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	04/28/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34309 Based on record review and interview, the facility failed to ensure the physician was notified in a timely manner for 1 of 3 residents reviewed for a change in condition. (Resident 1) Findings include: The record for Resident 1 was reviewed on 4/24/25 at 1:37 p.m. The resident's diagnoses included but were not limited to chronic iron deficiency anemia secondary to blood loss, type 2 diabetes mellitus, schizoaffective disorder, bipolar disorder, epilepsy, functional dyspepsia, constipation, personal history of diseases of the digestive system, and atherosclerotic heart disease. The care plan, dated 8/17/20 and revised 4/24/25, indicated the resident was diabetic and at risk for hypoglycemic, hyperglycemic episodes related to the diagnosis. Possible negative outcomes of not following the prescribed diet. Consumes sugary snacks, ice cream, shakes, Pepsi and other items not on the resident's diet. Per the resident's preference, the resident kept these at her bedside and consumed through the day. The resident had a new diagnosis of a hernia with a recommendation to start 5 smaller meals starting November 2024. The interventions, dated 4/30/21, included, but were not limited to a diet per the medical doctor (MD) order for a regular diet of 3 small portion meals and 2 snacks, to honor preferences, and lab work as ordered with the results reported to the MD. Monitor blood sugars as needed for signs and symptoms of hypoglycemia or hyperglycemia. Nursing would notify the MD as needed, and provide medications as ordered. The physician's order, dated 9/21/23, indicated staff were to administer to the resident, 1 gram of carafate three times daily. The order was discontinued on 6/17/24. The physician's order, dated 9/25/23, indicated staff were to administer to the resident, 81 milligrams (mg) of chewable aspirin daily. The order was discontinued on 11/14/24. The nurse's note, dated 11/11/24 at 8:35 a.m., indicated Certified Nurse Aides (CNAs) reported the resident's vomiting to the Licensed Practical Nurse (LPN). Upon arriving to the resident's room, the resident had large brownish black emesis with little black spots in it. The resident complained of feeling bad, feeling sick and tired. The resident's vital signs were stable, however due to the appearance of possible blood in the emesis, the Nurse Practitioner (NP) gave an order to send the resident to a local hospital for evaluation and treatment. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's evaluation, dated 11/15/24 at 10:46 a.m., indicated an order to increase the protonix to twice daily and to add carafate. The resident had an upper endoscopy, which showed grade 4 esophagitis with a hiatal hernia. The resident had been on aspirin since 2023. The same thing happened 1 year ago, and the resident remained on aspirin. The physician took the resident off her carafate one month ago. For the future, the resident should stay off of aspirin without documented cerebrovascular or coronary artery disease. Nursing could try to take the resident off carafate again in a year, if the resident did not have any further bleeding. The resident was complaining of abdominal pain and nausea at that time. A recent upper gastrointestinal (GI) bleed appeared to be stabilized. The nurse's note, dated 11/27/24 at 10:02 p.m., indicated the resident had reported not feeling well and vomiting throughout the day after drinking ordered boost. The vomit was dark in color as if the resident had been eating and drinking something dark. The NP and Director of Nursing (DON) were made aware. The resident requested to be sent to the hospital at that time. The resident was not sent out to the hospital. The nurse's note, dated 11/28/24 at 12:07 a.m., indicated the resident requested to drink soda to attempt to settle her stomach and to prevent being sent out to the hospital. There were no signs or symptoms of vomiting for several hours. The resident was educated not to drink too many Boost protein drinks. Drinking too many Boost drinks caused the resident to not eat anything throughout the day. The resident was educated to let staff know if she vomited again. An order was given by the NP to send the resident out to the emergency room (ER) if needed. The physician's order, dated 11/15/24, indicated to provide small portions with regular meals and 2 snacks between meals. The order was discontinued on 12/20/24. The physician's order, dated 12/10/24, indicated staff were to administer to the resident, 100 milligrams (mg) iron-250 mg/5 milliliters (mL) 325 mg twice daily of Protect iron liquid (iron polysaccharide-vitamins C and B 12 complex). The order was discontinued on 12/17/24. The laboratory results, dated 12/18/24, indicated the resident had a Hemoglobin of 11.0 grams per deciliter (g/dL) and a Hematocrit of 34.6%. The normal range of Hemoglobin was 12.0 to 15.5 g/dl and the normal range of Hematocrit was 36 % to 48%) The nurse's note, dated 1/26/25 at 2:02 a.m., the resident reported pain that started in the stomach and radiated to her chest. The resident had requested as needed (PRN) pain medication at the medication pass. The resident was able to rest for a few hours after receiving the medication. The resident pressed her call light to notify staff she had vomited a large amount of emesis. The resident's blood pressure was 91/62 millimeters of mercury (mm Hg), a heart rate of 103 beats per minute (bpm), oxygen (O2) saturation at 93%, a temperature of 97.8 degrees Fahrenheit (F), and a respiratory rate (RR) of 18 breaths per minute. The resident requested to go to the ER. The NP, DON and Executive Director (ED) were notified. The resident continued to vomit. The vomit was dark with almost a look of coffee grounds to it. The resident then proceeded to demand to go to the ER related to feeling weak and continued vomiting. The NP, DON, and ED were notified, and the resident was sent to a local hospital. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 2/4/25 at 1:56 a.m., indicated the resident had an episode of vomiting, which was brown in color. The resident was on iron supplements, two times daily and had no history of ulcers or GI bleeds. The resident's vital signs were stable and within normal limits and the resident was alert and oriented. The resident denied the need for pain medication or any PRN medication. The record indicated the resident had a history of GI bleeding in November of 2024. The record lacked documentation of notification to the NP, DON, or ED of the resident's episode of dark brown emesis (vomiting) on 2/4/25 at 1:56 a.m. The NP, DON, or ED was not notified until 8:28 a.m. (6 hours and 24 minutes after the initial change in condition). The nurse's note, dated 2/4/25 at 8:28 a.m., indicated the resident had an elevated heart rate of 120 bpm and dark brown emesis. The resident refused her morning medications. The NP was notified, and a new order was received to send the resident to the ER for evaluation and treatment. The nurse's note, dated 2/4/25 at 8:50 a.m., indicated Emergency Medical Services (EMS) took the resident to a local hospital and left the building at 8:50 a.m. The nurse's note, dated 2/4/25 at 4:40 p.m., indicated the resident arrived back from the local hospital with diagnoses of gastroenteritis and acute cystitis without hematuria. A new order was placed in the computer for an antibiotic and antiemetic. The nurse's note, dated 2/4/25 at 5:24 p.m., indicated an order for Keflex from the ER was verified with the NP. The resident was currently on Augmentin for a UTI. The NP indicated to keep the Augmentin order and discontinue the Keflex order. The Minimum Data Set (MDS) Significant Change in Status assessment, dated 3/14/25, indicated the resident was cognitively intact. During an interview, on 4/28/25 at 9:53 a.m., RN 1 indicated the resident had been hospitalized on [DATE] for a gastrointestinal (GI) issue and was diagnosed with gastroenteritis and acute cystitis without hematuria. She was vomiting and had abdominal pain prior to hospitalization . The resident was vomiting brown emesis. She had complained of stomach pain at times in the past. It was one o'clock in the morning when the resident began vomiting and at 8:24 a.m., the same day, the resident was still vomiting and had an increased heart rate. The NP was notified and gave the order to send the resident to the ER. LPN 2 should have reached out to the Director of Nursing (DON), but LPN 2's note didn't reflect that he did that. During an interview, on 4/28/25 at 9:56 a.m., the DON indicated she was not contacted by the LPN on 2/4/25 about the resident vomiting brown emesis. The current Resident Change of Condition Policy, included, but was not limited to, . It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place . 3.1-5(a)(2)