STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Scottsburg	1100 N Gardner Ave Scottsburg, IN 47170

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34231 Based on observation, interview and record review, the facility failed to ensure physician orders were followed for residents during medication administration for 3 of 5 residents reviewed for pharmacy services. (Resident's B, C, F and G) Findings included: 1. The clinical record for Resident B was reviewed on 12/5/24 at 12:12 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure and gastroesophageal reflux disease. The December 2024 physician's orders indicated the resident was to receive the following morning medications: - Calcium carbonate (TUMS), 500 mg tablets, give 2 1/2 tabs to equal 1,250 mg - Advair Diskus (COPD) 250-50 mcg (microgram)/dose, one puff via inhalation. Special instructions rinse mouth after use. During a medication administration observation on 12/6/24 at 9:17 a.m., QMA (Qualified Medication Aide) 4 was observed to remove 2 tablets from the bottle of calcium carbonate rather than 2 1/2 tabs and the QMA did not take the Advair Diskus into the resident's room during the medication administration observation. During an interview on 12/6/24 at 9:55 a.m., the Director of Nursing indicated the resident typically refused the Advair Diskus, however, QMA 4 should have taken the medication to the resident during the medication pass and offered the medication to the resident. During an interview on 12/6/24 at 11:26 a.m., LPN (Licensed Practical Nurse) 5 indicated all physician orders were to be followed. 2. The clinical record for Resident C was reviewed on 12/5/24 at 12:39 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and diabetes. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2024 physician's orders indicated the resident was to receive the following morning medications: - Breo Ellipta (inhaled medication for COPD) 200-25 mcg/dose, one puff via inhalation. Special instructions: After use rinse mouth and spit. - Incruse Ellipta (COPD) 62.5 mcg, one puff via inhalation. Special Instructions: Rinse mouth after use. On 12/6/24 at 8:55 a.m., during the medication administration observation, QMA 4 did not have the resident rinse out her mouth after the use of both inhalers. 3. The clinical record for Resident G was reviewed on 12/6/24 at 10:55 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and iron deficiency anemia. - Advair HFA aerosol inhaler (COPD) 115-21 mcg/actuation, 2 puffs via inhalation: Special instructions: Rinse mouth and spit. On 12/6/24 at 7:42 a.m., during the medication administration observation, QMA 4 did not have the resident rinse and spit after the administration of the Advair Diskus. On 12/6/24 R 9:55 a.m., the Director of Nursing provided a current copy of the document titled General Dose Preparation and Medication Administration dated 4/30/24. It included, but was not limited to, Procedure .Prior to Administration .Facility staff should take all measures required by facility policy and applicable law .Verify each time a medication is administered that is is the correct .dose .Follow manufacturer medication administration guidelines This Citation relates to Complaints IN00447152 and IN00447339. 3.1-25(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34231 Based on interview and record review, the facility failed to ensure a resident's (Resident D) medication administration record reflected the administration of narcotic medication for 1 of 3 residents reviewed for medical records. Findings include: The clinical record for Resident D was reviewed on 12/5/24 at 1:29 p.m. The resident's diagnoses included, but were not limited to, irritable bowel syndrome, anxiety and pain. The physician's order, dated 2/8/22, indicated the resident was to receive Xanax (narcotic antianxiety medication) 0.5 mg (milligrams) twice daily for anxiety at 9:00 a.m. and 9:00 p.m. Review of the October 2024 controlled substance record indicated the resident received the medication on the following dates and times: - 10/04/24 at 8:00 p.m. - 10/07/24 at 8:00 p.m. - 10/08/24 at 8:00 p.m. - 10/10/24 at 8:00 a.m. - 10/18/24 at 8:00 p.m. - 10/21/24 at 8:00 p.m. The resident's October 2024 Medication Administration Record lacked documentation of the administration of the medication. The physician's order, dated 3/15/22, indicated the resident was to receive Viberzi 75 mg twice daily for irritable bowel syndrome at 9:00 a.m. and 9:00 p.m. Review of the October 2024 Controlled Substance Record indicated the resident received the medication on the following dates and times: - 10/04/24 at 8:00 p.m. - 10/07/24 at 8:00 p.m. - 10/08/24 at 8:00 p.m. - 10/10/24 at 8:00 a.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10/18/24 at 8:00 p.m. - 10/21/24 at 8:00 p.m. The resident's October 2024 Medication Administration Record lacked documentation of the administration of the medication. The physician's order, dated 4/23/24, indicated the resident was to receive hydrocodone-acetaminophen (narcotic) 5-325 mg twice daily for pain at 9:00 a.m. and 9:00 p.m. Review of the October 2024 Controlled Substance Record indicated the resident received the medication on the following dates and times: - 10/04/24 at 8:00 p.m. - 10/07/24 at 8:00 p.m. - 10/08/24 at 8:00 p.m. - 10/10/24 at 8:00 a.m. - 10/18/24 at 8:00 p.m. - 10/21/24 at 8:00 p.m. The resident's October 2024 Medication Administration Record lacked documentation of the administration of the medication. During an interview on 12/6/24 at 11:26 a.m., LPN (Licensed Practical Nurse) 5 indicated when a narcotic medication had been administered, the nurse would sign the medication as administered on the medication administration record. On 12/6/24 at 9:55 a.m., the Director of Nursing provided a current copy of the document titled General Dose Preparation and Medication Administration dated 4/30/24. It included, but was not limited to Procedure . Document the administration of controlled substances in accordance with applicable law .After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to .Document necessary medication administration This Citation relates to Complaints IN00447152 and IN00447339 3.1-50(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34231 Based on observation, interview and record review, the facility failed to ensure staff hand sanitized during a medication pass and failed to ensure staff did not touch medications prior to medication administration for 6 of 6 residents reviewed for infection control. (Resident's B, C, E, F, G and H) Findings include: 1. The clinical record for Resident B was reviewed on 12/5/24 at 12:12 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic respiratory failure and gastroesophageal reflux disease (GERD). The December 2024 physician's orders indicated the resident was to receive the following morning medications: Anastrozole (cancer medication), Propranolol (hypertension), Folic acid (supplement), Isosorbide mononitrate (hypertension), Pimidone (tremors), Eliquis (blood thinner), Calcium carbonate (TUMS), Advair Diskus (COPD), Omeprazole (GERD), Claritin (allergies), Diltiazem (atrial fibrillation), Preservision (eye vitamin), Zoloft (depression), and Magnesium oxide (supplement). During a continuous medication administration observation on 12/6/24 at 9:17 a.m., QMA (Qualified Medication Aide) 4 was observed to remove 2 tablets from the bottle of calcium carbonate into her bare left hand and place in the medication cup. QMA 4 then removed the 2 tablets from the medication cup and placed in another medication cup with her bare fingers. Prior to this, QMA 4 had removed her medication cart keys from her pocket and unlocked the medication cart. She then opened the medication cart drawer with her right hand. She removed the medications from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not hand sanitize prior to or after the medication administration to the resident. On 12/6/24 at 9:25 a.m., QMA 4 indicated when passing medications staff were not suppose to touch the medications with their bare hands. During an interview on 12/6/24 at 11:26 a.m., LPN Licensed Practical Nurse) 5 indicated during a medication pass, hands should be sanitized before and after each resident. 2. The clinical record for Resident C was reviewed on 12/5/24 at 12:39 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and diabetes. The December 2024 physician's orders indicated the resident was to receive the following morning medications: Myrbetriq (overactive bladder), Breo Ellipta (inhaled medication for COPD), Acetaminophen (pain), Hydroxychloroquine (rheumatoid arthritis), Isosorbide mononitrate (COPD), Levetiracetam (seizure medication), Spironolactone (heart failure), Cymbalta (depression), Paxil (depression), Clonazepam (seizures), Morphine (pain), Incruse Ellipta (COPD), Depakote (schizoaffective disorder), Seroquel (schizoaffective disorder), and Oxybutynin chloride (overactive bladder). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous medication administration observation on 12/6/24 at 8:55 a.m., QMA 4 was observed to remove her medication cart keys from her pocket and unlocked the medication cart. She then opened the medication cart drawer with her right hand. She removed the medications from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not hand sanitize prior to or after the medication administration to the resident. 3. The clinical record for Resident E was reviewed on 12/6/24 at 10:30 a.m. The resident's diagnoses included, but were not limited to, malignant neoplasm of the pharynx and chronic obstructive pulmonary disease. The December 2024 physician's orders indicated the resident was to receive the following morning medications: Eliquis (blood thinner), Ondansetron (nausea), Docusate Sodium (constipation), Sodium Chloride (hyponatremia), Diphenhydramine (antihistamine), and Tramadol (pain medication). During a continuous medication administration observation on 12/6/24 at 7:29 a.m., QMA 4 was observed to remove her medication cart keys from her pocket and unlocked the medication cart. She then opened the medication cart drawer with her right hand. She removed the medications from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not hand sanitize after the medication administration to the resident. 4. The clinical record for Resident F was reviewed on 12/6/24 at 10:48 a.m. The resident's diagnoses included, but were not limited to, mild dementia with mood disturbance, endometriosis and stage 3 kidney disease. The December 2024 physician's orders indicated the resident was to receive the following morning medications: Vitamin B12 (supplement), Carvedilol (hypertension), Potassium Chloride (supplement), Omeprazole (GERD), and Alprazolam (anxiety). During the continuous medication administration observation on 12/6/24 at 7:35 a.m., QMA 4 entered the resident's room and obtained the resident's blood pressure. QMA 4 then walked back to the medication cart had removed her medication cart keys from her pocket and unlocked the medication cart. She then opened the medication cart drawer with her right hand. She removed the medications from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not sanitize her hands after she obtained the blood pressure or prior to or after the administration of the resident's medications. 5. The clinical record for Resident G was reviewed on 12/6/24 at 10:55 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and iron deficiency anemia. The December 2024 physician's orders indicated the resident was to receive the following morning medications: Advair HFA aerosol inhaler (COPD), Lamotrigine (epilepsy), Fluoxetine (depression), Clozapine (schizoaffective disorder), Polyethylene glycol (constipation), Ferrous Sulfate (anemia), Levetiracetam (epilepsy), Xanax (anxiety), Gemfibrozil (hyperlipidemia), Linzess (constipation), Haloperidol (schizoaffective disorder), Potassium Chloride (supplement), Sucralfate (dyspepsia), Tylenol Extra Strength (pain), and Saline Nasal mist (allergies). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the continuous medication administration observation on 12/6/24 at 7:42 a.m., QMA 4 had removed her medication cart keys from her pocket and unlocked the medication cart. She then opened the medication cart drawer with her right hand. She removed the medications from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not sanitize her hands before or after the administration of the resident's medications. 6. The clinical record for Resident H was reviewed on 12/6/24 at 11:03 a.m. The resident's diagnoses included, but were not limited to, end stage liver disease and depression. The December 2024 physician's orders indicated the resident was to receive the following morning medications: Escitalopram oxalate (depression), Folic acid (supplement), Spironolactone (diuretic), Thiamine (supplement), Xifaxan (irritable bowel), Zinc sulfate (supplement), and Omeprazole (GERD). During a continuous medication administration observation on 12/6/24 at 8:50 a.m., QMA 4 was observed to remove her medication cart keys from her pocket and unlocked the medication cart. She then opened the medication cart drawer with her right hand. She removed the medications from individualized package cards and touched her computer mouse after the removal of each medication from the cart. QMA 4 did not hand sanitize after the medication administration to the resident. On 12/6/24 at 9:55 a.m., the Director of Nursing provided a current copy of the document titled General Dose Preparation and Medication Administration dated 4/30/24. It included, but was not limited to, Procedure . Appropriate hand hygiene should be performed before and after direct resident contact .Medications should not come into contact with any surface except for the medication cup .Facility staff should avoid touching the medication with bare hands This Citation relates to Complaints IN00447152 and IN00447339. 3.1-18(a)