STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155406	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Peru	390 W Boulevard Peru, IN 46970

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, the facility failed to ensure a resident had qualifying criteria to warrant a new schizoaffective disorder diagnosis for 1 of 5 residents reviewed for unnecessary medications. (Resident 5) Finding includes:A record review for Resident 5 was completed on 12/18/2025 at 1:05 P.M. Diagnoses included, but were not limited to: schizoaffective disorder, bipolar disorder, depressive disorder, generalized anxiety and epilepsy.A Quarterly MDS Assessment, dated 10/22/2025, indicated Resident 5 had moderate cognitive impairment and received an antipsychotic medication.Nursing Progress Notes, dated 12/19/2024 through 1/27/2025, were reviewed. The following behaviors had been documented:-12/19/2024 10:09 A.M. Resident 5 exhibited sexual inappropriateness and verbal aggression. Resident 5 was redirected and removed from the situation. A recent gradual dose reduction of Depakote was noted.- 12/20/2024 at 10:44 A.M. Resident 5 had verbal aggression, yelling and cursing at staff in the main dining room and hallway. Resident 5 had been effectively re-directed to his room to finish his breakfast meal and educated on appropriate language.-12/20/2024 at 1:21 P.M. Resident 5 had refused radiation therapy. Resident 5 had been educated and responded with cursing language.-12/23/2024 at 12:25 P.M. Resident 5 had refused radiation therapy.-12/24/2024 at 9:26 A.M. Resident 5 had refused morning medications.-12/26/2024 at 10:40 A.M. Resident 5 had refused radiation therapy.-12/27/2024 at 11:31 A.M. Resident 5 had refused his radiation therapy.-12/30/2024 at 9:31 A.M. Resident 5 had verbal aggression towards staff with breakfast in room. Resident 5 was offered an alternative meal. The potential root cause per the interdisciplinary team included the behaviors could have been contributed to radiation treatment and dealing with a cancer diagnosis and treatment.-1/6/2025 at 12:11 P.M. Resident 5 had refused his radiation therapy.-1/7/2025 at 9:22 A.M. Resident 5 had cursed at nursing staff due to his breakfast had been sent to his room instead of the dining room-1/7/2025 at 3:28 P.M. Resident 5 had used vulgar language in the dining room. Resident 5 was effectively redirected and educated on language.-1/8/2025 at 4:17 P.M. Resident 5 had foul language directed at staff. Re-education had been attempted, but Resident 5 responded with racial slurs and cursing.-1/10/2025 at 10:25 A.M. Resident 5 had been cursing at staff. Resident 5 was redirected and reeducated on language. The interdisciplinary team indicated the root cause could have been ongoing stressors for radiation and chemotherapy.-1/17/2025 at 4:09 P.M. Resident 5 had refused all morning medications.-1/27/2025 at 11:24 A.M. Resident 5 had been belligerent in the main dining room. Resident 5 had been educated and removed from the dining room. The interdisciplinary team felt the behavior was related to the environment and his bi-polar disorder.-1/27/2025 at 5:33 P.M. Resident 5 had been hostile towards other residents and used vulgar language. Resident 5 returned to his room.A Nursing Progress Note, on 1/28/2025 at 10:40 A.M., indicated the interdisciplinary team had attempted to discuss inappropriate behaviors of vulgar language, disruptive behaviors in the dining room, mood swings, unprovoked irritability and lashing out at others with Resident 5. Resident had not been receptive to the conversation and used vulgar language towards the interdisciplinary team.A Nursing Progress (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note, on 1/28/2025 at 4:45 P.m., indicated an order had been obtained from the psychiatric nurse practitioner for an in-patient psychiatric evaluation and treatment.A Nursing Progress Note, on 1/28/2025 at 5:01 P.M., indicated the social services staff member and Resident 5's power of attorney (POA) had attempted to meet with the resident in his room. Resident 5 had continued to be resistive to conversations, and yelled and cursed.A Nursing Progress Note, on 1/29/2025m at 11:11 A.M., indicated the interdisciplinary team, Resident 5's POA's and the resident had a care plan to discuss his behaviors. Resident 5 continued with vulgar language and threatened others in the meeting.A Psychiatric Nurse Practitioner (NP) Progress Note, on 1/9/2025 at 5:55 P.M., indicated a visit had occurred for an acute visit for medication follow-up for behaviors, psychotropic medication review and management and continued evaluation of moods and behaviors. Resident 5 had the current diagnoses of bipolar disorder, anxiety, other depressive episodes and restlessness and agitation. The NP indicated the Depakote medication would be increased for Resident 5's bipolar disorderA Discharge Summary , dated 2/5/2025, from the psychiatric hospital indicated Resident 5 had been admitted due to some increased physical aggression and agitation. He had received a new diagnosis of schizoaffective disorder, bipolar type, during this hospitalization. There was no documentation of any delusional or hallucinatory behaviors during the acute psychiatric hospital stay.A form titled, Schizoaffective Disorder Diagnosis Assessment had been signed by the facility nurse practitioner, on 3/12/2025. The Assessment indicated Resident 5 had had a major mood episode that had lasted for an uninterrupted period of time, mood symptoms had been present for the majority of the illness and the symptoms had not been caused by substance abuse. In addition, the nurse practitioner indicated Resident 5 had exhibit behaviors of aggression, verbal threats, irritability and mood swings. She indicated Resident 5 was sent for an inpatient psychiatric stay and had received the diagnosis of schizoaffective disorder. However, the assessment indicated Resident 5 had not had delusions or hallucinations for two or more consecutive weeks without a major mood disorder/symptoms sometime during the life of the illness.A policy was requested for schizoaffective disorder, on 12/23/2025 at 11:32 A.M. The Director of Nursing indicated at 12:36 P.M., the facility did not have a policy for schizoaffective disorder, and the facility followed the federal regulations.3.1-35(g)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interview, the facility failed to ensure interventions from a prior elopement were in place to prevent the potential of future elopements at the facility for 1 of 1 resident reviewed for elopement. (Resident 27)Finding includes:A record review for Resident 27 was completed on 12/19/2025 at 9:37 A.M. Diagnoses included, but were not limited to: Alzheimer's disease, major depressive disorder and anxiety.An admission Minimum Data Set (MDS) assessment, dated 9/9/2025, indicated Resident 27 had severe cognitive impairment, was independent with mobility and had a behavior of wandering that placed Resident 27 at significant risk to potentially get to a dangerous place and intrude on the privacy of others. An Elopement Risk Assessment, dated 9/2/2025, indicated Resident 27 was at risk for elopement A Care Plan, initiated on 9/2/2025 and revised on 9/5/2025, indicated Resident 27 was at risk for elopement per the Elopement Risk Assessment related to Alzheimer's disease, was independently mobile, requested to go home and searched for home, wandered aimlessly and was often seen pushing or tried to open doors. Interventions included, but were not limited to: redirect Resident 27 to her room with the Food Network channel, all facility exits secured and a Wanderguard (magnetic door locking system) in place per the physician order.During an observation, on 12/19/2025 at 10:38 A.M., the dry food storage door was unlocked without a staff member in the room and the exit door, located within the dry storage room, had a key to the door, on a keychain ,hanging from the locked door.During an observation, on 12/22/2025 at 2:37 P.M., the Dietary Manager was observed walking into the dry storage room without using a key to unlock the door. A Nursing Progress Note, on 9/2/2025 at 3:15 P.M., indicated a nursing assistant had observed Resident 27 wandering the facility and standing at the back door. A Nursing Progress Note, on 9/2/2025 at 4:30 P.M., indicated Resident 27 had been walking the hallways looking for her husband. A Nursing Progress Note, on 9/3/2025 at 3:18 A.M., indicated Resident 27 was awake and upset her husband had left her at the facility. Resident 27 indicated she wanted to go home.A Behavioral Note, on 9/3/2025 at 9:59 A.M., indicated Resident 27 had been observed wandering in the hallway and at the facility's back door. The interdisciplinary team felt the root cause had been she was a new admission to the facility and unfamiliar with her surroundings. A Nursing Progress Note, on 9/5/2025 at 1:44 P.M., indicated Resident 27 had been walking in the facility and stated she needed to leave and go to her sister's house. Resident 27 also had stated she had been waiting on her husband to pick her up and she did not want to be at the facility. A Nursing Progress Note, on 9/5/2025 at 9:21 A.M., indicated Resident 27 had been wandering into other residents' rooms and lingering by the door. Resident 27 had indicated she did not need to be at the facility and wanted to go home. A Nursing Progress Note, on 9/7/2025 at 3:26 P.M., Resident 27 had been observed going to the facility side door. A Nursing Progress Note, on 9/8/2025 at 2:40 P.M., indicated Resident 27 had been walking the hallways all morning and afternoon. Resident 27 had not made any attempts to exit the facility, but had continued to make statements about going home and leaving the facility. A Behavioral Progress Note, on 9/9/2025 at 10:17 A.M., indicated Resident 27 had exited the facility through the dry storage door but had remained on the facility's property. A Care Plan, initiated on 9/2/2025 and revised on 9/5/2025, indicated Resident 27 was at risk for elopement per the Elopement Risk Assessment related to Alzheimer's disease, was independently mobile, requested to go home and searched for home, wandered aimlessly and often seen pushing or tried to open doors. Interventions included, but were not limited to: redirect Resident 27 to her room with the Food Network channel, all facility exits secured and a Wanderguard in place per the physician order.During an interview, on 12/23/2025 at 10:46 A.M., Qualified Medication Assistant (QMA) 4 indicated the dry storage door and the exit door inside the dry storage (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room should both have been locked. During an interview, on 12/23/2025 at 10:46 A.M., the Director of Nursing indicated the exit door in the dry storage room doors should have been locked, both the outside and inside doors. A current policy was provided, on 12/23/2025 at 12:36 P.M., by the Director of Nursing. The policy titled, Elopement Prevention and Response Programs, indicated, .It is the policy of the facility that staff who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensure appropriate action is taken.3.1-45(a)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure narcotics were reconciled for 2 of 2 medication carts reviewed for narcotic reconciliation. (Front and Back Medication Carts)Findings include:During a medication cart observation with LPN 2, on 12/18/2025 at 8:14 A.M., the Shift Change Verification of Controlled Substances was reviewed and the following dates did not contain signatures that the shift to shift reconciliation's had been completed. Front Cart-December 5, 11 and 12, 2025Back Cart-December 3, 10, and 17, 2025During an interview on 12/18/2025 at 8:20 A.M., the Director of Nursing (DON) indicated narcotics should have been counted after each shift and the narcotic log signed. A policy titled American Senior Communities policy-Controlled Substances: Storage, Documentation, Inventory, and Description was provided by the ADM on 12/18/2025 at 1:57 P,M., and deemed as current. The policy indicated: .The incoming nurse or QMA will count all controlled substances being stored at the facility while the outgoing nurse watches the process. Both staff members sign the that the count sheets and verification have been completed with no discrepancies 3.1-25(n)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on observation interview, and record review, the facility failed to monitor for the continued need for a PRN (as needed) antianxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 1)Findings included:A record review was completed on 12/19/2025 at 11:16 A.M. for Resident 1. Diagnoses included, but were not limited to, anxiety disorder.An admission Minimum Data Set (MDS) assessment, dated 11/26/2025, indicated Resident 1's cognition was intact she had not exhibited any behavior issues and she had received antianxiety medication.Current Physician Orders included, but were not limited to:-On 11/20/2025 lorazepam 1 milligram (mg) by mouth 3 times a day as needed (PRN) for anxiety, discontinue on 11/21/2025.-On 11/21/2025 lorazepam 1 mg by mouth 3 times a day as needed for anxiety, discontinue on 11/25/2025.-On 11/25/2025 lorazepam 1 mg by mouth 3 times a day as needed for anxiety, discontinue on 12/5/2025.-On 12/10/2025 lorazepam 1 mg by mouth 3 times a day as needed for anxiety, discontinue on 12/11/2025.-On 12/11/2025 lorazepam 1 mg by mouth 3 times a day as needed for anxiety, discontinue on 12/23/2025. A Care Plan problem, dated 11/26/2025, indicated Resident 1 was at risk for signs and symptoms of anxiety. Interventions included, maintain a calm environment or move to a quiet area, administer medications as ordered, and psychological services as needed.There was no documentation of Resident 1's symptoms of anxiety prior to administering an as needed (PRN) lorazepam. In addition, there was no documentation of any non-pharmacological interventions attempted and effectiveness of the interventions prior to the administration of the medication. Finally, there was no documentation of the effectiveness of the lorazepam medication.During an interview on 12/23/2025 at 9:48 A.M., Resident 1 indicated sometimes she could not sleep because her mind was racing and it (the lorazepam medication) helped to calm her so she could sleep. In addition, Resident 1 indicated the other reasons she asked for the medication was if it was not time for her pain medication, it helped to calm her and brought her anxiety down from 7 or 8 to 5 rate while she waited on her next dose of pain medication.During an interview on 12/23/2025 at 9:53 A.M., LPN 2 indicated Resident 1 was overall visibly very anxious and her pulse and respirations were elevated. She also indicated she does not usually document in the Nurses Progress Notes because when signing out the lorazepam in the medication administration record, she marked it was for anxiety. She indicated she had tried non-pharmaceutical interventions but she had not documented them.During an interview on 12/23/2025 at 9:58 A.M., the DON indicated that best practice would have been to document symptoms and reasons for the PRN lorazepam, non-pharmacological interventions tried, and the effectiveness of the lorazepam.On 12/23/2025 at 10:03 A.M. the DON indicated there was not a policy that specifically addressed PRN psychotropic medications.3.1-48(a)(3)