024 at 3:25 P.M., the Director of Nursing indicated the catheter tubing							
	should have been o							
	should have been o	if the floor.						
	During an observation, on 6/10/2024 at 10:16							
	A.M., Resident 13's catheter tubing was on the							
	floor.							
	On 6/10/2024 at 1:36 P.M., the Regional Nurse							
	Consultant provided the policy tithed,"Shared Glucometer Cleaning and Disinfecting", dated							
		-						
		ed the policy was the one ne facility. The policy						
		oughout thee procedure,						
		e hand hygiene. c. Perform						
		ediately after removal of gloves						
		g other medical supplies						
	intended for use on							
	On 6/10/024 at 1:3	6 P.M., the Regional Nurse						
	_	d a "Skills Competency-						
		(Urinary)", dated 5/2023, and						
		was the one currently used						
	1 -	policy indicated17. Remove						
	_	h hand hygiene. 19. Dispose of						
	soiled linen properl	y. 20. Perform hand hygiene"						
	On 6/10/2024 at 1:3	30 P.M. the Regional Nurse						
		d the policy titled,"Bowel and						
Bladder Program", dated 5/2019. The policy did								
	not address the catheter tubing and or drainage							
	1		1				Ī	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED			
		155430	B. WING			06/10/2024			
NAME OF PROVIDER OR SUPPLIER				STREET A	ET ADDRESS, CITY, STATE, ZIP COD				
					8TH STREET				
HICKORY CREEK AT ROCHESTER				ROCHESTER. IN 46975					
			,						
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	bag placement.	·		·		·			

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