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	07/28/2023

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00413927. Complaint IN00413927 - No deficiencies related to the allegations are cited. Survey dates: July 24, 25, 26, 27, and 28, 2023 Facility number: 000418 Provider number: 155565 AIM number: 100274870 Census Bed Type: SNF: 36 Total: 36 Census Payor Type: Medicare: 3 Medicaid: 24 Other: 9 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 8, 2023.	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. 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 Post Survey Revisit.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

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

Tega Brume | Executive Director | 08/22/2023

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.

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	07/28/2023

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
	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident's dignity was maintained when the resident was not changed after an incontinence episode and	F 0550	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Resident 5 has been provided**	08/27/2023

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	07/28/2023

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
	instead asked to eat alone in her room while seated in a soiled brief and wheelchair instead of eating her meal in the main dining room per her usual preference for 1 of 16 residents reviewed for dignity (Resident 5). Findings include: During an observation, on 7/24/23 at 12:20 p.m., Resident 5 was observed seated in her wheelchair in her room staring out the window and appeared upset. Resident 5 indicated her husband used to visit daily, but for the last few months he had been unable to visit her. She enjoyed eating breakfast and lunch in the main dining room to socialize with everyone. However, today, she was in the therapy room with Physical Therapist (PT) 5 and had wet herself and the urine ran onto the therapy floor. PT 5 told Resident 5 that she would take her down to her room to be changed from the wet brief before lunch. PT 5 wheeled the resident out of the therapy room, to the resident's room, and told the staff that the resident needed to be changed. Certified Nursing Assistant (CNA) 17 had come into the resident's room and told the resident that the resident was going to be assisted to eat in her room, then the resident would be laid down in bed and the brief changed after eating lunch. On 7/24/23 at 12:26 p.m., CNA 17 brought Resident 5's lunch tray into her room and indicated she was told by staff, CNA 10, to assist Resident 5 with her meal in her room, because Resident 5 had soiled in her brief. CNA 17 was to lay her down after feeding the resident lunch. CNA 17 indicated she did not have the time to change Resident 5's brief now. Resident 5 told CNA 17 she wanted to eat the ice cream first, because the ice cream was already melting. CNA		**incontinent care as needed with no changes in her condition. Resident has been informed about importance of receiving incontinence care timely and accommodations that can be made if incontinence care needs to be provided during meal times** - 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 with incontinent episodes have the potential to be negatively impacted by this deficient practice.** **Nursing staff will receive education on or before ___8/25/23_____ from the DNS/designee regarding providing incontinence care, information regarding risks/possible negative outcomes to be provided to a resident who delays provision of incontinent care and accommodations that can be made if care interrupts a meal or other activity.** - what measures will be put into place or what systemic changes will be made to ensure	

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	07/28/2023

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
	17 opened the partially melted ice cream container and fed Resident 5 the soft ice cream, while Resident 5 sat in her wheelchair in the urine saturated brief. On 7/24/23 at 12:39 p.m., PT 5 indicated at about noon Resident 5 was in the therapy room receiving therapy. The resident was repositioned in the wheelchair, the resident was saturated in urine, and the urine was running onto the therapy floor. PT told Resident 5 that she would take her down to her room to be changed from the wet brief before lunch. PT 5 indicated she had told CNA 10 that Resident 5 was wet and needed to be changed. CNA 10 told CNA 17, Resident 5 needed to be changed from the wet brief. On 7/24/23 at 12:59 p.m., the Administrator indicated she had spoken to Resident 5 and the resident had indicated she would eat her meal in her room, before being changed from the wet brief. The Administrator then had spoken to CNA 10. CNA 10 told the Administrator that she had told CNA 17 to feed Resident 5 in her room, then change her wet brief. Staff had not asked Resident 5 if the resident wanted to be changed from the wet brief, prior to eating lunch. The Administrator indicated she had sent CNA 10 and CNA 17 home for not providing incontinence care to the resident before the resident was assisted to eat her lunch. On 7/24/23 at 1:20 p.m., the Administrator indicated she had spoken to the PT 5. PT 5 indicated she had told CNA 10 and CNA 17 that Resident 5 needed to be changed from the wet brief. The Administrator indicated she was going to have staff complete a skin sweep of all residents in the building. On 7/24/23 at 3:03 p.m., the Regional Vice		that the deficient practice does not recur; **Nursing staff will receive education on or before ___8/25/23_____ from the DNS/designee regarding providing incontinence care and information regarding risks/ possible negative outcomes to be provided to a resident who delays provision of incontinent care.** **The DNS will meet with the Resident Council and discuss the right to refuse care and the importance in not delaying incontinence care and accommodations that can be made if care interrupts a meal or other activity** - 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 Resident Rights CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the**	

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	07/28/2023

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
	President (VP) indicated, CNA 17 was sent home today for not providing incontinence care to Resident 5. The facility was completing a facility wide skin check review of all the residents. On 7/25/23 at 10:05 a.m., Resident 5 indicated yesterday at lunch time, my ice cream was already melting, and my sandwich was warm. So I wanted to eat my meal, while the ice cream was still partially frozen, and the sandwich was still warm. On 7/26/23 at 10:48 a.m., the Vice President (VP) indicated Resident 5 had soiled her brief in the therapy room. PT 5 took the resident back to her room and notified CNA 10 the resident needed incontinence care due to a wet brief. CNA 10 had communicated that information of Resident 5's wet brief to CNA 17. CNA 17 had asked CNA 10 for guidance because it was mealtime. So, CNA 17 had asked Resident 5 what the resident preferred, being fed lunch or being changed now. Resident 5 indicated she would eat first. The CNA left the room to get the resident's lunch tray and then fed her lunch. Resident 5 was cognitive and was able to make her needs known. The facility had suspended from work CNA 17 and CNA 10 for not providing incontinence care, prior to feeding Resident 5 her lunch. On 7/27/23 at 8:45 a.m., the Regional Director of Clinical Operations (RDCO) 14 indicated she had spoken to Resident 5 and Resident 5 had indicated, staff had asked her if she wanted to be transferred into the bed and changed or did the resident want to eat her lunch first. Resident 5 had told staff that she would eat her lunch first and then be changed from the wet brief. Resident 5's record was reviewed, on 7/26/23 at 9:15 a.m. Diagnoses included, but were not limited		**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. **8/27/23**	

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	07/28/2023

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
	to, major depressive disorder (mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life), unspecified anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), quadriplegia (a symptom of paralysis [loss of the ability to move and sometimes to feel anything in part or most of the body] that affects all a person's limbs and body from the neck down), contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the right hand, right wrist, left wrist, dysphagia-oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat) and complete traumatic amputation at level between the right knee and ankle. A significant change in status Minimum Data Set (MDS) assessment, dated 4/25/23, indicated Resident 5 was cognitively intact; required total dependence of two staff members for bed mobility, transfer, bathing, and toilet use; total dependence of one staff member for eating and personal hygiene; had functional limitation in range of motion in the upper and lower extremities on both sides of the body; was always incontinent of bladder and bowel; and had a stage 3 pressure ulcer injury (full-thickness skin loss potentially extending into the subcutaneous tissue layer), and was at risk for pressure ulcers. An ADL's functional status/rehabilitation potential care plan, dated 4/11/23, indicated the resident required assistance with ADL's including bed mobility, transfers, eating, and toileting with interventions included, but were not limited to, assist with transfers as needed per mechanical lift			

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	07/28/2023

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
	and two staff assistance, assist with eating and drinking as needed, and assist with dressing/grooming/hygiene as needed, with the goal of the resident had a desire to improve current functional status. A progress note, dated 4/3/23 at 6:39 p.m., indicated, Resident 5 had acquired a new wound/skin injury, stage 3 pressure ulcer, to the right gluteal fold (the horizontal skin crease that forms below the buttocks, separating the upper thigh from the buttocks) with pain of tenderness to touch or pain when pressure was on the area. The root cause of the pressure ulcer determination was of high friction area, incontinence, and staying in a wheelchair. A new intervention was initiated of staff to assist resident to bed between meals. A pressure ulcer/injury care plan, dated 4/7/23, indicated Resident 5 had a pressure ulcer to the right gluteal fold, with interventions included, but were not limited to, staff to assist resident to bed between meals, if the resident preferred to stay up, offer to lay down and change resident prior to getting back up, keep off affected area as much as possible, and keep area clean and dry. A urinary incontinence care plan, dated 4/11/23, indicated Resident 5 required assistance with toileting/incontinence due to diagnoses and medication use, with interventions included, but were not limited to, assist with elimination and incontinence care as needed, with the goal of the resident will be free from adverse effects from incontinence. A Physical Therapy treatment encounter note, dated 7/24/23 at 1:31 p.m., indicated Resident 5 had received physical therapy on that day and the			

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	07/28/2023

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
	session had ended early due to the resident requiring assistance for clean up from soiling her brief and during the therapy session had experienced 4 out of 10 intermittent pain scale in the right thigh region and both knees. A note, handwritten and signed by PT 5, dated 7/24/23 at 3:22 p.m., indicated, PT 5 had Resident 5 in the therapy gym, repositioned the resident in her wheelchair, and noticed a puddle of urine on the floor. CNA 12 walked by the gym and Resident 5 told CNA 12 that she needed to be changed. CNA 12 told Resident 5 and PT 5 the name of the CNA in charge of the resident's care (CNA 17) and to let her know. PT 5 took the resident back to her room. On the way back, CNA 12 and CNA 17 passed each other in the hallway and CNA 12 told CNA 17 that Resident 5 needed to be changed and she glanced in our direction. PT 5 took Resident 5 to her room, gave the resident her call light, and went to find towels. As PT 5 exited the linen closet, CNA 17 was observed walking into Resident 5's room. Resident 5 indicated to CNA 17 that she needed to be change. PT 5 returned to the therapy gym. A handwritten note, dated 7/24/23, signed by CNA 17, indicated therapist had pushed Resident 5 down and the hall, 12:10 p.m., lunch time, and told CNA 17 Resident 5 was wet and left a puddle on the floor in therapy. CNA 17 had felt under the resident's wheelchair, and it was not wet, and CNA 17 did not observe any wetness. CNA 17 had asked another CNA what to do. The CNA told CNA 17 to ask Resident 5 if it was okay to feed her in her room today for lunch and then change her brief . Resident 5 had indicated she wanted to eat first, and that was what CNA 17 did, fed her then laid Resident 5 down and changed her.			

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	07/28/2023

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

A handwritten note, dated 7/24/23, signed by CNA 10, indicated, a CNA came to her and asked what she would do. CNA 10 indicated, she would ask Resident 5 what she wanted to do, get changed or eat first. Resident 5 told the other CNA she wanted to eat first. So, the CNA fed the resident in her room for her dignity.

A Social Services Director (SSD) handwritten note, dated 7/24/23, indicated Resident 5 had told the SSD, the therapy lady had told Resident 5 that she had a "little puddle" underneath her, when she was in therapy and the therapist brought the resident back to her room and told staff the resident was wet and needed to be changed. Staff told the therapist to leave the resident in her room, staff would feed the resident in her room, then put the resident in her bed to change her wet brief, and that was fine with the resident. The resident would like to be changed, but it was feeding time now. The food came and the ice cream was already melting, and she ate that first.

A handwritten note, dated 7/26/23, signed by the RDCO, the Administrator, and the Registered Nurse/Unit Manager (RN) 8 indicated, during an interview, Resident 5 had indicated, on Monday 7/24/23, the aide came into her room without her lunch tray and asked Resident 5 if she wanted to be changed first and then eat. The resident had told the aide that she wanted to eat first. The aide returned to the resident's room with the lunch tray.

A psychologist note, dated 7/28/23 at 1:26 p.m., indicated a session with Resident 5 had been conducted, on this date, via telehealth of a staff request for a wellness check for Resident 5, related to the event, on Monday 7/28/23. Resident

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	07/28/2023

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
	5 described the event in question. She indicated she experienced an incontinence episode around the time lunch was being served. Resident 5 shared how she was hungry and her lunch, notably included ice cream, so she elected to be changed after she finished her ice cream and meal. Resident 5 reported it was her decision to eat first before initiating the care/hygiene process. Resident 5 denied having been denied access to care, any emotional distress or mental anguish related to this event. She denied it as having been traumatic and further denied any associated related trauma or distress symptom response. The resident's record and incident investigation lacked documentation that the resident was educated that her food would be kept warm and her ice cream cold if she elected to get changed first and taken to the dining room. The record lacked documentation that the resident was educated on the effects on her pressure ulcers of sitting in urine. The record lacked documentation the resident was assessed for pain when sitting in her urine. "Prevention and Care for Incontinence-Associated Dermatitis Among Older Adults: A Systematic Review - PMC (nih.gov)" (2010) was retrieved on 7/25/23 from the National Library of Medicine website. The guidance included, "...Damage to the skin can occur within 10-15 minutes following contact with moisture from stool or urine, causing overhydration and a slight swelling. In addition, the presence of friction and shear mechanical forces can decrease skin functioning and cause skin injury. Thus, the potential for skin breakdown among incontinent older adults requires careful assessment and care..."			

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	07/28/2023

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
	On 7/24/23, the ADM provided and identified a document as the facility's admission agreement, including the Resident Rights policy, for all residents and was the current facility policy, dated 12/2022. The policy indicated, " ...Nursing Home Resident Rights ...The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident ...Respect and Dignity ...The resident has the right to be treated with respect and dignity, including the right to: ...Reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents ...." 3.1-9(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure incontinence care was provided for dependent residents for 1 of 16 residents reviewed for Activities of Daily Living (ADL) (daily self-care activities) care (Residents 17). Findings include: On 7/27/23 at 10:30 a.m., during the Resident Council meeting, Resident 17 indicated he had been double briefed at night, several times a	F 0677	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 17 has been provided incontinence care per approved procedures. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/27/2023

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	07/28/2023

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
	month over past several months. He did not know why. He was blind and unable to identify the staff members. He was double briefed again the previous night and was left without being changed and was a mess, soaked in urine, in the morning. The Resident Council Members indicated the staff came in and woke them up during the night and ask if they needed to be changed. The residents indicated there were not enough supplies. The facility staff told them they were often out of briefs and the supplies would not come in for several days. On 7/28/23 at 9:35 a.m., Certified Nurse Aide (CNA) 16 indicated the facility had not had enough briefs at times for the residents. When the resident was wet, they gave them a shower or bed bath. They used pink pads when they did not have briefs available. She indicated she had provided care to several residents who were found to be double briefed and saturated in urine, staff gave lots of showers and bed baths because of this. On 7/28/23 at 9:45 a.m., Resident 17's record was reviewed. Diagnoses included but were not limited to, hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength), following cerebral infarction (when blood flow to a part of your brain is stopped either by a blockage or the rupture of a blood vessel), affecting right dominant side, chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high) with diabetic neuropathy (a type of nerve		action(s) will be taken; Residents with incontinent episodes are at risk to be impacted by this deficient practice. Nursing staff will receive education on or before _____8/25/23_____ from the DNS/designee regarding providing incontinence care and appropriate brief use following approved procedure - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff will receive education on or before _____8/25/23_____ from the DNS/designee regarding providing incontinence care and appropriate brief use following approved procedure. Nurse managers will check for proper brief use during daily rounds - 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 - Incontinent Brief Application skills validation check will be completed on all shifts daily for one week, bi weekly for 1 week,	

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	07/28/2023

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
	damage that can occur if you have diabetes). A quarterly Minimum Data Set (MDS) assessment (a standardized assessment tool that measures health status in nursing home residents), dated 6/27/23, indicated the resident required extensive assistance of two persons for dressing and toileting. Care plans, dated 4/11/23, indicated the resident was experiencing complications/residual effects which impact daily function related to diagnosis Cerebral Vascular Accident (CVA) (when blood flow to a part of your brain is stopped either by a blockage or the rupture of a blood vessel) with right dominate hemiplegia. An approach, dated 4/11/23, indicated to assist with Activities of Daily Living (ADLs) (activities related to personal care), as needed. Urinary Incontinence care plan, dated 4/11/23, indicated the resident required assistance with toileting due to impaired and decreased mobility ..., approaches dated 4/11/23, assist with elimination assist with incontinent care. On 7/28/23 at 2:52 p.m., Registered Nurse (RN) 8 indicated, all residents should be provided incontinence care when wet or soiled. On 7/28/23 at 2:52 p.m., RN 8 indicated the facility did not have a policy for ADL care, and provided document, titled "INCONTINENT BRIEF APPLICATION", dated 02/2010 and review dated 4/2012. RN 8 indicated it was the current policy for the facility. The policy indicated,"...Procedure steps...1. Verify resident and explain procedure ... 2. Provide policy... 3. Wash hands ... 4. Put on gloves ... 5. Unfasten and remove brief resident is currently wearing ... 6. Provide perineal care ... 7.		weekly times 2 week, and monthly for six months by DNS/Designee . Results of the skills validation will be reviewed by the CQI committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed to ensure compliance. - - by what date the systemic changes will be completed. 8/27/23	

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	07/28/2023

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
	Place back of brief between resident's ... 8. Bring front of brief between resident's legs and up to waist... 9. Fasten each side of brief and adjust to fit ... 10. Redress or position resident as needed ... 11. Remove gloves... 12. Wash hands ... 13. Soiled or used brief should be secured in plastic bag and disposed of in soiled utility room ...14. Do not leave in residents' room...." 3.1-38(a)(3)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure proper storage of a respiratory bilevel positive airway pressure (BiPAP) equipment (machine used to supply pressure to push air into the lungs) (Resident 15) and failed to ensure a physician's order for oxygen therapy was followed (Resident 13) for 2 of 2 residents reviewed for respiratory care. Findings include: 1. On 7/25/23 at 11:15 a.m., Resident 15's BiPAP mask was observed unbagged, on the resident's bed. On 7/26/23 at 12:57 p.m., Resident 15's BiPAP	F 0695	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Resident 15 has been educated to place CPAP mask in bag when not in use. The oxygen orders for Resident 13 have been clarified and Resident 13 has received oxygen per MD order** - how other residents having the potential to be affected by the same deficient practice will be	08/27/2023

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	07/28/2023

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
	mask was observed unbagged, on the resident's bed. Resident 15 indicated, he used the BiPAP every night to help with his breathing and sleep. On 7/27/23 at 11:54 a.m., Resident 15's BiPAP mask was observed on the resident's bed, not bagged. On 7/27/23 at 2:56 p.m., the Regional Director of Clinical Operations (RDCO) observed Resident 15's unbagged BiPAP mask on the resident's bed and indicated, the BiPAP face mask should be bagged, when not in use. Resident 15's record was reviewed, on 7/27/23 at 2:04 p.m. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the tissues in the body) and chronic obstructive pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed airflow from the lungs). A quarterly Minimum Data Set (MDS) assessment, dated 6/29/23, indicated the resident was cognitively intact, experienced shortness of breath when lying flat, and received oxygen therapy. A care plan, dated 11/22/22, indicated the resident was at risk for impaired gas exchange related to chronic respiratory failure with hypoxia and COPD. Interventions included, but were not limited to, BiPAP treatments as ordered. A physician's order, dated 11/22/22, indicated, BiPAP Settings: 12-16cm H2O (water) with 3 liters (L) of oxygen at bedtime and off upon waking. On 7/28/23 at 8:50 a.m., the RDCO provided and identified an undated document as a current		identified and what corrective action(s) will be taken **Residents using respiratory equipment are at risk due to this deficient practice.** **Residents on hospice with oxygen orders have been reviewed to verify that hospice orders and facility orders match.** **Education regarding proper storage of respiratory equipment and oxygen orders will be provided on or before _____8/25/23_____ by DNS/designee.** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Education regarding proper storage of respiratory equipment and oxygen orders will be provided on or before _____8/25/23_____ by DNS/designee.** **Nurse managers will observe for proper storage of respiratory equipment during daily rounds.** **Hospice orders and facility orders will be reviewed monthly by nurse managers 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	07/28/2023

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
	facility policy, titled "Bi-Level Therapy," and she indicated, the facility policy did not specify the storage of a BiPAP mask, but the BiPAP face mask should be bagged, when not in use. 2. On 7/24/23 at 10:00 a.m., during an observation, Resident 13 was sleeping in bed. The head of the bed was slightly elevated. The call light was under the left hand. A water pitcher was on a table against the far wall out of the reach of the resident. Oxygen was being administered via an oxygen concentrator, (concentrators pull in room air, separates the other gases from the oxygen, exhausts the other gasses, and delivers the oxygen to the patient), at 4 liters (L) via nasal cannula (NC) (a medical device to provide supplemental oxygen therapy to people who have lower oxygen levels). On 7/25/23 at 11:15 a.m., observed the resident lying in bed with call light under her left hand. The head of the bed was in a slightly elevated position. Oxygen was being administered at 4 L via NC per an oxygen concentrator. Resident appeared to be anxious and tearful and indicated she was in pain. Licensed Practical Nurse (LPN) 5 administered pain medication. Resident was groaning and made gurgling sounds. Registered Nurse (RN) 8 observed resident. The resident vomited a large amount of yellow liquid. The head of the bed was elevated, and personal care was provided to the resident. On 7/26/23 at 2:16 p.m., observed the resident lying in bed. The head of the bed was elevated, and oxygen was being administered at 4 L via NC per an oxygen concentrator. The resident denied pain, the call light was within reach. The resident indicated she did not feel well but gave no specific complaints and indicated she had no recurrence of nausea or vomiting from the day		**discrepancies** - 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 Respiratory Care CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts 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.**	

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	07/28/2023

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
	before. On 7/27/23 at 9:15 a.m., observed the resident lying in bed. The water pitcher was on the overbed table within reach. The call light was on the left side of the bed within reach. Oxygen was being administered at 4 L via NC per an oxygen concentrator. On 7/27/23 at 11:45 a.m., interview with RN 8, RN observed the oxygen delivery was set at 4 L and being administered via a nasal cannula (NC). The RN indicated the oxygen order was for oxygen administration 2 L at bedtime. The RN lowered the oxygen to 2 L. On 7/27/23 at 11:50 a.m., RN 8 reviewed the medical record, current orders, and the current hospice orders, and identified a physician order dated 5/10/23 for oxygen administration 2 to 5 L as needed for diagnosis of, Chronic Obstructive Pulmonary Disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems). The current medical record indicated, an order dated 4/14/23, oxygen administration 2 liters per nasal cannula at night. RN 8 acknowledged the oxygen was administered continuously and orders were different. On 7/27/23 at 2:00 p.m., phone interview with hospice nurse, the nurse indicated an order was written and dated, 5/10/2023 for oxygen to be administered at 2 to 5 L as needed. The hospice nurse indicated the order had been initiated during hospice admission and the hospice nurse would write an order and would notify the facility nurse of any new orders that were written during the admission process. During follow-up visits the hospice nurse would review and verify all orders, any orders that were written during that visit were			

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	07/28/2023

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
	given to the nurse assigned to the resident. On 7/25/23 at 12:12 p.m., the medical record for Resident 13 was reviewed. The medical record indicated an order for hospice care services for diagnosis of COPD. Hospice physician order, dated 5/10/23, indicated oxygen administration 2 to 5 L as needed for diagnosis of COPD. The current medical record indicated an order, dated 4/14/23, oxygen administration, 2 liters per nasal cannula at night. The oxygen order for both medical records lacked documentation of oxygen administration device and lacked documentation for an indication to administer oxygen as needed and at night. Diagnoses included, but were not limited to, hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength), following other cerebrovascular disease affecting right dominant side, COPD, Hypertensive heart disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), unspecified dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), with anxiety (a feeling of fear, dread, and uneasiness) It can be a normal reaction to stress), Unspecified sequelae (residual effects or conditions produced after the acute phase of an illness or injury has ended) of cerebral infarction (the medical term for a stroke. A stroke is when blood flow to a part of your brain is stopped either by a blockage or the rupture of a blood vessel).			

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	07/28/2023

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
	The Quarterly Minimum Data Set, (MDS-a standardized assessment tool that measures health status in nursing home residents), dated 7/6/23, indicated a diagnosis of COPD, Hospice services, and oxygen administration. A Care Plan dated 4/11/2023, indicated the Resident has potential for impaired gas exchange related to diagnosis of COPD and shortness of breath when lying flat. Goal date 8/27/2023, the resident will have adequate respiratory functions as evidenced by decreased or absence of dyspnea, improved breath sounds, decreased or absence of shortness of breath and improved oximetry results. An intervention, dated 4/11/23, included but were not limited to, administer medications as ordered, and administer oxygen as ordered 2 L at night. Documentation lacked evidence of communication between the facility and the hospice nurse identifying correct oxygen orders for oxygen delivery device, liter flow or administration times. On 7/28/23 at 10:14 a.m., the Regional Director of Clinical Operations (RDCO) provided a document titled, "Hospice Policy" dated 1/2016, revision dates 11/17, 10/18, 8/19 and indicated it was the policy currently being used by the facility. The policy indicated, " ...Policy: It is the policy of this facility that when a resident elects the hospice benefit that the contracted hospice company and facility will coordinate to establish both a person-centered plan of care reflecting the physical, spiritual, mental, and psychosocial needs of the resident as well as a pattern of communication between the hospice company, healthcare professionals, facility staff and resident/representative. Procedure: ...2. c. Care and services (including medications and supplies)			

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	07/28/2023

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
	that the facility and hospice will provide in order to be responsive to the residents needs and desire for hospice care ...." On 7/28/23 at 10:45 a.m., the Regional Director of Clinical Operations (RDCO) provided an undated document titled, "Oxygen Therapy and Devices" and indicated it was the policy currently being used by the facility. The policy indicated, " ... Indications for oxygen use ... 1. Obstructive pulmonary disease ... Definition of Oxygen ... 1) Oxygen is a drug which must be ordered by a physician ... c. Concentrated ... i. Units plugs into the wall ... ii. Concentrators pull in room air, separates the other gases from the oxygen, exhausts the other gasses, and delivers the oxygen to the patient ...Initiation of oxygen ...1) Verify physician order ...7) Apply device to the patient with appropriate liter flow ...Oxygen Devices ...1) Nasal cannula ...a. Low flow device by which nasal prongs are placed in the nares to deliver up to 44% oxygen using 1-6 LPN ...." 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, when 3 errors were observed during 35 opportunities resulting in an error rate of 8.57% related to not administering	F 0759	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Resident 20 has had a Self-Administration assessment**	08/27/2023

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	07/28/2023

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
	medication in accordance with physician's orders and manufactures instructions for 3 of 3 residents observed for insulin administration (Residents 20, 17, and 9). Findings include: During a random continuous observation, on 7/26/23 from 11:25 a.m. to 12:44 p.m., Registered Nurse (RN) 11 indicated there were 4 residents with orders for blood glucose monitoring using a glucose meter and insulin coverage before lunch. Resident 24 was observed to refuse to have her blood sugar checked per glucose meter, RN 11 indicated the refusal was normal for this resident. 1. On 7/20/23 at 12:41 p.m., RN 11 was observed preparing a glucose meter and Novolog flex pen (a rapid-acting insulin available in a disposable insulin pen with a push-button extension) for Resident 20. RN 11 indicated the resident had always done his own blood sugar check and given his own insulin as he did not like the staff poking him. RN 11 gave Resident 20 the glucose meter, and observed as he checked his glucose, the reading was 259 (normal range for an adult per the American Diabetic Association 70-99). RN 11 was observed to prepare a Novolog flex pen, indicated the resident was to receive 11 units (U) per the routine dose, and due to his high blood sugar reading would get an additional 6 U. RN prepared the flex pen by putting a needle on the opened pen, dialed up the dosage, and handed the flex pen and alcohol prep pad to the resident. RN 11 observed the resident as he cleaned the skin on the back of his right upper arm out of his sight, place the flex pen against his skin, pushed the button, and immediately pulled the needle back out. During this process, RN 11 was		**completed and has a physician's order to self-administer insulin. Resident 20 has received education on administering insulin using the Novolog flex pen and has a care plan for self-administering medication. Resident 17 continues to receive medications as ordered with no changes in condition. Resident 9 continues to receive medications as ordered with no changes in condition** - 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 **Residents who receive insulin are at risk due to this deficient practice.** **No other residents self-administer insulin** **Licensed nursing staff will be inserviced by the DNS/designee on or before _____8/25/23_____ on the approved procedure for administering insulin using a flex pen.** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Licensed nursing staff will be**	

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	07/28/2023

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
	not observed to clean the end of the flex pen before putting a needle on the pen, did not prime the pen (perform an air shot by dialing up 2 U of insulin, press the button, and make sure insulin came out of the needle to assure no air bubbles and pen functional), and did not prompt the resident to hold the needle in his arm long enough to allow the insulin medication time to administer (slowly counting to 10 after pressing the dose button). Additionally, the sliding scale insulin was administered late. Resident 20's record was reviewed on 7/27/23 at 9:54 a.m. Diagnoses on Resident 20's profile included, but were not limited to, schizophrenia (mental disorder characterized by continuous or relapsing episodes of psychosis), and type 2 diabetes mellitus (the body either doesn't produce enough insulin, or it resists insulin) with skin ulcer, diabetic kidney disease, and diabetic retinopathy (damage to the retina). A physician's order, dated 5/5/23, indicated Novolog Flex Pen U-100 Insulin, administer insulin subcutaneous per sliding scale according to blood glucose results three times daily at 7:00 a.m., 11:00 a.m., and 4:00 p.m. If Blood Sugar is less than 60, call MD (physician). If Blood Sugar is 0 to 119, give 0 Units. If Blood Sugar is 120 to 160, give 2 Units. If Blood Sugar is 161 to 200, give 5 Units. If Blood Sugar is 201 to 240, give 8 Units. If Blood Sugar is greater than 240, give 11 Units. If Blood Sugar is greater than 400, call MD. A physician's orders, dated 5/22/23, indicated Novolog Flex Pen U-100 Insulin give 6 U subcutaneous three times a day at 7:30 a.m., 12:00 p.m., and 5:00 p.m., administer with sliding scale		**inserviced by the DNS/designee on or before _____8/25/23_____ on the approved procedure for administering insulin using a flex pen.** **Licensed nursing staff will be inserviced on insulin administration using a flex pen upon hire and annually by the Clinical Education Nurse.** - 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; **Insulin Pen Administration skills validation check will be completed on all shifts daily for one week, bi weekly for 1 week, weekly times 2 week, and monthly for six months by DNS/Designee . Results of the skills validation will be reviewed by the CQI committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed to ensure compliance.** - by what date the systemic changes will be completed. **8/27/23**	

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	07/28/2023

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
	dosage. A physician's order, dated 7/11/23, indicated Lantus Solostar U-100 Insulin give 13 U twice daily 6:00 a.m. - 11:00 a.m., and 6:00 p.m. - 11:00 p.m. RN 11 indicated, this insulin was administered around 5:00 a.m. by the night nurse. Blood sugar monitoring for Resident 20, dated July 2023, indicated his blood glucose levels were documented 3 to 5 times daily, and ranged from 79 to 346. There were only 2 readings within the normal range. Resident 20's record, dated 1/16/23 to 7/27/23, lacked documentation a medication self-administration assessment was completed. The record lacked a physician's order for self-administration of insulin, a care plan for self-administration of medication, and documentation the resident was educated on proper procedure for administering insulin with a Novolog flex pen. A quarterly Minimum Data Set (MDS) assessment, dated 6/27/23, indicated the resident had the ability to make himself understood and to understand others. A Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicated the resident had moderately impaired cognition. Documentation of 7 insulin injections were received during the last 7 days. A care plan for Resident 20, indicated the resident was at risk for effects of hyperglycemia (blood glucose levels too high) or hypoglycemia (blood glucose levels too low) related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. The goal was for the resident to not experience symptoms of hyperglycemia or			

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	07/28/2023

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
	hypoglycemia. Interventions included diet as ordered, document abnormal findings and notify the MD, medications as ordered, and monitor blood sugars as ordered. During an interview, on 7/27/23 at 9:48 a.m., RN 11 indicated she was not sure if Resident 20 had a physician's order to self-administer his medications. But he would not let the staff poke him, he had done it before being admitted, and it was his choice to do his own. During an interview on 7/27/23 at 10:20 a.m., Resident 20 was observed lying on the bed. He indicated he had been back into the facility for about 7 months. During his stay staff had allowed him to check his own blood sugars and administer his own insulin. When giving his insulin he held the needle in the skin about 2 seconds. Staff had not educated him on the use of the glucose monitor or giving his own insulin. 2. During a random insulin administration observation for Resident 17 on 7/26/23 at 11:39 a.m., RN 11 was observed to check the blood glucose level with a result on 212. She then prepared a Novolog flex pen but putting a needed onto an opened pen, dialed up 6 U of Novolog insulin, put the insulin needle into the abdomen, pushed in the plunger, and immediately pulled the needle back out. RN 11 did not clean the pen before putting on a needle, did not prime the flex pen, and when the insulin was administered she put the needle into the skin and pulled it back out in one fluid movement, not giving time for the insulin to administer. Resident 17's record was reviewed on 7/27/23 at 10:39 a.m. Diagnoses on Resident 17's profile included, but were not limited to, type 2 diabetes			

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	07/28/2023

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
	mellitus with diabetic neuropathy (nerve damage that occurs with diabetes that most often affects the legs and feet). A physician's order, dated 8/20/23, indicated to administer Novolog Flex Pen U-100 Insulin per sliding scale according to blood glucose results three times daily at 7:00 a.m., 11:00 a.m., and 4:00 p.m. If Blood Sugar is less than 60, call MD. If Blood Sugar is 0 to 129, give 0 Units. If Blood Sugar is 130 to 175, give 3 Units. If Blood Sugar is 176 to 225, give 6 Units. If Blood Sugar is 226 to 275, give 9 Units. If Blood Sugar is 276 to 325, give 12 Units. If Blood Sugar is 326 to 400, give 20 Units. If Blood Sugar is greater than 400, call MD. Blood sugar monitoring for Resident 17, dated July 2023, indicated his blood glucose levels were documented 3 times daily, ranged from 75 to 398, and had only 5 readings within the normal range. A quarterly MDS assessment, completed on 6/27/23, indicated the resident had the ability to make himself understood and to understand others. BIMS score 12/15 indicated moderately impaired cognition. Documentation of 7 insulin injections were received during the last 7 days. A care plan for Resident 17, indicated the resident was at risk for effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. The goal was for the resident to not experience symptoms of hyperglycemia or hypoglycemia. Interventions included, diet as ordered, document abnormal findings and notify the MD, medications as ordered, and monitor blood sugars as ordered.			

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	07/28/2023

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
	3. During a random insulin administration observation for Resident 9 on 7/26/23 at 12:14 p.m., RN 11 was observed to check the blood glucose level with a result of 354. She then dialed up 18 U of Novolog insulin (Novolog 8 U routine and 10 U sliding scale), put the insulin needle into the abdomen, push in the plunger, and immediately pull the needle back out. She was observed to take the insulin pen out of the refrigerator and administer. It should have been used at room temperature by taking the flex pen out of the refrigerator 1 to 2 hours before use. When the insulin was administered, she put the needle into skin and pulled it out in one fluid movement, not giving time for the insulin to administer. Additionally, the medication was administered late after removing the resident from the dining room after she had already started eating. Resident 9's record was reviewed on 7/27/23 at 11:42 a.m. Diagnoses on Resident 9's profile included, but were not limited to, Alzheimer's disease, and type 2 diabetes with kidney disease and diabetic neuropathy. A physician's order for Resident 9, dated 7/11/23, indicated Novolog Flex Pen U-100 Insulin, administer 8 U subcutaneous three times daily at 7:00 a.m., 11:00 a.m., and 4:00 p.m. Hold if blood sugar under 120. A physician's order for Resident 9, dated 7/18/23, indicated Novolog Flex Pen insulin, administer insulin subcutaneous per sliding scale according to blood sugar results three times daily at 7:00 a.m., 11:00 a.m., and 4:00 p.m. If Blood Sugar is less than 60, call MD. If Blood Sugar is 0 to 119, give 0 Units. If Blood Sugar is 120 to 200, give 4 Units.			

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	07/28/2023

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
	If Blood Sugar is 201 to 250, give 7 Units. If Blood Sugar is greater than 250, give 10 Units. If Blood Sugar is greater than 400, call MD. Blood sugar monitoring for Resident 9, dated July 2023, indicated her blood glucose levels were documented 3 times daily, always documented as above normal, ranged from 102 - 544, with 3 readings over 400 on 7/7 at 544, 7/10 at 496, and 7/16 at 436. A quarterly MDS assessment, completed on 6/21/23, indicated resident usually had the ability to make herself understood and usually to understand others. BIMS score 12/15 indicated moderately impaired cognition. Documentation of 7 insulin injections were received during the last 7 days. A care plan for Resident 9, indicated the resident was at risk for effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. The goal was for the resident to not experience symptoms of hyperglycemia or hypoglycemia. Interventions included, diet as ordered, document abnormal findings and notify the MD, medications as ordered, and monitor blood sugars as ordered. During an interview on 7/27/23 at 9:40 a.m., Registered Nurse (RN) 11 indicated, at lunch time there were 6 residents that had orders for blood sugar monitoring with insulin coverage, and if she was the only nurse or working with a Qualified Medication Aide (QMA), she checked the blood sugar levels and administered the insulin for all of them. There were 3 glucose monitors that were shared between residents for blood sugar monitoring, and the residents all had flex pens with insulin. The insulin pens were kept in the			

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	07/28/2023

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
	medication room refrigerator before being opened. After a flex pen was opened it was stored at room temperature on the medication cart for up to 28 days. Her process for administering insulin included, put a needle on the insulin pen, dial up the amount of insulin to be administered, ask the resident where they wanted their shot, put the needle in the skin, push the dial button, hold a couple to 3 seconds, and take out the needle. During an interview on 7/27/23 at 2:15 p.m., RN 11 indicated she had received education on use of the Novolog flex pen in the past but had not had education at this facility. She was not aware of needing to bring the flex pen up to temperature when removing from the refrigerator by waiting 1 to 2 hours before using or holding the flex pen in the skin by counting to 10, per manufacturer instructions. She thought she only needed to hold the pen in the skin for administration for 3 seconds. During an interview on 7/27/23 at 3:45 p.m., the Executive Director (ED) indicated blood glucose monitoring and insulin administration education had been provided to staff in preparation for their annual survey, she was unable to locate documentation of the education. On 7/27/23 at 3:45 p.m., the Regional Director of Clinical Operations (RDCO) provided a Nursing Skills Competency list, titled, Insulin Pen Administration, dated 10/2019, and indicated the competency was the one currently being used by the facility. The competency indicated, "8. Attach pen needle by twisting the needle onto end of insulin. 9. Pull off and remove outer pen needle protective cap and cover. 10. Prime the pen by dialing 2 units. 11. Push the end of the pen to push out the 2 units. [A small drop of insulin			

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	07/28/2023

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
	should be visible. If insulin does not appear, repeat]. 12. Dial desired insulin dosage to be administered to resident. 13. Choose an injection site. 14. Cleanse injection site with alcohol swab and allow to dry. 15. Grasp about one inch of skin between thumb and finger of non-dominant hand. 16. Insert pen needle at a 45 - 90 - degree angle into skin. 17. Push injection button down at end of pen completely to give insulin. 18. Wait 5 - 10 seconds while keeping insulin pen and pen needle in place, to ensure all insulin is given. 19. Pull the insulin pen and needle out from the injection site..." 3.1-48(c)(1)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional			

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	07/28/2023

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
	standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure proper handling of linens used in the kitchen and to ensure paper towels were available for proper handwashing, during 1 of 2 kitchen observations. This deficient practice had the potential to effect 36 of 36 residents who received food from the kitchen. Findings include: 1. On 7/24/23 at 9:46 a.m., Housekeeper 6 was observed carrying clean linen into the kitchen area. The linens were being held up against the housekeeper's uniform. 2. The initial kitchen observation was completed with Cook 7, on 7/24/23 at 10:04 a.m. While washing their hands at the handwashing sink, the visitor observed there were no paper towels available to dry their hands and to turn off the water at the sink. At the same time, Cook 7 indicated since there were no paper towels available, there were clean towels in the bin under the sink, which would be used to dry their hands and turn off the water at the sink. She had not yet seen a housekeeper to request more paper towels be placed next to the handwashing sink. A towel from the bin was used, by the visitor, to dry their hands. When retrieving a second towel to turn off the water at the sink, the visitor pulled what appeared to be a dry mop head from the bin. On 7/24/23 at 10:07 a.m., Cook 7 retrieved the used towels from the visitor and then touched a lid of the receptacle, she identified as the receptacle to place the dirty towels into after use, with her bare hands. After touching the lid of the receptacle,	F 0812	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were found to be affected.** - 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 are at potential risk due to this practice.** **All staff will be inserviced on or before _____8/25/23_____ by the Clinical Education Nurse on the facility hand hygiene procedure, including checking for availability of paper towels.** **All staff will be inserviced on or before _____8/25/23_____ by the CEN on proper handling of clean linen** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **All staff will be inserviced on or before _____8/25/23_____ by the Clinical Education Nurse on the facility hand hygiene**	08/27/2023

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	07/28/2023

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
	she indicated had completed a safe food handing course and understood she needed to wash her hands after touching the lid. The Cook was not observed to wash her hands during the remainder of the kitchen observation. During an interview, on 7/24/23 at 11:18 a.m., the Housekeeping Supervisor indicated there should always be paper towels in the kitchen and staff should not be using the towels in the bin below the handwashing sink to dry their hands. The kitchen staff should have notified one of the housekeeping staff and got the paper towels refilled. The towels in the bin under the handwashing sink were for use in the sanitation of the kitchen. The housekeeping staff would always ensure there were paper towels in the kitchen storage room available for the kitchen staff. At the same time, she indicated no staff should ever carry clean linens up against their bodies. During an interview, on 7/25/23 at 10:59 a.m., the Culinary Manager indicated paper towels were not routinely kept in the kitchen storage room. Housekeeping provided the paper towels to the kitchen. When paper towels were needed, the kitchen staff were to notify the housekeeper to replace their stock. The cloth towels in the bin were used for cleaning purposes only. On 7/25/23 at 11:36 a.m., the Regional Director of Clinical Operations (RDCO) provided a document, with a revision date of 7/2022, titled, "Hand Hygiene," and indicated it was the policy currently being used by the facility. The policy indicated, "...Hand Hygiene with soap and water [hand washing]. 1. Check that the sink area are supplied with soap and paper towels...8. Use clean paper towel; dry hands and wrists thoroughly. 9. Discard paper towels in wastebasket. 10. Use		**procedure, including checking for availability of paper towels.** **All staff will be inserviced on or before _____8/25/23_____ by the CEN on proper handling of clean linen** **Laundry staff will bag clean linen for transport to the kitchen** **The culinary aide will ensure that paper towels are available at the hand washing sink daily** - 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; **Environmental control audit tool will be utilized 5 days a week for four weeks, once a week for four weeks, and monthly for four months by the Dietary Manager/and or designee. Threshold of 95% will be maintained throught. If not an additional action plan may be developed.** - by what date the systemic changes will be completed. **8/27/23**	

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	07/28/2023

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
	paper towels to turn off faucet...." On 7/25/23 at 12:00 p.m., the RDCO provided a document, with a revision date of 12/2021, titled, "Laundry/Linen," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...2...i. Clean linen should be carried away from body to prevent contamination...." 3.1-19(g) 3.1-21(i)(3)			