

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2024
NAME OF PROVIDER OR SUPPLIER  Hickory Creek of Athens		STREET ADDRESS, CITY, STATE, ZIP CODE  51 East 4th Street The Plains, OH 45780	

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 0740</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>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47985</p> <p>Based on record review, observation, and interview, the facility failed to provide continued mental health services and implement interventions for a resident at risk of suicide. This affected one resident (#24) of three residents reviewed for depression. The facility census was 74.</p> <p>Findings include:</p> <p>Record review revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including dementia without behavioral disturbance, bipolar disorder, major depressive disorder, contracture of muscle to right lower leg, unspecified personality disorder, and bilateral osteoarthritis of knees. Additional diagnoses of anxiety disorder and brief psychotic disorder were added on 06/19/24.</p> <p>Review of orders revealed Resident #24 had orders in place for Aricept tablet 10 milligrams (mg) one tablet by mouth (06/20/24); sensor bed alarm to alert staff of resident's desire to transfer and check placement every shift (06/20/24); low bed for safety (06/20/24); and lurasidone hci tablet 60 mg give one tablet by mouth once daily (08/02/24).</p> <p>Review of a discharge minimum data set (MDS) completed on 06/17/24 revealed Resident #24's memory was OK and her ability to make decisions required modified independence, she had an acute onset of mental status change, had delusions, refused care daily, required maximum assistance for bed mobility, and was dependent for transfers.</p> <p>Review of nursing note dated 06/19/24 at 9:39 P.M. revealed during an emergency telehealth visit with Psych360, Resident #24 was asked if she had suicidal thoughts and replied, yes, the voices are telling me do to it. They are saying I don't belong. When asked if she had a plan, Resident #24 stated, yes and was placed on one to one with staff at all times and charting every two hours until further orders received from physician and a Columbia Suicide Risk Assessment was completed per facility policy. Physician and Director of Nursing (DON) were made aware.</p> <p>Review of a Columbia Suicide Risk assessment dated [DATE] at 9:39 P.M. revealed Resident #24 had thoughts of wishing she was dead, had suicidal thoughts, suicidal intent without a specific plan, and scored a 6 indicating moderate suicide risk.</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 0740</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>Review of an additional nursing note dated 06/19/24 at 9:39 P.M. revealed Resident #24 received new orders to start Ativan 0.5 mg by mouth as needed for 14 days and risperidone 0.5 mg by mouth every 12 hours for bipolar disorder, then discontinue order once Latuda arrives from the pharmacy. Family and primary care physician (PCP) made aware.</p> <p>Review of a note dated 06/19/24 at 10:39 P.M. revealed multiple purple colored bruising noted to bilateral upper extremities and a discontinued peripheral IV site on left arm. Tiny multiple red colored scattered scratch marks were noted to Resident #24's face, bilateral arms, and chest. Resident #24 voiced she is scratching her body as a result of being anxious. PCP and family made aware and a new order was received for lotion applied twice a day for dry skin.</p> <p>Review of a nursing note dated 06/19/24 at 11:39 P.M. revealed Resident #24 continued one to one with staff and had no behaviors at this time.</p> <p>Review of a provider note from Nurse Practitioner (NP) #121 revealed she received a call regarding Resident #24 having worsening symptoms of agitation and restlessness including clawing at her eyes and was not able to be redirected. A new order was given to send Resident #24 to the emergency room for psychiatric evaluation.</p> <p>Review of nursing notes dated 06/20/24 at 1:39 A.M. and 3:39 A.M. revealed Resident #24 continued to be one to one with staff and had no behaviors at this time.</p> <p>Review of a behavior note dated 06/20/24 at 4:16 A.M. revealed Resident #24 was attempted to scratch her right eye then attempted to gouge right eye and pull off her eyelid stating she was digging her own grave and knows the drug cartels and all the drugs Dr. [NAME] and all his drugs. Resident continued to have increased false beliefs and remained one to one with staff. Physician was made aware.</p> <p>Review of an addendum to behaviors note dated 06/20/24 at 4:35 A.M. revealed Resident #24 was redirected by staff with success, with a cold wash clothe to wipe her face. Psych360 was made aware and gave an order to send Resident #24 to hospital for evaluation.</p> <p>Review of a Transfer out of Facility Form dated 06/20/24 revealed Resident #24 transferred to the emergency room for self-harm, increased false beliefs, and increased hallucinations.</p> <p>Review of a nursing note dated 06/20/24 at 2:40 P.M. revealed Resident #24 returned to the facility with no new orders, was placed on one to one with staff, and precautions. Resident #24 was refusing to speak to staff. PCP was made aware and gave an order to change Ativan 0.5 mg to every three hours as needed for 48 hours. Family aware.</p> <p>Review of a social service note dated 06/20/24 at 3:13 P.M. revealed an attempt was made to complete the Columbian Suicide Risk Assessment, but Resident #24 kept her eyes closed and refused to speak.</p> <p>Review of a social service note dated 06/20/24 at 3:15 P.M. revealed Resident #24 was one to one with staff for safety until the Columbian Suicide Risk Assessment could be completed over a period of time and no further concerns are reported.</p> <p>Review of a social service note dated 06/20/24 at 4:24 P.M. revealed the Columbian Suicide Risk Assessment was completed and Resident #24 scored a 0 indicating no risk at this time.</p> <p>(continued on next page)</p>		

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<p>F 0740</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>Review of a nursing note dated 06/20/24 at 8:31 P.M. revealed Psych360 gave a new order to discontinue risperidone 0.5 mg due to Latuda being delivered and available.</p> <p>Review of a social service note dated 06/21/24 at 4:01 P.M. revealed a Columbian Suicide Risk Assessment was completed and Resident #24 was pleasant, smiling, and stated she would never try to hurt herself in any way.</p> <p>Review of a nursing note dated 08/02/24 at 8:56 A.M. revealed a new order was received from Psych360 to discontinue Aricept and increase Lurasidone to 60 mg at dinner. PCP was notified and gave an order not to discontinue Aricept, resident and family were notified.</p> <p>Observation on 08/05/24 at 8:27 A.M. revealed Resident #24 was resting in bed with a slight lean to the left and the bed was not in a low position.</p> <p>Observation on 08/05/24 at 10:59 A.M. revealed Resident #24 was resting in bed, but the bed was not in a low position.</p> <p>Interview on 08/05/24 at 12:56 P.M. with Resident #24 revealed she struggles with depression, and she does have negative thoughts such as wanting to hurt herself. Resident #24 stated she does not know if the facility assists with managing depression well, she thinks she gets medications and she sees doctors and the social worker. During the interview, Resident #24's bed was not in a low position. At the end of the interview, a state tested nursing assistant (STNA) entered Resident #24's room and was made aware of her statements.</p> <p>Interview on 08/05/24 at 1:03 P.M. with Social Worker (SW) #125 revealed Resident #24 had a sudden change overnight, was sent to the hospital, came back and was placed on one to one with staff, they traded her call light with a bell, served meals on paper plates and gave plastic silverware, family was notified and Pysch360 evaluated her. SW #125 revealed the facility used to have a counselor but she went on maternity leave and never came back. SW #125 stated the facility is switching psych companies in the next couple weeks. SW #125 stated Resident #24 had scored 0's on her suicide risk assessments for awhile but she could benefit from counseling services.</p> <p>Interview on 08/05/24 at 2:15 P.M. with the Director of Nursing (DON) revealed Resident #24 has an order in place for a low bed because of her behaviors, they were worried she would throw herself out of bed. The DON confirmed Resident #24's bed was not in low position during observations. The DON stated she was not sure if Resident #24 received counseling services but thought counseling could help anybody.</p> <p>Interview on 08/05/24 at 3:32 P.M. with Regional Nurse (RN #130) revealed Resident #24 was seen by psychiatric services, but not counseling services. RN #130 stated the psychiatric services reviewed Resident #24's medications but also provided behavioral health services because they asked how she was doing and if she had thoughts of harming herself. RN #130 confirmed counseling services were not provided because the facility wanted to make sure medications were effective prior to attempting another intervention. RN #130 did not express knowledge of benefits of therapeutic intervention versus pharmacologic intervention.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155225.</p>		