STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HICKORY CREEK AT HUNTINGTON	**1425 GRANT ST HUNTINGTON, IN 46750**

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 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure timely medical treatment was provided and the physician was notified following a critical low blood glucose level and an unresponsive episode, which resulted in hospitalization for 1 of 10 reviewed for quality of care (Resident E). Findings include: The clinical record for Resident E was reviewed on 8/24/20 at 10:59 a.m. [DIAGNOSES REDACTED]. A health care plan, dated 2/15/19, indicated I have diabetes and am at risk for hypo/hyperglycemic episodes Interventions included, but were not limited to, blood sugar checks as ordered and notify physician of result. An order, dated 3/3/20 at 4:11 p.m., indicated .new order given for (sic) monitor to alarm when BS (blood sugar) gets to 60 and to notify NP (nurse practitioner) Resident E had an order, dated 1/29/20, which indicated to administer [MEDICATION NAME] (to treat severe hypoglycemic) 1 mg intramuscularly as needed for a hypoglycemic reaction. The order indicated to recheck blood sugar after 15 minutes. No specific blood glucose level was specified. A progress note, dated 3/13/20 at 11:05 a.m., indicated At approx (approximately) 1105, CNA came to this nurse and reported that resident was not responding to her and his BG (blood glucose) monitor was reading low got Accucheck supplies and went to residents room to check BS (blood sugar) manually. Accucheck read low. This nurse asked nurse down the hall for help and went to get a [MEDICATION NAME] (to treat severe low blood sugar). Injection was given at 1110. BS read 24 after a couple of minutes .rubbed glucose gel on residents gums and under tongue. BS went up to 51. At that time other nurse told this nurse that she and CNA would stay with resident while this nurse went on to get the rest of the buildings blood sugars before lunchtime. A progress note, dated 3/13/20 at 11:30 a.m., indicated .called into room by CNA and Floor (sic) nurse for assistance, when writer entered room res (resident) was non-responsive and nurse stated blood sugar monitor read LOW, writer instructed floor nurse to get [MEDICATION NAME] injection and gave it .CNA and writer stayed with resident .writer and CNA remained with res to monitor blood sugar was rechecked about 5 minutes after injection and monitor read 25, res was still unresponsive. sugar (sic) paste was placed in res cheek while waiting for injection to get into res system, about 11:45am blood sugar was rechecked and read 51. CNA and writer continued to attempt to get res to respond and res showed some eye movements performed sternal rub and res had slight reaction blood sugar rechecked at 11:55am and read 82 stayed with res allowing blood sugar to come up more and res remained unresponsive but showing signs of slight responsiveness slight mouth movements and attempting to drink, small amounts of orange juice placed in res cheek and res swallowed it rechecked at 12:10 pm and read 137, and again at 12:15 and read 153. Vitals obtained HR: 125, Temp 96.0, BP 131/66, warm wash clothes (sic) placed on res head and armpits to help with temp still remains unresponsive and 911 was notified. 12:25 blood sugar reading 167. ambulance (sic) arrived to facility about 12:30 pm. res (sic) was transferred to gurney and taken to hospital. A progress note, dated 3/13/20 at 12:18 p.m., indicated the Assistant Director of Nursing (ADON) was notified of Resident E's condition, vital signs and blood, glucose level. The ADON notified the Nurse Practitioner (NP) of the blood glucose levels and indicated the resident had received [MEDICATION NAME] and was still not responding to verbal stimuli. The NP gave an order to send the resident to the hospital. On 3/13/20 at 12:37 p.m., Resident E was transported to the local hospital. He returned to the facility on [DATE]. Review of a transfer form, dated 3/13/20 at 12: 47 p.m., indicated Resident E was not alert. On 3/13/20 at 8:00 a.m., the Medication Administration Record [REDACTED]. Review of the MAR, [MEDICATION NAME] (treat very low blood sugar) 1 mg was given at 11:10 a.m. by RN 1. During an interview on 8/25/20 at 9:29 a.m., LPN 2 indicated RN 1 went in to check the resident's blood sugar or an aide told her he was out of it. She thought RN 1 had given the injection and the sugar gel was already in the room. LPN 2 thought she was checking his blood glucose levels but she was not sure and RN 1 was getting his vital signs. The Assistant Director of Nursing (ADON) and Director of Nursing (DON) had gone to assess someone and when they came back they sent him out. She indicated she did not call the physician, but thought his blood glucose parameters were set at 40 for low and 400 for high, but it could be 50 or 60. She just kept thinking his blood sugar level would come up. During an interview on 8/25/20 at 9:30 a.m., RN 1 indicated they had just passed drinks for lunch and they left a drink on his bedside table. When she came around to do his blood sugars he was very diaphoretic. She was at his room and he did not respond to her. LPN 2 came to help her, got the [MEDICATION NAME] and stayed in the room with him. They did give him the sugar gel and they were able to get some orange juice down his throat. LPN 2 indicated his blood sugar had low before and have let the blood sugars come up. Even after his blood sugars came up he was still not coming around. The DON and ADON had went somewhere and then came back and said that he needed to go out. They were waiting to see if his blood sugars came up and always notified the NP, but was not sure why she did not document it. She did go ahead and finish her afternoon blood sugars. On 8/25/20 at 11:26 a.m., the ADON indicated when they came back, the resident was not responding or answering questions. When they walked into the building, the aides grabbed them and said to go to his room. When she saw the resident, she knew immediately and had the DON call 911. She was unsure of why they did not send the resident to the hospital. During an interview on 8/26/20 at 1:08 p.m., the DON indicated her and the ADON had left the building to find hand sanitizer. When they got back to the facility, a CNA came to them and said something was wrong with Resident E. They had gotten food for the staff and as she put it in the break room, she could see into his room. The ADON was already in the room then left to call 911. The resident can have very low blood sugars and still carry on a conversation. She was very upset with the incident and provided a teaching moment for both nurses'. Review of a facility policy, dated 6/04 and revised 2/19, titled Diabetic Testing, provided by the DON on 8/24/20 at 2:10 p.m., indicated the following: POLICY: .DOCUMENTATION: .Blood glucose level in mg/dl, including time and date of test. Physician notification in blood glucose level is above or below normal range, as indicated by the parameters set by physician's orders [REDACTED].; and notify, consistent .when there is: An accident . A significant change in the resident's physical, mental, or psychosocial status, such as a .life-threatening conditions or clinical complications This Federal Tag relates to complaints IN 520, IN 463, IN 039, IN 980, and IN 411. 3.1-37(a)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide adequate supervision to prevent a resident from consuming another resident's medication for 1 of 3 residents reviewed for medication errors (Resident D). Findings include: On 8/24/20 at 9:30 a.m. Resident D was ambulating independently in a merry walker in the hallway near the nurses station. Resident D's clinical record was reviewed on 8/24/20 at 1:15 p.m. [DIAGNOSES REDACTED]. dementia in other diseases classified elsewhere with behavioral disturbance, [MEDICAL CONDITION] disorder, [MEDICAL CONDITION] type and major [MEDICAL

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) CONDITION]. Her medications on 5/29/20, included but were not limited to, [MEDICATION NAME] sodium delayed release (anticonvulsant) 375 milligrams (mg) daily, [MEDICATION NAME] sodium delayed release 500 mg twice daily, [MEDICATION NAME] (antianxiety) 0.5 mg three times daily, [MEDICATION NAME] sodium (stool softener)100 mg twice daily, [MEDICATION NAME] (antitremor) 2 mg daily, [MEDICATION NAME] 1 mg daily, [MEDICATION NAME] (antimanic)150 mg daily, [MEDICATION NAME] 300 mg daily, sertaline [MEDICATION NAME] (HCL) (antidepressant) 7.5 milliliters (ml) daily and [MEDICATION NAME] (antipsychotic) 150 mg twice daily. A quarterly Minimum Data Set (MDS), dated [DATE] indicated the resident was severely cognitively impaired. A focused care plan, initiated on 2/7/19, indicated at times the resident would take others food or drinks. Her goal was she would have no negative outcomes from taking others food through next review. Interventions included, offer her something to eat, redirect her form the area and redirect her to an activity she may enjoy. A health status note, dated 5/29/20 at 6:55 p.m., indicated the resident was in the dining room in merry walker, she took a swallow of a drink of another resident, containing the medications of the other resident. Resident was not showing adverse side effects at that time. Resident D was up and walking in merry walker. Nurse Practitioner was notified, no new orders were given. Administrator, DON, and Power of Attorney (POA) were also notified. A Medication Error Report, dated 5/30/20 and completed by the Assistant Director of Nursing (ADON), indicated the time/date of the medication error was 5/30/20 at 5:30 p.m. The medication ordered was [MEDICATION NAME] and [MEDICATION NAME], the medication given was [MEDICATION NAME] and [MEDICATION NAME]. Resident D took another resident's medication and was unable to determine the amount taken due to the medication was in liquid. Corrective measures taken were staff were educated on proper procedure and order to place in one bite of food to be give to all residents. On 8/25/20 at 9:56 a.m., the Administrator indicated the medication error was not reported due to the facility policy which indicated they only report if the resident would require additional treatment outside of the facility. During an interview with the Director of Nursing (DON) on 8/25/20 at 11:54 a.m., she indicated she was in her office at the time of the medication error. QMA 17 had given the other resident's medication in a cup, she wasn't sure if QMA 17 had just turned her back and Resident D took a drink out of it. Nurse 21 was in the dining room also due to a nurse needed to be present when the residents were eating. The ADON made an error of the date and time the medication error occurred on the Medication Error Report. An inservice was completed on proper medication pass and the medication policy was reviewed during the education with QMA 17. Medication Administration Observation form, dated 5/11/20, provided by the DON on 8/25/20 at 12:12 p.m. for QMA 17, indicated she was observed during a medication pass. The DON indicated there was no documentation for education provided, had a conversation or a reminder with QMA 17. An inservice, titled Documentation, Medication, dated 5/18 and 5/20 at 1:00 p.m., provided by the ADON on 8/25/20 at 12:18 p.m., indicated the ADON provided education for risk management, investigations and medication administration. The inservice indicated QMA 17 and LPN 21 attended the inservice. An interview with QMA 17 on 8/25/20 at 12:28 p.m., she indicated they were sitting down for supper and they were handing out trays to the residents, she had her back towards the resident that she had put her medication in her liquid and Resident D took a drink, she took the cup away from Resident D and reported it. She was reeducated verbally by the ADON to put the medication in the residents food rather than the drink. She usually puts their medication in their super pudding when the tray comes out of the kitchen and before it gets to the resident, some residents will not take their medication so they put it in their food. She usually tries to give the residents the first bite with the medication in it. A review of a current facility policy, titled Accident/Incident/Reportable/State Officials - Indiana, revised 7/15 and provided by the Administrator on 8/25/20 at 9:56 a.m., indicated the following: .6. Occurrence that Directly Threatens the Welfare, Safety, or Health of a Resident . Examples . medical errors resulting in outcomes that require medical treatment beyond an ER/Physician evaluation or monitoring vital signs A review of a current policy titled, Medications - General Policies, revised 5/13 and provided by the DON on 8/25/20 at 11:54 a.m., indicated the following: .Administration of Medications .5. Administer the medication. Remain in the room while the resident takes the medication This Federal Tag relates to complaints IN 520, IN 463, IN 039, IN 980, and IN 411. 3.1-45(a)