

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 06/10/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>45120</p> <p>Based on record review and interview, the facility failed to provide a transfer/discharge form for 2 of 2 residents reviewed for hospitalization s. (Residents 11 & 1)</p> <p>Findings include:</p> <p>1. A record review for Resident 11 was completed on 6/6/2024 at 9:49 A.M. Diagnoses included, but were not limited to, sepsis, Alzheimer's disease, and cerebral infarction (stroke).</p> <p>A Nurse's Note, dated 5/28/2024 at 5:59 P.M., indicated Resident 11 refused to eat or drink. She had eaten one bite of pureed food, and refused to swallow which allowed food to run out of her mouth. Vital signs included: blood pressure 100/48 mmHg (millimeters of mercury), pulse 102 beats per minute, respirations 20 per minute, and temperature 98.9 Fahrenheit. The physician was notified, and he indicated the resident's Power of Attorney (POA) wanted Resident 11 sent to the hospital.</p> <p>During an interview, on 6/10/2024 at 10:18 A.M., the Director of Nursing (DON) indicated the transfer/discharge form was part of the Hospital-ER Transfer Form under the Observation tab of the electronic health record. She indicated the form should have been completed when a resident was transferred from the facility.</p> <p>The form, Hospital-ER Transfer Form could not be found in the electronic medical record for Resident 11.</p> <p>2. A record review for Resident 1 was completed on 6/5/2024 at 10:37 A.M. Diagnoses included, but were not limited to, nondisplaced intertrochanteric fracture of right femur, hemiplegia and hemiparesis following CVA (stroke), and osteoporosis.</p> <p>A Nurse's Note, dated 4/13/2024 at 11:00 P.M., indicated Resident 1 was helped with a transfer when she stumbled and spun around, falling on her buttocks. Resident 1 complained of right hip and back pain. The physician was notified, and an order was obtained to send Resident 1 to the emergency department.</p> <p>A Nurse's Note, dated 4/14/2024 at 2:00 A.M., indicated Resident 1 was admitted to the hospital.</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
---	-------	-----------

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 06/10/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview, on 6/10/2024 at 10:18 A.M., the Director of Nursing (DON) indicated that the transfer/discharge form was part of the Hospital-ER Transfer Form under the Observation tab of the electronic health record. She indicated the form should be completed when a resident is transferred from the facility.</p> <p>The form, Hospital-ER Transfer Form, dated 4/13/2024 at 11:00 P.M., indicated the resident or resident representative was not provided the transfer/discharge form.</p> <p>A form titled, Notice of Transfer or Discharge was provided by the Regional Nurse Consultant on 6/10/2024 at 12:49 P.M. A policy was not attached to the form.</p> <p>3.1-12(a)(6)(A)</p>		

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 06/10/2024
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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>45120</p> <p>Based on record review and interview, the facility failed to provide the bed hold policy for 2 of 2 residents reviewed for hospitalization s. (Residents 11 & 1)</p> <p>Findings include:</p> <p>1. A record review for Resident 11 was completed on 6/6/2024 at 9:49 A.M. Diagnoses included, but were not limited to, sepsis, Alzheimer's disease, and cerebral infarction.</p> <p>A Nurse's Note, dated 5/28/2024 at 5:59 P.M., indicated Resident 11 refused to eat or drink. She had eaten one bite of pureed food and refused to swallow, which allowed food to run out of the her mouth. Vital signs included: blood pressure 100/48 mmHg (millimeters of mercury), pulse 102 beats per minute, respirations 20 per minute, and temperature 98.9 Fahrenheit. The physician was notified, and he indicated the Resident's Power of Attorney (POA) wanted Resident 11 sent to the hospital.</p> <p>During an interview, on 6/10/2024 at 10:18 A.M., the Director of Nursing (DON) indicated that the bed hold policy was part of the Hospital-ER Transfer Form under the Observation tab of the electronic health record. She indicated the policy should be completed when a resident is transferred or discharged from the facility.</p> <p>The form, Hospital-ER Transfer Form could not be found in the electronic medical record for Resident 11.</p> <p>2. A record review for Resident 1 was completed on 6/5/2024 at 10:37 A.M. Diagnoses included, but were not limited to, nondisplaced intertrochanteric fracture of right femur, hemiplegia and hemiparesis following CVA (stroke), and osteoporosis.</p> <p>A Nurse's Note, dated 4/13/2024 at 11:00 P.M., indicated Resident 1 was helped with a transfer when she stumbled and spun around, falling on her buttocks. Resident 1 complained of right hip and back pain.</p> <p>The physician was notified, and an order was obtained to send Resident 1 to the emergency department.</p> <p>A Nurse's Note, dated 4/14/2024 at 2:00 A.M., indicated Resident 1 was admitted to the hospital.</p> <p>During an interview, on 6/10/2024 at 10:18 A.M., the Director of Nursing (DON) indicated the bed hold policy was part of the Hospital-ER Transfer Form under the Observation tab of the electronic health record. She indicated the policy should be completed when a resident was transferred or discharged from the facility.</p> <p>The form, Hospital-ER Transfer Form, dated 4/13/2024 at 11:00 P.M., indicated neither the resident nor the resident's representative was provided with a copy of the bed hold policy.</p> <p>(continued on next page)</p>		

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 06/10/2024
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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A policy was provided on, 6/10/2024 at 12:49 P.M. by the Regional Nurse Consultant. The policy titled, Bed Hold, indicated, .If a private pay resident leaves the facility for a temporary stay in an acute hospital or elsewhere for a medical therapeutic leave, the resident or resident's responsible party may request the facility to hold open the resident's bed during the absence by paying the full daily rate. If a Medicare/Medicaid resident leaves the facility for a temporary stay in an acute hospital or elsewhere for a medical therapeutic leave, the bed will be held .2. The residents will be provided the bed hold policy at the time of the hospital transfer or therapeutic leave. 3. The Resident's Representative will be informed of the bed hold policy at the time of notification of the transfer. The Resident's Representative will be provided a copy of the bed hold policy. 4. The staff will document the notification to thee resident and resident representative of the bed hold policy on the Emergency Resident Transfer Form</p> <p>3.1-12(a)(25)(A)</p>

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 06/10/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>38845</p> <p>Based on observation, record review and interview, the facility failed to notify the physician of a non healing wound with eschar (dead tissue) for 1 of 2 residents reviewed for non pressure skin conditions. (Resident 13)</p> <p>Finding includes:</p> <p>During an observation on 6/4/2024 at 11:11 A.M., Resident 13 had a dressing to her lower back that was not adhering to the area. There was bloody drainage observed on her shirt.</p> <p>The record for Resident 13 was reviewed on 6/05/2024 at 2:36 P.M. Diagnoses included but were not limited to: diabetes, neuromuscular dysfunction of bladder and intellectual disabilities.</p> <p>A Quarterly MDS, (Minimum Data Set) Assessment, dated 3/22/2024, indicated the resident required extensive assist of 1 staff for bed mobility, transfers, and extensive assist of 2 staff for toilet use.</p> <p>A Nurses Progress Note, dated 5/9/2024, indicated the resident had an open area to the middle of her back measuring 2 x 2 centimeters.</p> <p>An IDT (Interdisciplinary Team) Note, dated 5/10/2024, indicated Resident 13 had a non pressure wound. The note indicated the following: a reopened small wound to the center of her lower back with yellow base. No drainage or redness noted. Patient has a pimple to her back and she was picking at the area, provider saw patient today and new orders for oral antibiotic for the redness along with new treatment order to cleanse site daily with iodine until area has healed. Signs or symptoms of infection present: No. Interventions in place prior to wound / skin injury development: showers, weekly skin assessments. Root-cause determination: self inflicted scratching New interventions initiated: treatment initiated, bari bed initiated.</p> <p>A Physicians Order, dated 5/18/2024, indicated the current treatment order was to cleanse the area with soap and water and apply Opti-foam every 3 days and PRN (as needed) until resolved.</p> <p>A Nurses' Note, dated 5/18/2024, indicated an infection was identified to her lower back wound area. New orders were received for doxycycline (antibiotic) 100 mg (milligrams) twice a day until 5/24/2024.</p> <p>A Nurses' Progress Note, dated 5/22/2024, indicted the resident continued to receive antibiotic therapy for her back wound. Area continues to look infected. Resident continues to pick area.</p> <p>A Nurses' Progress Note, dated 5/29/2024, indicated the writer assessed area on lower back at this time. No dressing was on. The Resident was seated in a chair in the common area and ha her shirt pulled up. The area was rubbing against her chair back. The wound bed was white, and the surrounding tissue was red. The Assistant Director of Nursing was notified about the area. The writer applied iodine and Opti-foam to the area at the time the note was made</p> <p>(continued on next page)</p>		

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 06/10/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A current Care Plan, revised on 5/26/2024 at 3:05 P.M., indicted the following : .Infection to her middle of her back from open wound with slough and purulent drainage noted. Interventions 5/18/2024--Antibiotic Medication ordered per provider orders .</p> <p>During an observation of Resident 13's back with RN 6, on 6/7/2024 at 1:25 P.M., there was an open area approximately the size of a nickel, with a brownish area in the middle of the wound bed. The edges around the area were white in color, with an outer ring of redness around the area. There was a small amount of drainage noted to the dressing when removed.</p> <p>During an interview with RN 6, on 6/7/2024 at 2:06 P.M., she indicated the area had slough that needed to be debrided. She indicated the physician had not been notified of the current condition of the area and the need for a new treatment but should have been notified.</p> <p>On 6/10/2024 at 12:49 P.M.,the Regional Nurse Consultant provided the policy titled, Resident Change of Condition Policy, dated 11/2028, and indicated the policy was the one currently used by the facility. The policy indicated .It is the policy of thin 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 . Non-Urgent Medical Change. a. All symptoms and unusual sign will be documented in the medical record and communicated to the attending physician promptly</p> <p>3.1-37</p>		

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 06/10/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45120</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, record review, and interview, the facility failed to properly store a Bi-Pap (bi-level positive airway pressure) mask for 1 of 1 resident reviewed for oxygen/respiratory equipment. (Resident 131)</p> <p>Finding includes:</p> <p>A record review for Resident 131 was completed, on 6/5/2024 at 1:08 P.M. Diagnoses included, but were not limited to, pulmonary hypertension, chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea.</p> <p>During an observation, on 6/4/2024 at 9:35 A.M., Resident 131's Bi-Pap mask was observed on the floor under the bed.</p> <p>A Physician's Order, dated 5/31/2024, indicated Bi-Pap on at bedtime and off upon waking.</p> <p>A Care Plan, dated 6/3/2024, indicated Resident 131 had the potential for impaired gas exchange related to pulmonary hypertension and COPD. The goal indicated Resident 131 would have adequate respiratory functions as evidenced by decreased or absence of dyspnea, improved breath sounds, decreased or absence of shortness of breath, and improved oxygen saturation results. The care plan did not address the use of the Bi-Pap.</p> <p>During an interview, on 6/10/2024 at 10:17 A.M., the Director of Nursing (DON) indicated the Bi-Pap mask should be stored in a respiratory bag when not in use.</p> <p>A policy was provided on, 6/10/2024 at 12:49 P.M. by the Regional Nurse Consultant. The policy titled, Bi-Level Therapy. The policy did not address the storage of the mask when not in use.</p> <p>3.1-47(a)(6)</p>		

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 06/10/2024
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 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>38845</p> <p>Based on interview and record review the facility failed to ensure performance evaluations were completed annually for 4 of 4 employee files reviewed. (CNA 3, CNA 4, CNA 7 & CNA 8)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an interview on 6/10/2024 at 10:05 A.M., CNA 3 indicated they (the facility) do not do competencies every year or evaluations. 2. During an interview on 6/10/2024 at 11:01 A.M., CNA 4 indicated she had not received a performance evaluation since she started working here (at the facility). 3. During an interview on 6/10/2024 at 1:23 P.M., the Business Office manager indicated they (the facility) used to do them (competency evaluations) but when the new company took over they gave out the raises in January and they just didn't get done, but we are starting it back again. 4. During an interview on 6/10/2024 at 1:29 P.M., the Administrator indicated she and the Director of Nursing complete them and they should be done every year. There were some that were done, but there was a lot of turn over and she did not think they were all done. <p>The employee file for CNA 3 was reviewed on 6/10/2024 at 1:36 P.M. CNA 3 was hired on 2/8/2023. No annual performance evaluation was located in the file.</p> <p>The employee file for CNA 4 was reviewed on 6/10/2024 at 1:38 P.M. CNA 4 was hired on 4/17/2023. No annual performance evaluation was located in the file.</p> <p>The employee file for CNA 7 was reviewed on 6/10/2024 at 1:40 P.M. CNA 7 was hired on 8/11/2017. No annual performance evaluation was located in the file.</p> <p>The employee file for CNA 8 was reviewed on 6/10/2024 at 1:43 P.M. CNA 8 was hired on 9/22/2019. No annual performance evaluation was located in the file.</p> <p>During an interview on 6/20/2024 at 1:45 P.M., the Business Office Manger indicated the performance evaluations should be done every year.</p> <p>During an interview on 6/10/2024 at 1:46 P.M., the Administrator indicated she did not have a policy regarding the performance evaluations.</p> <p>3.1-14(h)</p>		

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 06/10/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38845</p> <p>Based on observation, interview and record review, the facility failed to ensure kitchen equipment were in good working condition in 1 of 1 kitchen reviewed.</p> <p>Finding includes:</p> <p>During a kitchen tour with the Dietary Manager on 6/4/2024 at 9:26 A.M., the following was observed:</p> <ul style="list-style-type: none"> -broken seals to both doors of the freezer. -broken seals to both doors on 2 refrigerators. <p>During an interview on 6/4/2024 at 9:45 A.M., the Dietary Manager indicated the seals needed to be fixed.</p> <p>On 6/10/2024 at 1:36 P.M., the Regional Nurse Consultant provided the policy titled, Kitchen Safety Guidelines, dated 4/2024, and indicated the policy was the one currently used by the facility. The policy indicated .2. All employees will report defective equipment, unsafe condition, acts, or safety hazards to the supervisor and/or the maintenance department . 13. The maintenance department is responsible for routine inspections and repair of fans, vents and equipment</p> <p>3.1-21(i)(3)</p>		

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 06/10/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>38845</p> <p>Based on observation, record review and interview, the facility failed to ensure proper infection control practices were implemented related to Enhanced Barrier Precautions (EBP) for 1 of 4 residents reviewed for EBP; failed to follow infection control practices when completing a blood sugar check for 1 of 1 resident reviewed for blood sugar assessments and failed to complete changing gloves and hand washing during catheter care for 1 of 1 resident observed for urinary catheter care. (Resident 28, QMA 2, CNA 5, Resident 23)</p> <p>Findings include:</p> <p>1. During an interview on 6/5/2024 at 8:27 A.M., Resident 28 indicated he went to dialysis 3 times a week. There was no signage and or indication the resident was to be in EBP isolation.</p> <p>The record for Resident 28 was reviewed on 6/6/2024 at 9:58 A.M. Diagnoses included, but were not limited to: cellulitis to the right leg, diabetes type 2, and end stage renal disease.</p> <p>A current Care plan, dated 5/7/2024 at 3:46 P.M., indicated the resident was receiving hemodialysis and was at risk for complications such as fluid imbalance, bleeding or infection due to a right jugular perma catheter.</p> <p>During an interview on 6/10/2024 at 10:05 A.M., CNA 3 indicated they had 3 residents on EBP. Resident 28 was not named.</p> <p>During an interview on 6/10/2024 at 10:27 A.M., the Director of Nursing indicted the resident had a porta cath (implanted port). The Regional Nurse Consultant indicated yes that is an indwelling catheter.</p> <p>2. During an observation of a blood sugar check, on 6/6/2024 at 12:11 P.M.,with QMA 2, the following was observed:</p> <p>QMA 2 placed the glucometer (a device for obtaining a blood sugar level) on the bedside table without placing a barrier first. She then donned gloves. QMA 2 wiped the residents' finger with an alcohol pad, then with an opened hand fanned the area that had just been cleansed. She then obtained a blood sample. QMA 2 exited the resident's room with her gloves on, and went to the medication cart. She removed the gloves and threw away her trash.</p> <p>During an interview on 6/6/2024 at 11:56 A.M., QMA 2 indicated she should have used a barrier, not fanned the area, and removed her gloves prior to coming out of the room.</p> <p>3. During an interview on 6/4/2024 at 9:46 A.M., Resident 6 indicated she had 2 catheters.</p> <p>The record for Resident 6 was reviewed on 6/5/2024 at 10:43 A.M. Resident 6's diagnoses included, but were not limited to Multiple Sclerosis, pressure ulcers stage 4 sacral region, left buttocks, right buttocks, and neuromuscular dysfunction of bladder.</p> <p>(continued on next page)</p>		

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 06/10/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Quarterly MDS (Minimum Data Set) Assessment, dated 3/28/2024, indicated the resident required total assist of 2 staff for bed mobility, transfers, and toilet use.</p> <p>A Care Plan, dated 5/6/2024, indicated the resident required a suprapubic (SP) urinary catheter and also had a Foley indwelling catheter due to: diagnosis of neuromuscular dysfunction of bladder. The resident had an indwelling Foley catheter placed upon return to the facility due to leakage of the SP catheter to keep urine off of her wounds to her bottom.</p> <p>On 6/7/2024 at 1:40 P.M., CNA 5 was observed to provide catheter care to Resident 6. The aide put her supplies on the over-the-bed table. She then washed her hands, applied a gown and gloves and filled the water basins with water. She then completed the washing, rinsing and drying of the catheter tube and the peri area. With the same gloves on, CNA 5 then rearranged the residents legs, moved a pillow, used the bed controls and then rearranged the sheet over the resident.</p> <p>During an interview, on 6/7/2024 at 2:02 P.M., CNA 5 indicated she knew she should have washed her hands and changed her gloves after completing peri and catheter care.</p> <p>4. During an observation on 6/4/2024 at 11:11 A.M., Resident 13 was observed to have an urinary catheter drainage tube with a large amount of sediment in the tubing.</p> <p>The record for Resident 13 was reviewed on 6/5/2024 at 2:36 P.M. Resident 13's diagnoses included, but were not limited to: diabetes, neuromuscular dysfunction of bladder, and intellectual disabilities.</p> <p>A Quarterly MDS (Minimum Data Set) Assessment, dated 3/22/2024, indicated the resident required extensive assist of 1 staff for bed mobility, transfers, and extensive assist for 2 staff for toilet use, and had an indwelling urinary catheter.</p> <p>A current Care Plan, dated 5/4/2023, indicated the resident required an indwelling urinary catheter due to neuromuscular dysfunction of the bladder. Interventions included, but were not limited to: Do not allow the tubing or any part of the drainage system to touch the floor. Store the collection bag inside a protective dignity pouch.</p> <p>During an observation, on 6/6/2024 at 10:29 A.M., Resident 13's catheter drainage bag was uncovered with the catheter tubing on the floor.</p> <p>During an observation, on 6/6/2024 at 12: 15 P.M., Resident 13's catheter tubing was on the floor.</p> <p>During an observation, on 06/6/2024 at 1:14 P.M., Resident 13's catheter tubing was on the floor.</p> <p>During an observation, on 6/6/2024 at 3:16 P.M., Resident 13's catheter tubing was on the floor.</p> <p>During an observation, on 6/7/2024 at 2:06 P.M., Resident 13's catheter tubing was on the floor.</p> <p>During an interview, on 6/7/2024 at 3:25 P.M., the Director of Nursing indicated the catheter tubing should have been off the floor.</p> <p>During an observation, on 6/10/2024 at 10:16 A.M., Resident 13's catheter tubing was on the floor.</p> <p>(continued on next page)</p>

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 06/10/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/10/2024 at 1:36 P.M., the Regional Nurse Consultant provided the policy titled, Shared Glucometer Cleaning and Disinfecting, dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated . 2. Throughout thee procedure, perform appropriate hand hygiene. c. Perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other residents</p> <p>On 6/10/024 at 1:36 P.M., the Regional Nurse Consultant provided a Skills Competency- Title:Catheter Care (Urinary), dated 5/2023, and indicated the policy was the one currently used by the facility. The policy indicated .17. Remove gloves. 18. Perform hand hygiene. 19. Dispose of soiled linen properly. 20. Perform hand hygiene</p> <p>On 6/10/2024 at 1:30 P.M. the Regional Nurse Consultant provided the policy titled,Bowel and Bladder Program, dated 5/2019. The policy did not address the catheter tubing and or drainage bag placement.</p>		