| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155406 | A. BUILDING 00<br>B. WING | 09/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| HICKORY CREEK AT PERU | 390 W BOULEVARD<br>PERU, IN 46970 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: September 25, 26, 27 and 30, 2024<br><br>Facility number: 000475<br>Provider number: 155406<br>AIM number: 100290540E<br><br>Census Bed Type:<br>SNF/NF: 31<br>Total: 31<br><br>Census Payor Type:<br>Medicare: 1<br>Medicaid: 25<br>Other: 5<br>Total: 31<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality Review completed on 10/8/2024 | F 0000 | Plan of correction for Hickory Creek Healthcare, Peru Indiana. 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 a Post Certification Desk Review in lieu of a post survey visit. | |
| F 0570<br>SS=E<br>Bldg. 00 | 483.10(f)(10)(vi)<br>Surety Bond-Security of Personal Funds<br><br>Based on interview and record review, the facility failed to ensure the Surety Bond amount was sufficient to cover the Resident's personal fund account. This deficient practice had the potential to effect 31 of 31 residents in the facility.<br><br>Finding includes:<br><br>During an interview, on 9/30/2024 at 10:38 A.M., the Business Office Manager (BOM) indicated the | F 0570 | F 570 Surety Bond<br>SS=E<br><br>It is the policy of this facility to ensure that accounts containing resident personal funds are protected with a Surety Bond. | 10/18/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Brenda Shepherd | Executive Director | 10/19/2024 |

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| | Surety Bond amount was $25,000.00 and the resident funds accounts totaled $28,511.66 in June and $26,803.46 in July The Business Office Manager indicated the amount of the surety bond would not cover the total amount in the resident funds account.<br><br>During an interview, on 9/30/2024 at 1:25 P.M., the Administrator indicated the surety bond would not always cover the total amounts in the resident fund account.<br><br>She indicated she did not have a policy for the surety bond.<br><br>3.1-6(i) | | 1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice.<br><br>Surety Bond Rider increased to the amount of 35,000.00<br><br>2 How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>All residents have the potential to be affected by this same practice.<br><br>3 What measures will be put in place or systemic measures to ensure that the deficient practice will not reoccur?<br><br>As part of our Business Office Meeting and monthly review, our facility Business Office Manager, Business Office Specialist and Executive Director will review resident personal fund accounts ensuring our surety bond protects the account balance.<br><br>4 How will the facility monitor its corrective action to ensure that the deficient practice will not recur?<br><br>Quality Improvement Plan will be completing a monthly audit reviewing the resident funds comparing to our surety bond | |

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| | | | amount. Presentation of audit will occur bi-monthly during our QA meetings. Monthly audits will remain ongoing for the next 6 months.<br>At the 6 months if 100% compliance is achieved during each audit the QA Committee can decide to stop the monthly resident fund and surety bond amount audit. The Executive Director is responsible for implementation and monitoring this audit process. | |
| F 0656<br>SS=D<br>Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br><br>Based on observation, record review and interview, the facility failed to develop a comprehensive person-centered care plan for a resident with positioning issues for 1 of 17 residents reviewed. (Resident 11)<br><br>Finding includes:<br><br>During an observation, on 9/25/2024 at 11:30 A.M., Resident 11 was leaned over to the left side of his wheelchair while in the dining room and there was a stuffed animal placed in between Resident 11's left arm and the armrest of his wheelchair.<br><br>The medical record for Resident 11 was reviewed on 9/26/2024 at 3:32 P.M. Diagnoses included but were not limited to: diffuse traumatic brain injury, hemiplegia and hemiparesis following cardiovascular accident, conversion disorder with | F 0656 | F 656 Develop/Implement Comprehensive Care Plan.<br>SS=D<br><br>It is the policy of this facility to ensure a Comprehensive Care Plan is developed and maintained during the residents stay at the facility.<br><br>1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice.<br><br>Resident #11 positioning needs have been reviewed by the IDT team and care plan for positioning | 10/18/2024 |

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| | seizures, anxiety, depression, hypertension, chronic pulmonary obstructive disease, pulmonary embolism, cardiac arrest, contracture of left shoulder, difficulty in walking and coronary artery disease.<br><br>The record lacked a person-centered care plan for the resident's positioning issues.<br><br>During an interview, on 9/27/2024 at 9:21 A.M., CNA (Certified Nursing Assistant) 2 indicated if staff noticed Resident 11 was leaning to the left, staff would put the resident in bed and lay him down.<br><br>During an interview, on 9/27/2024 at 9:28 A.M., the DON (Director of Nursing) indicated facility staff just used pillows to prevent Resident 11 from leaning to the left in his wheelchair. The DON indicated a half-lap tray to prevent the resident from leaning to the left was previously utilized, but Resident 11's mother had requested they quit using the tray. The DON indicated staff should have placed pillows between the resident's wheelchair and his left arm to prevent pressure. The DON indicated preventing Resident 11 from leaning to his left side with pillows should have been included in the resident's current care plan.<br><br>On 9/30/2024 at 10:28 A.M., the Social Service Director provided a policy titled, "IDT Comprehensive Care Plan Policy," dated 8/2023 and indicated the policy was the one currently used by the facility. The policy indicated " ...each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented ...must include measurable goals and resident specific interventions based on resident needs ..." | | has been reviewed.<br><br>2 How will the facility identify other resident having the potential to be affected by the same deficient practice?<br><br>All residents have the potential to be affected. Residents with positioning devices have been reviewed and care plan cross referenced with resident profile sheet which indicates to direct care staff what type of positioning devices are needed.<br><br>3 What measures will be put in place or systemic made to ensure that the deficient practice will not reoccur?<br><br>As resident needs and level of function changes, IDT along with therapy will review positioning devices needed, this review may occur during our daily clinical mtg. Weekly during our therapy meeting or at any time resident has an increase or decrease in level of function.<br><br>4 How will the facility monitor its corrective action to ensure that the deficient practice will not recur?<br><br>Ongoing compliance with this | |

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| | 3.1-35(a) | | corrective action will be monitored via facility QAPI program, with meetings being held bimonthly, and is overseen by the Executive Director.<br><br>CQI tool identified as Comprehensive Care Plan will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br><br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance. | |
| F 0657 SS=D Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br><br>Based on record review and interview, the facility failed to revise care plans for fluid consumption for 1 of 17 residents whose care plans were reviewed. (Resident 4)<br><br>Finding includes:<br><br>The record for Resident 4 was reviewed on 9/26/2024 at 1:46 P.M. Diagnoses included, but were not limited to, heart failure, end stage renal disease, diabetes and bipolar disorder.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 6/28/2024, indicated the | F 0657 | F 657 Care Plan Timing and Revision<br>SS=D<br><br>It is the policy of this facility to develop/implement/revise care plans according to the residents current level of care and function.<br><br>**1.What corrective actions will** | 10/18/2024 |

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| | resident received dialysis.<br><br>Current Physician's Orders included an order for regular diet and dialysis every Monday, Wednesday and Friday.<br><br>A current Care Plan, initiated on 5/12/2023, indicated the resident was at risk for a fluid imbalance due to end stage renal disease, heart failure, hypo-osmolality and hyponatremia. Interventions included, but were not limited to: administer medications as ordered and encourage fluids.<br><br>A current Care Plan, initiated on 5/12/2023, indicated the resident was at risk for constipation due to end stage renal disease, decreased mobility and polypharmacy (multiple drug use). Interventions included, but were not limited to: administer medications as ordered and encourage fluids.<br><br>A current Care Plan, initiated on 5/15/2023, indicated the resident was at risk for altered nutritional status related to diagnoses of end stage renal disease, morbid obesity and diabetes type 2. Interventions included, but were not limited to: attends dialysis 3 x/week. regular diet. No water pitcher at bedside and communicate with the dialysis Register Dietician.<br><br>A current Care Plan, initiated on 8/27/2024, indicated the resident had bruising to her left upper arm. Interventions included, but were no limited to: encourage fluids.<br><br>The care plans for Resident 4 related to fluids contradicted themselves and were not revised to accurately reflect the resident's fluid needs and physician orders. | | **be accomplished for those residents found to have been effective by the deficient practice?**<br><br>Resident #4 was identified care plan has been updated to reflect the current intervention for appropriate fluid consumption.<br><br>2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>All residents in this facility have the potential to be affected by this practice. The IDT, team will review if any each resident's limited fluid consumption. To make sure their care plans reflect current interventions. During this review IDT will update interventions as needed.<br><br>**3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>All staff were re-educated on 10/15/2024 regarding Hickory Creek policies and procedures as well as state guidelines regarding timing and revision. Care Plan | |

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| | During an interview, on 9/30/2024 at 9:30 A.M., the Director of Nursing indicated the care plans were not updated to and should have been. She indicated previously Resident 4 was consuming too much water.<br><br>On 9/30/2024 at 10:38 A.M. the Social Service staff provided the policy titled, "IDT Comprehensive Care Plan Policy", dated 8/2023, and indicated the policy was the one currently use by the provider. The policy indicated "...Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MDS assessment...."<br><br>3.1-35(d)(2)(B) | | Timing and Revision.<br><br>As part of the daily clinical review meeting, the IDT will review any resident who has had a change in status for fluid consumption. The care plan at that time will be reviewed and updated including any changed interventions. The changes and interventions will be communicated and updated and be reflected on the resident profile sheet for direct care staff.<br><br>**4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?**<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.<br><br>· CQI tool identified as Care Plan Revision will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br><br>· If Threshold of 100% is not met, an action plan will be developed to ensure compliance. | |

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| F 0692 SS=D Bldg. 00 | 483.25(g)(1)-(3)<br>Nutrition/Hydration Status Maintenance<br><br>Based on record review and interview, the facility failed to ensure a resident received the appropriate therapeutic diet for 1 of 1 residents reviewed for reviewed for dialysis. (Resident 4)<br><br>Finding includes:<br><br>The record for Resident 4 was reviewed on 9/26/2024 at 1:46 P.M. Diagnoses included, but were not limited to, heart failure, end stage renal disease, diabetes and bipolar.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 6/28/2024, indicated the resident received dialysis.<br><br>Resident 4's admission orders initiated 5/12/2023, indicated the diet order was: "3-4 GM (grams) NA (sodium) CCD (controlled carbohydrate diet), no orange or tomato juices or bananas. May have 8 oz milk every day, low NA bologna sandwich 1-2 times week if does not like what is served."<br><br>A dialysis note/order, dated 10/11/2023, indicated the resident was to receive a diet-1GM K (potassium), 23 GM phosphorus, 2 GM or less NA and 48 oz. fluid restriction.<br><br>A current Physician's Order Sheet, initiated on 10/25/2023, from the dialysis unit indicated a new order for Nephro (dietary supplement) twice a day | F 0692 | F 692 Nutrition/Hydration Status Maintenance<br>SS=D<br><br>It is the policy of this facility to ensure that Nutrition and hydration status for residents is maintained.<br><br>**1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Resident #4 diet order has been clarified with MD.<br><br>2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>All residents with renal diet restrictions were reviewed to | 10/18/2024 |

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| | until patient starts eating better.<br><br>Resident 4's current Physician's Orders, dated 9/30/2024, included a regular diet, ordered on 5/12/2023, and there was no order for the Nephro.<br><br>Resident 4's record lacked the documentation to show the diet order from admission on 5/12/2023 and the Nephro supplement order form 10/25/2023 had been followed.<br><br>During an interview, on 9/30/2024 at 12:42 P.M., the Director of Nursing indicated she could not provide any further documentation for why the diet had been changed. She indicated the admission diet and the Nephro orders had not been transcribed correctly, and the resident had not received the Nephro supplement.<br><br>On 9/30/2024 at 12:45 P.M. the Director of Nursing provided the policy titled, "Dialysis Care", dated 11/207, and indicated the policy was the one currently used by the facility. The policy indicated" ... The facility will ensure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice including: Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services... 5. The nurse in charge at time of return will review paperwork for new orders and/or notes accompanying the resident...."<br><br>3.1-46 | | ensure residents are receiving diets per order.<br><br>**3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>As part of our clinical review meeting, the IDT will review dialysis residents' communication binder. All recommendations made by dialysis center will be acted upon.<br><br>DNS/designee will provide education to staff regarding communication with dialysis center.<br><br>Dietician will be contacted when diet orders have multiple nutrient different restrictions to ensure resident nutrient needs are met. If needed new orders will be obtained from MD<br><br>**4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?**<br>-<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive | |

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| | | | Director.<br><br>· CQI tool identified as Dialysis Communication will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br><br>· If Threshold of 100% is not met, an action plan will be developed to ensure compliance. | |
| F 0732 SS=D Bldg. 00 | 483.35(g)(1)-(4)<br>Posted Nurse Staffing Information<br><br>Based on observation and interview, the facility failed to post daily nurse staffing data timely.<br><br>Finding includes:<br><br>During an observation on 9/25/2024 at 10:43 A.M., the nurse staffing data posting form was observed to be dated 9/24/2024.<br><br>During an observation on 9/27/2024 at 8:02 A.M., the nurse staffing data posting fomr was observed to be dated 9/26/2024.<br><br>During an observation on 9/30/2024 at 8:34 A.M., the nurse staffing data posting form was observed to be dated 9/27/2024.<br><br>During an interview on 9/30/2024 at 10:44 A.M., the Executive Director indicated the Director of Nursing was responsible for posting the nurse | F 0732 | F Tag 732<br>SS=D<br><br>Posted Nurse Staffing Information<br><br>It is the policy of American Senior Communities to make staffing information readily available in a readable format and publicly posted to residents and visitors at any given time.<br><br>1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice.<br><br>No individual residents were | 10/18/2024 |

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| | staffing data every morning.<br><br>A policy was provided by the Regional Director of Nursing on 9/30/2024 at 1:04 P.M. The policy, titled, "Posted Staffing Data and Retention Requirements", indicated, " ...To allow public access to posted nursing staffing data per federal regulations ...It is the policy of [facility organization name] to make staffing information readily available in a readable format and publicly posted to residents and visitors at any given time ...." | | identified as affected by the deficient practice.<br><br>2 How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>No residents were identified as affected by the deficient practice.<br><br>3 What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.<br><br>All staff were educated on 10/15/24 regarding the location and the importance of the required staff posting.<br>Executive Director, DNS/Designee will review and confirm the required nurse staff posting in posted for each day and the start of each shift.<br><br>4 How will the facility monitor its corrective action to ensure that the deficient practice will not recur.<br><br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being bimonthly, and is overseen by the Executive Director. | |

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| | | | · CQI tool identified as Nurse staff posting will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br><br>· If Threshold of 100% is not met, an action plan will be developed to ensure compliance. | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br><br>Based on observation, interview and record review, the facility failed to ensure medication carts were free from loose pills and failed to ensure medications were labeled in 1 of 2 medication storage areas observed. (Front hall medication cart)<br><br>Finding includes:<br><br>During an observation of the front hall medication cart, on 9/30/2024 at 10:28 A.M. with RN 4, the following was observed:<br>- an opened bottle of Dr. Love Roar dietary supplement with no resident identifiers.<br>- opened containers of Equate allergy relief, Equate gas relief and a container of Relaxium sleep tablets all with no resident identifiers.<br>- and there were 3 looses pills in the mediation cart drawers.<br><br>During an interview, on 9/30/2024 at 10:36 A.M., | F 0761 | F 761 Label/Store Drugs and Biologicals<br>SS=D<br><br>It is the policy of this facility to store medications in a clean and orderly manner.<br>**1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>No individual residents were identified to be affected by this deficient practice.<br><br>2. **How other residents having** | 10/18/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155406 | A. BUILDING 00<br>B. WING | 09/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HICKORY CREEK AT PERU | 390 W BOULEVARD<br>PERU, IN 46970 |

| (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 |
|---|---|---|---|---|
| | RN 4 indicated the pill containers should have had labels on them and there should be no loose pills in the medication cart.<br><br>On 9/30/2024 at 12:45 P.M., the Director of Nursing provided a printed sheet titled "Clinical Nurse Highlight- Medication Storage", and indicated this was the policy currently used by the facility. The policy indicated"...Medication storage areas should always be clean and orderly... Medications are properly labeled with patient name, lot #, and expiration date. Over-the-counter med's for individual patients should have the patients name and expiration date noted on the medication (follow state regulations)...."<br><br>3.1-25(j) | | **the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>No other residents were identified to be affected by this deficient practice.<br><br>**3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>Nursing staff, RN's LPN's and QMA's were re-educated on 10 /15/2024 on the policy for Labeling and Storage of Drugs and Biologicals.<br><br>DNS/Designee will review medication storage areas weekly for 4 weeks, monthly for 6 months, and quarterly thereafter.<br><br>**4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?**<br><br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | | · CQI tool identified as medication storage will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br><br>· If Threshold of 100% is not met, an action plan will be developed to ensure compliance. | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br><br>Based on observation and interview, the facility failed to ensure infection control practices were followed when administering insulin for 1 of 1 resident reviewed for insulin administration. (Resident 13)<br><br>Finding includes:<br><br>During an observation, on 9/27/2024 at 7:33 A.M., RN 4 washed her hands and applied gloves. She cleansed Resident 13's left outer arm with an alcohol pad and with an opened hand, she fanned the area she had just cleansed.<br><br>During an interview, on 9/27/2024 at 7:35 A.M., RN 4 indicated she should not have fanned the area.<br><br>On 9/30/2024 at 12:45 P.M., the Director of Nursing provided a "Skills Competency titled Insulin Pen Administration", dated 10/2019, and indicated the policy was the one currently used by the facility. The policy indicated"...14. Cleanse | F 0880 | F Tag 880<br>SS=D<br><br>Infection Prevention & Control<br><br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Resident 13<br><br>2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>All residents in this facility have | 10/18/2024 |

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| | injection site with alcohol swab and allow to dry...."<br><br>3.1-18(a) | | the potential to be affected by this practice.<br><br>**3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>Nursing staff re-education was held on 10/15/2024 where Insulin Pen Administration skills competency was reviewed. The Director of Nursing or designee will conduct observations to ensure appropriate use of Insulin Pen Administration.<br><br>**4. How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?**<br><br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.<br><br>· CQI tool identified as insulin pen administration will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br><br>· If Threshold of 100% is not | |

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| | | | met, an action plan will be developed to ensure compliance. | |