STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155430	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HICKORY CREEK AT ROCHESTER	340 E 18TH STREET ROCHESTER, IN 46975

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the ombudsman notified of residents discharge for 2 of 3 residents reviewed for hospitalization . (Resident 15 & 23) Findings include: 1. During an interview, on 3/1/2020 at 11:11 AM., Resident 15 indicated he had been in the hospital 3 times. A clinical record review was completed on 3/3/2020 at 3:29 P.M., and indicated Resident 15's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 1/21/2020, indicated Resident 15 had a BIMS (Brief Interview for Mental Status) score of 14, cognition intact. A nurses note, dated 7/7/2019, indicated the resident was admitted to the hospital for pneumonia. A nurses note, dated 9/4/2019, indicated the resident was admitted to the hospital for possible aspiration. A nurses note, dated 12/3/2019, indicated the resident was admitted to the hospital for low pulse, neck and arm pain and inability to stand. A nurses note, dated 12/24/2019, indicated the resident was admitted to the hospital for respiratory issues. During an interview, on 3/4/2020 at 1:36 P.M., the Social Service staff indicated she had no documentation to show the ombudsman was notified of Resident 15's discharges to the hospital. 2. A clinical record review was completed on 3/4/2020 at 9:53 A.M., and indicated Resident 23's [DIAGNOSES REDACTED]. A progress note, dated 1/30/2020, indicated Resident 23 was sent to the hospital. A progress note, dated 1/30/2020, indicated Resident 23 was admitted to the hospital with [REDACTED]. During an interview, on 3/4/2020 at 2:30 P.M., the Social Service Director indicated the Ombudsman had not been notified of Resident 23's discharge to the hospital. On 3/4/2020 at 4:15 P.M., the Director of Nursing provided the policy titled, Interfacility Transfers/Discharges, dated 6/2017, and indicated the policy was the one currently used by the facility. The policy indicated .Copies of notices for emergency transfers must also be sent to the ombudsman. A list of residents who have had emergency transfers and a copy of the associated notice of transfer will be sent to the ombudsman on the last working day of each month 3.1-12(a)(6)(A)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure hydration and individualized dementia care plans were in place for 2 of 13 residents whose care plans were reviewed. (Resident 6 & 7) Findings include: 1. A clinical record review was completed, on 3/1/2020 at 12:31 P.M., and indicated Resident 6's [DIAGNOSES REDACTED]. A progress note, dated 2/14/2020, indicated Resident 6 had a critically high sodium of 162. A progress note, dated 2/14/2020, indicated Resident 6 was to have normal saline solution running at 150 ml (milliliters) an hour for 48 hours and to encourage food and drink. The medical record had no dehydration care plan in place to address Resident 6's needs. During an interview, on 3/4/2020 at 2:15 P.M., the DON (director of nursing) indicated Resident 6 should have a risk for dehydration care plan, however one was not completed. 2. A clinical record review was completed on 3/03/2020 at 8:03 A.M., and indicated Resident 7's current [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 7/11/2019, indicated Resident 7 had a BIMS (Brief Interview for Mental Status) score of 3, severe cognitive impairment. A current, 9/17/2019, care plan problem indicated the resident had a [DIAGNOSES REDACTED]. Interventions included redirect resident to thoughts that are pleasant, allow her to voice her feelings, take to a quiet area and reassure resident things are fine. During an interview, on 3/4/2020 at 11:55 A.M., the Social Service staff indicated the care plans were not individualized for Resident 7's dementia. On 3/4/2020 at 4:10 P.M., the Director of Nursing provided the policy titled, Care Planning-Comprehensive, dated 7/2018, and indicated the policy was the one currently used by the facility. The policy indicated .The facility will develop and implement a comprehensive person-center care plan for each resident that included measurable objectives and timeframe's to meet a resident's medical, nursing, mental and psychosocial well-being. Person- centered care: means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives 3.1-35(a)
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure pressure ulcers were assessed weekly and staged appropriately for 1 of 1 residents reviewed for pressure ulcers. (Resident 7) Finding includes: A clinical record review was completed on 3/03/2020 at 8:03 A.M., and indicated Resident 7's current [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 7/11/2019, indicated Resident 7 had a BIMS (Brief Interview for Mental Status) score of 3, indicating severe cognitive impairment and required extensive assist of 1 staff for bed mobility, dressing and eating, extensive assist of 2 staff for transfers and toilet use and was at risk for pressure ulcers but had none. A nurse's note, dated 9/17/2019, indicated the resident was noted to have 4 x 4 round shaped pressure area on her inner left heel. The area was intact, purplish in color and the skin was non blanchable. Staff were reeducated on proper positioning techniques and an order for [REDACTED]. Current treatment plan: [REDACTED]. Resident 7 was admitted to the hospital on [DATE] and returned to the facility on [DATE]. The next wound assessment was completed 3 days later on 9/30/2019. The wound type was pressure; wound stage; DTI; wound size: 4.5 cm x 7.0 cm x 0; wound bed: closed/ [MEDICATION NAME] (wound with new tissue) to the left heel. Current treatment plan: [REDACTED]. A weekly wound assessment, dated 10/2/2019, indicated: wound type: pressure; wound stage DTI; wound size; 4.5 x 7.0 x 0; wound bed: closed/[MEDICATION NAME] to the left heel. Current treatment plan: [REDACTED]. The next wound assessment was completed 9 days later. A weekly wound assessment, dated 10/11/2019, indicated: wound type: pressure; wound stage DTI; wound size 4.5 x 8.0 x 0; wound bed: closed/[MEDICATION NAME] to the left heel. Current treatment plan: [REDACTED]. The next wound assessment was completed 14 days later. A weekly wound assessment, dated 11/1/2019, indicated: wound type; pressure: wound stage DTI: wound size 3.0 x 3.5 x 0. wound bed: closed/[MEDICATION NAME] to the left heel. Current treatment plan: [REDACTED]. Apply skin prep, dry then apply gauze and change daily. A weekly wound assessment, dated 11/22/2019, indicated: wound type; pressure: wound stage DTI: wound size 2.0 x 1.0 x 0; wound bed: closed/[MEDICATION NAME] to the left heel. Current treatment plan: [REDACTED]. No drainage and no [DIAGNOSES REDACTED] (redness). Continue current treatment. The next wound assessment was completed 11 days later. A weekly wound assessment, dated 12/9/2019, indicated: wound type; pressure: wound stage DTI: wound size 1.5 x 1.0 x 0: wound bed:

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) closed/[MEDICATION NAME] to the left heel. Current treatment plan: [REDACTED]. No drainage and no [DIAGNOSES REDACTED]. Continue current treatment. The next wound assessment was completed 10 days later on 12/19/2019. A weekly wound assessment, dated 12/19/2019, indicated: wound type; pressure: wound stage DTI: wound size 1.5 x 0.8 x 0: wound bed: closed/[MEDICATION NAME] to the left heel. Current treatment plan: [REDACTED]. No drainage and no [DIAGNOSES REDACTED]. Continue current treatment. A weekly wound assessment, dated 2/13/2020, indicated: wound type; pressure: wound stage DTI: wound size 0.6 x 0.9 x 0: wound bed: closed/[MEDICATION NAME] to the left heel. Current treatment plan: [REDACTED]. No drainage or odor noted. Continue current treatment of [REDACTED]. Current treatment plan: [REDACTED]. Will change treatment to Santyl (a [MEDICATION NAME] agent for dead tissue) ointment and dry dressing daily. A weekly wound assessment, dated 2/26/2020, indicated: wound type; pressure: wound stage DTI: wound size 0.6 x 0.9 x 0.3: wound bed: closed/[MEDICATION NAME] to the left heel. Current treatment plan: [REDACTED]. Treatment changed to skin prep daily. A nurses note, dated 2/26/2020, indicated Resident 7 had a new deep tissue injury to her right heel. New orders for low air loss mattress, skin prep three times a day and protective padded boot. A weekly wound assessment, dated 2/26/2020, indicated: wound type; pressure: wound stage DTI: wound size 4.0 x 4.5 x 0: wound bed: 100% eschar: to the right heel. Current treatment plan: [REDACTED]. Interventions included, but were not limited to: apply heel protectors, foot buddy to wheel chair. On 3/03/2020 at 11:05 A.M., Resident 7's pressure ulcer was observed. Licensed Practical Nurse 4, indicated she was unsure of what they were staging the area to the left heel at. The area presented as a white calloused area measuring 1 cm x 0.6 cm . LPN 4 indicated the treatement was for skin prep and padding daily. On 3/3/2020 at 11:07 A.M., Resident 7's pressure ulcer was observed. LPN 4 indicated the pressure area to the right heel was an unstageable, with a dark purplish/black area of firmness measuring 3 x 2.4 and the depth was undetermined. She indicated the treatment was skin prep daily and padding. On 3/03/2020 at 2:39 P.M., the Director of Nursing indicated the pressure wound should have been assessed weekly, and indicated the pressure area was not stage correctly and should not have had a [MEDICATION NAME] agent for granulation tissue. On 3/4/2020 at 4:10 P.M., the Director of Nursing provided the policy titled, Development and Staging of Pressure Ulcers, dated 6/2009, and indicated the policy was the one currently used by the facility The policy indicated . The staging of pressure ulcers depicts tissue damage related to pressure, shear, or friction over a bony prominence. Pressure ulcers are staged using a universal system from the Wound Ostomy, and Continence Nurse (WOCN) Society and the National Pressure Ulcer Advisory Panel. Each stage reflects the type and depth of observed damage. Staging in intended to show tissue destruction, not healing . Stage III: Full thickness skin loss involving damage or necrosis of subcutaneous tissue, which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater, with or without undermining of adjacent tissue. Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures, such as tendon, or joint capsule. As per RAI Manual guidelines, if necrotic eschar is present, prohibiting accurate staging, the skin ulcer will be coded as a Stage IV until the eschar has been debrided to allow staging 3.1-40(a)(2)
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based in interview and record review, the facility failed to ensure an adequate indication for the increase of medication and ensure target behaviors were documented for 3 of 5 residents reviewed for unnecessary medications(Residents 6, 7 & 22) Findings include: 1. A clinical record review was completed, on 3/3/2020 at 2:40 P.M., and indicated Resident 6's [DIAGNOSES REDACTED]. A progress note, dated 11/17/2019, indicated Resident 6 had a new order to increase [MEDICATION NAME] (a mood stabilizing medication) to 500 mg(milligrams) twice a day. A progress note, dated 11/22/2019, indicated Resident 6 had new orders to increase [MEDICATION NAME] to 500 mg three times a day, due to increased behaviors. A progress note, dated 12/2/2019, indicated Resident 6 had a new order for [MEDICATION NAME] (an antidepressant medication)10 mg(milligrams). A progress note, dated 2/13/2020, indicated Resident 6 had a new order for [MEDICATION NAME] 25 mg at bedtime for two weeks and then to begin [MEDICATION NAME] (a mood stabilizing medication) 50 mg at bedtime. Resident 6's medical record did not indicate a documented increase in behaviors prior to the increase in the medications. During an interview, on 3/4/2020 at 3:00 P.M., the Social Service Director indicated she did not have any further behaviors documented in her record. 2. A clinical record review was completed, on 3/4/2019 at 9:19 A.M., and indicated Resident 22's [DIAGNOSES REDACTED]. A physicians order, dated 7/1/2019, indicated Resident 22 was ordered to receive [MEDICATION NAME] (a mood stabilizing medication) 250 mg (milligrams) twice a day for unspecified mood disorder. Resident 22's medical record did not provide a targeted behavior for the use of [MEDICATION NAME]. During an interview, on 3/4/2020 at 3:00 P.M., the Social Service Director indicated she did not have any other documented target behaviors available. 3. A clinical record review was completed on 3/3/2020 at 3:29 P.M., and indicated Resident 15's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 1/21/2020, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 14, cognition intact. A Behavioral Medicine Evaluation Management Note, dated 12/2/2019, indicated the staff had reported the resident made paranoid statements daily. The treatment plan was to start [MEDICATION NAME] (an antipsychotic) medication 25 mg (milligrams) twice daily for paranoia and hallucinations. A Behavioral Medicine Evaluation Management Note, dated 1/6/2020, indicated Resident 15 had tolerated the initiating of the [MEDICATION NAME] and the staff had reported the resident still had some paranoia. The treatment plan was to increase the [MEDICATION NAME] to 50 mg twice daily. A Behavior monitoring record for Resident 15 indicated he had been monitored for the following behaviors: 1. Depression/Psychotic behavior. 2. Verbally inappropriate. 3. Resistive. 4. Irritable/Anger. 5. [MEDICAL CONDITION]. 6. Verbal agitation. 7. Delusions. The Behavior Log, dated December 2019, indicated Resident 15 had one behavior #4 (irritable/anger) on 12/23/2019. The Behavior Log, dated January 2020, listed the following behaviors: one behavior of rudeness on 1/1/2020. one behavior of refusing, rudeness and yelling on 1/5/2020. The January Behavior log lacked documentation of any behaviors of, #1 Depression/Psychotic, #7 delusions, or any paranoid statements prior to the increase of the [MEDICATION NAME]. During an interview, on 3/4/2020 at 2:33 P.M., the Director of Nursing indicated the behaviors did not warrant an increase of the [MEDICATION NAME]. On 3/4/2020 at 4:15 P.M., the Director of Nursing provided the policy titled, Medication-Unnecessary, dated 6/2004 and revised 11/2017, indicated the policy was the one currently used by the facility. The policy indicated .1. Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used: In excess dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 2 .Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs 3.1-48(b)(1) 3.1-48(b)(2)