

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Hickory Creek at Rochester		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966</p> <p>Based on interview and record review, the facility failed ensure a resident's responsible party was notified in a timely manner of condition and roommate changes for 1 of 3 residents reviewed for notification, (Resident B).</p> <p>Finding includes,</p> <p>During an interview on 2/4/25 at 9:37 A.M., Resident B's family member indicated that the residents' POA (Power of Attorney) and emergency contact was never notified that Resident B had been assessed to have a pressure area when he was admitted to the facility, that the pressure ulcer had worsened or that an additional pressure ulcer had developed. In addition, Resident B had multiple roommate changes and there was no notification of those changes.</p> <p>During an interview, on 2/4/25 at 2:12 P.M., the Administrator indicated Resident B had had room and roommate changes and the residents' POA and/or family member was not notified of the changes. The Administrator indicated the facility's Social Service Director, at the time of the moves, should have notified the resident's POA and/or family member. The Administrator indicated roommate changes had occurred on 10/19/24, 10/25/24, 11/17/24, 12/22/24, and 12/29/24 and the resident's POA and/or family member should have been notified.</p> <p>Resident B's clinical record was reviewed on 2/3/25 at 9:21 A.M. Resident B was admitted to the facility on [DATE] from an acute care facility. Diagnosis included, but were not limited to, non-pressure chronic ulcer, paraplegia, muscle wasting, unspecified psychosis, adjustment disorder, chronic total occlusion of artery of extremities, hypertension, fusion of spine, tortuous aortic arch, traumatic compartment syndrome of lower extremity, and an unspecified open wound of the abdominal wall.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 10/16/24, indicated Resident B had moderate cognitive impairment, was always incontinent of bladder, was frequently incontinent of bowel, and had a stage 2 pressure ulcer that was present on admission.</p> <p>An Observation Report form, dated 10/10/24 at 3:29 P.M., indicated Resident B was admitted with an ulcer type friction wound to the coccyx measuring 1 cm x 1 cm with no depth. There was no documentation the POA and/or family member was notified of the pressure ulcer.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Nursing Progress Note, dated 10/16/24 at 12:49 A.M., indicate the resident had a wound to the coccyx area. There was no documentation that indicated POA and/or family notification.</p> <p>A Nursing Progress Note, dated 10/24/24 at 2:42 A.M., indicated the resident had a wound to the buttock. There was no documentation that indicated Resident B's POA and/or family had been notified of the new wound.</p> <p>A Nursing Progress Note, dated 10/30/24 at 4:03 A.M., indicated Resident B had wound areas to the buttocks and coccyx. There was no documentation that indicated POA and/or family notification.</p> <p>A Nursing Progress Note, dated 10/31/24 at 10:33 P.M., indicated Resident B's family member was informed of Resident B's new skin area to the buttocks.</p> <p>A Care Plan dated 10/15/24 indicated Resident B was admitted to the facility with impaired skin integrity that was present on admission regarding a pressure ulcer to the coccyx. The care plan also referred to other wounds, including a sacral wound that merged with a coccyx wound, and right/left buttocks wounds.</p> <p>On 2/4/25 at 4:15 P.M., the Administrator provided a policy titled, Resident Change of Condition, dated 11/04. The policy indicated, .It is the policy of this Community that changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs.</p> <p>This citation relates to complaint IN00452399.</p> <p>3.1-5(a)(2)</p> <p>3.1-5(b)(1)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident received the necessary treatment and services to promote healing and prevent worsening of a pressure ulcer, as well as prevent the development of additional pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. This deficient practice resulted in the worsening of an identified pressure ulcer, from a Stage 2 to a Stage 4 and the development of multiple pressure ulcers which progressed from a DTI (Deep Tissue Injury) to unstageable wounds with slough, the need for treatment from a local wound treatment center and the need for an upcoming surgical colostomy procedure to reduce contamination and damage to the area. (Resident B)</p> <p>The Immediate Jeopardy began on 10/10/24 at 4:28 P.M., when the facility identified a wound to the coccyx upon admission and failed to notify the physician and obtain immediate treatment orders which placed the resident in immediate jeopardy of serious harm. The Administrator, Regional Nursing Consultant and Facility Nursing Consultant were notified of the Immediate Jeopardy on 2/5/25 at 2:50 P.M.</p> <p>The deficient practice was corrected on 11/8/24, prior to the start of the survey, and was therefore past noncompliance.</p> <p>Finding includes:</p> <p>Resident B's clinical record was reviewed on 2/3/25 at 9:21 A.M. Resident B was admitted to the facility on [DATE] from an acute care facility. Diagnosis, included but were not limited to, non-pressure chronic ulcer, paraplegia, muscle wasting, unspecified psychosis, adjustment disorder, chronic total occlusion of artery of extremities, hypertension, fusion of spine, tortuous aortic arch, traumatic compartment syndrome of lower extremity, and an unspecified open wound of the abdominal wall.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 10/16/24, indicated Resident B had moderate cognitive impairment, no behavioral issues, was always incontinent of bladder, frequently incontinent of bowel, required assistance for bed mobility and was dependent for all transfers and toileting hygiene. The resident required a wheelchair for mobility. The assessment indicated Resident B was at risk for pressure ulcers and had a stage 2 pressure ulcer that was present on admission. The assessment indicated Resident B had pressure reducing devices to his bed and chair. The assessment indicated Resident B was receiving pressure ulcer care including the application of nonsurgical dressings and application of ointments or medications.</p> <p>An Observation Report form, dated 10/10/24 at 3:29 P.M., indicated Resident B was admitted with an ulcer type friction wound to the coccyx measuring 1 cm x 1 cm with no depth. There was no documentation the physician was notified of the pressure ulcer.</p> <p>The Braden Scale for Predicting Pressure Sore Risk assessment, dated 10/10/24 at 4:24 P.M., indicated Resident B was at moderate risk for pressure wound development.</p> <p>The current Care Plans for Resident B related to skin and care needs included the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Start Date: 10/10/2024 Resident requires assistance with ADLs (activities of daily living) including bed mobility, transfers, eating and toileting related to: recent hospitalization for cellulitis, paraplegia, muscle wasting/atrophy, unspecified psychosis, adjustment disorder with depressed mood, fusion of lumbar spine, and presence of wounds.</p> <p>Start Date: 10/10/2024 Resident requires assistance with ADLs including bed mobility, transfers, eating and toileting related to: recent hospitalization for cellulitis, paraplegia, muscle wasting/atrophy, unspecified psychosis, adjustment disorder with depressed mood, fusion of lumbar spine, and presence of wounds.</p> <p>Start Date: 10/15/2024 Resident was admitted with impaired skin integrity: PRESENT ON ADMISSION pressure to coccyx. Other wounds include sacral wound that merged with coccyx wound, right/left buttocks. Factors contributing to wound development include slightly limited sensory perception, moisture, chair fast, impaired mobility, and friction/shearing, paraplegia, muscle wasting and atrophy, hypoalbuminemia, protein-calorie malnutrition, chronic total occlusion of extremity arteries, HTN, HLD, adjustment disorder with anxiety, and major depressive disorder.</p> <p>Start Date: 10/28/2024, Resident is at risk for skin breakdown or further skin breakdown due to, dx paraplegia and muscle wasting and atrophy, episodes of incontinence, impaired mobility and requiring staff assistance for mobility and transfers.</p> <p>Review of a Wound Management Detail Report for the Coccyx and wound indicated the following wound assessments and progression:</p> <p>10/10/24 at 4:39 P.M., stage 2 wound 1.5 cm x 1.6 cm x depth of 0.2 cm,</p> <p>10/18/24 at 1:45 P.M., stage 2 wound 1.5 cm x 1.5 cm x depth of 0.1 cm,</p> <p>10/25/24 at 9:14 A.M., stage not documented, wound 1.4 cm x 1.5 cm x depth not documented,</p> <p>10/31/24 at 10:46 A.M. stage not documented, wound 1.8 cm x 1.5 cm x depth of 1.2 cm</p> <p>Resident B's admission orders, dated 10/10/24, included no orders for pressure ulcer treatment.</p> <p>Progress notes between 10/10/24 and 10/31/24 included, but were not limited to the following related to the residents wound on the coccyx and buttock:</p> <p>10/15/24 at 8:37 A.M., the wound area was to the coccyx and healing.</p> <p>10/16/24 at 12:49 A.M., the wound area was to the coccyx.</p> <p>10/17/24 at 3:35 A.M., the wound area was to the coccyx.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>10/19/24 at 8:02 A.M., barrier cream was applied to the coccyx and nursing would continue to monitor.</p> <p>10/20/24 at 10:18 A.M., treatment was applied to buttock per a physician's order.</p> <p>10/22/24 at 10:20 A.M., there were no signs or symptoms of infection to the buttocks</p> <p>10/23/24 at 3:58 A.M., the wound area was to the coccyx.</p> <p>10/23/24 at 9:37 A.M., treatment continued to the buttocks and there was no noted drainage, odor, or signs or symptoms of infection.</p> <p>10/24/24 at 2:42 A.M., the wound area was to the buttock.</p> <p>10/24/24 at 10:12 A.M. the area to the buttocks continued with treatments. No noted odor or drainage, no noted worsening.</p> <p>10/25/24 at 9:52 A.M.,there was no noted drainage or odor to the buttock pressure ulcer.</p> <p>10/26/24 at 1:22 P.M., there was no noted drainage or odor area to buttock pressure ulcer.</p> <p>10/27/24 at 8:10 A.M., wound was to the buttock.</p> <p>10/29/24 at 1:35 A.M., wound was to the coccyx.</p> <p>10/29/24 at 9:11 A.M., wound on the coccyx was clean dry and intact</p> <p>10/30/24 at 4:03 A.M., wound area to buttocks and coccyx.</p> <p>10/31/24 at 2:19 A.M., wounds to coccyx, buttocks.</p> <p>10/31/24 at 8:57 P.M., resident was in bed and the dressings were clean dry and intact.</p> <p>The progress notes above identified 2 wounds, coccyx and buttock, but did not indicated the physician was notified of the coccyx or buttock wound or any orders were obtained for specific treatment for the areas identified.</p> <p>A Physician's Progress Note, dated 10/21/24, indicated the facility staff had denied any acute issues related to the resident and staff had denied any new wounds for Resident B.</p> <p>An Event Report for a new skin event, dated 10/31/24 at 6:00 A.M., indicated a new deep tissue pressure wound was identified to the left buttock that measured 6.9 cm x 7.2 cm. The report indicated the physician was notified of the new pressure ulcer on 10/31/24 at 6:35 A.M. and a new treatment order was received for collagen (an anti-infective and anti-inflammatory treatment), an air mattress, treatments and labs.</p> <p>Review of a Wound Management Detail Reports for the Sacrum wound indicated the wound was identified on 10/31/24 at 9:17 A.M. and indicated the following wound assessments and progression:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>10/31/24 at 9:17 A.M., stage not documented, wound 6.9 cm x 5.8 cm, depth could not be measured.</p> <p>Physician Orders related to skin care and pressure ulcer care included the following:</p> <p>10/31/24: Cleanse bilateral buttocks, pat dry. Apply remedy repair cream every shift and with peri care.</p> <p>Cleanse coccyx/buttocks with soap and water, pat dry. Moisten collagen and apply to wound bed of DTI (deep tissue injury) and cover with optifoam every day and as needed beginning 10/31/24 to 12/6/24.</p> <p>Positioning/Devices: cushion to wheelchair beginning.</p> <p>Positioning/Devices: Low Air Loss Mattress to bed check functioning every shift beginning.</p> <p>Progress notes between 11/3-11/8/25 indicated DTI to buttocks and both buttocks. The coccyx wound is not mentioned in the notes.</p> <p>11/03/24 at 8:58 A.M., resident had a deep tissue injury to the buttocks with a treatment ordered.</p> <p>11/04/24 at 3:48 A.M., resident was checked and changed (for incontinence) every two hours. During every check and change, staff requested the resident to turn side to side to relieve pressure on the buttock wound. The Resident refused every request from staff to turn. Treatment was done to the buttock wounds.</p> <p>11/05/24 at 3:42 A.M., pressure wound to the buttocks.</p> <p>11/05/24 10:37 A.M., resident continues to have a deep tissue injury to the buttocks and continues with treatment as ordered. Resident was encouraged to be in bed more often and turn from side to side but was not always compliant with being checked and changed every two hours. The resident remained on a specialty air mattress. Dressings were clean dry and intact.</p> <p>11/07/24 at 3:30 A.M., open areas to the buttocks with treatment.</p> <p>11/08/24 at 9:33 A.M., pressure ulcers continued to both buttocks. Treatment was applied as ordered. Physician was there and stated the resident's wounds were definitely starting to heal and educated the resident as well. The resident remained on a low air loss mattress.</p> <p>Physician orders:</p> <p>12/6/24: Cleanse coccyx/buttocks with soap and water, pat dry. Apply Santyl to wound bed of the deep tissue injury and pressure ulcers, then cover them with optifoam every day and as needed</p> <p>12/7/24-1/15/25:</p> <p>Santyl ointment topical to cleanse coccyx/buttocks with soap and water, pat dry. Apply Santyl to wound bed of DTI and cover with Optifoam daily and as needed.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>12/19/24: Left distal gluteus wound:</p> <p>Left distal gluteus wound -cleanse with wound cleanser and apply Santyl Collegenase cut Aquacel ribbon and insert into wound bed as instructed and cover with mepilex border dressing once daily beginning 12/19/24 to 1/15/25.</p> <p>12/19/24: Right distal gluteus:</p> <p>Right distal gluteus cleanse with wound cleanser apply santyl and cover with mepilex border dressing once daily.</p> <p>12/19/24: Right superior gluteus:</p> <p>Right superior gluteus cleanse with wound cleanser apply Santyl and cover with mepilex border dressing daily</p> <p>1/3/25: Appointment with local wound care center.</p> <p>1/15/25: Wound vac at 125 mm/hg to wounds sacrum/buttocks, will be done at wound care.</p> <p>2/3/25: Appointment with local wound care center.</p> <p>2/4/25: Appointment with local hospital anesthesia for colostomy consult.</p> <p>During an observation and interview on 2/4/25 at 9:05 A.M., Resident B was observed in his bed on his back with the head of the bed elevated. Resident B indicated when he was admitted to the facility, there had been no treatment for any pressure areas. The resident indicated he has some small pressure areas to his bottom that had gotten much worse after he was admitted to the facility and he had gone 2 to 3 weeks before the facility began any interventions for any pressure areas. Resident B indicated he had been going to a local wound care center for 4 weeks and the pressure ulcers seemed to be improving, but now he had a wound vac and would have to have a colostomy due to the pressure ulcers.</p> <p>During a telephone interview on 2/5/25 at 8:15 A.M., the facility Medical Director indicated he was first made aware of Resident B's pressure ulcers on 11/1/24 when he was at the facility for resident assessments. The Medical Director indicated he gave initial wound care orders on 11/1/24 and had not given any orders for pressure ulcer care before 11/1/24. The Medical Director indicated if the facility staff had notified him about Resident B's pressure ulcers earlier or upon admission, he would have started treatment immediately to possibly avoid the seriousness of the wounds.</p> <p>During an interview on 2/5/25 at 8:54 A.M., the Assistant Director of Nursing indicated she was doing new resident chart audits on 10/18/24 and noted the residents' pressure ulcer that had been identified on 10/10/24. The Assistant Director of Nursing indicated she believed she had notified the physician of Resident B's pressure ulcers on either 10/18/24 or 10/22/24 and received an order to apply Opifoam to the wound. The Assistant Director of Nursing did not document her communication with the physician.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a wound observation on 2/5/25 at 9:15 A.M., Resident B was noted to have four wounds to the sacral and buttock area. A wound was noted to the right of the sacrum that appeared to be approximately 3 cm x 3 cm with 5 cm depth, a wound to the coccyx that tunneled with the sacral wound that appeared to be approximately 5 cm x 5 cm x 5 cm depth, a wound to the right buttock proximal to the anus that appeared to be approximately 3 cm x 3 cm x 5 cm depth, and a wound to the left buttock proximal to the anus that appeared to be approximately 2 cm x 2 cm x 5 cm depth.</p> <p>On 2/4/25 at 4:15 P.M., The Administrator provided a policy titled, Resident Change of Condition, dated 11/04. The policy indicated, .It is the policy of this Community that changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs .Any sudden or serious change in a resident's condition .will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician .</p> <p>On 2/4/25 at 4:30 P.M., the Facility Consultant Nurse provided a policy titled Skin Management Program, most recently updated on 5/22, abd indicated it was the facility's current policy. The policy indicated it was the policy of the facility to ensure a resident with pressure ulcers received necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing. An avoidable pressure ulcer meant a resident had developed a pressure ulcer and the facility did not define and implement interventions that were consistent with the resident needs. Alterations in skin integrity was to be reported to the physician and treatment orders obtained.</p> <p>The deficient practice was corrected by 11/8/24 after the facility implemented a systemic plan of correction that included the following actions: a facility wide skin sweep to determine any resident with skin alterations/wounds, nursing staff re-education of the facility policies regarding change in condition, notification, assessment, documentation, weekly skin cheeks with notification of change, re-education of nurses and certified nursing assistants on completing shower sheets, notifying the nurse of any change in condition to include skin alterations, changes in condition notification to physician and family and documented in the clinical record, monthly skin sweeps, weekly skin assessments and shower sheet reviews by the interdisciplinary team, current wounds to be assessed for changes with physician notification, Care Plans and all prevention interventions and associated documents related to wound to be initiated or updated, In-service/Education for all licensed nurses regarding wound care, treatment, and physician notification and documentation for any changes in the wound. In addition, room rounds were to be completed daily for 5 weeks to ensure all preventative interventions were in place per the individual plan of care. Compliance for the plan of correction was to be monitored through the Quality Assurance and Performance Improvement Program and an audit tool related to Wound Management was to be completed monthly for 6 months.</p> <p>This Citation relates to complaint IN00452399.</p> <p>3.1-40(1)</p> <p>3.1-40(2)</p>		