

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/10/2012
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N LINCOLN ST GREENSBURG, IN 47240
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F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: May 7, 8, 9, and 10, 2012</p> <p>Facility number: 000244 Provider number: 155353 AIM number: 100288790</p> <p>Survey team: Janie Faulkner, RN TC Cheryl Fielden, RN [May 9 and 10, 2012] Jill Ross, RN [May 7, 8, and 9, 2012] Diana Sidell, RN [May 9 and 10, 2012] Susan Worsham, RN</p> <p>Census bed type: SNF/NF 30 Total 30</p> <p>Census payor type: Medicare 4 Medicaid 20 Other 6 Total 30</p> <p>Sample: 10 Supplemental sample: 2</p>	F0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Hickory Creek at Greensburg desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 6/9/12.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 17, 2012 by Bev Faulkner, RN</p>				

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F0253 SS=C	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observations and interview, the facility failed to ensure window sills and heater register grids were clean and not covered with a thick layer of dust. This was observed on 2 different occasions in 16 of 18 occupied residents rooms, the main dining room and the therapy/feed dining room. This affected 30 out of 30 residents in the facility at time of observation.</p> <p>Findings include:</p> <p>During the environmental tour on 5/8/12 at 1:27 p.m., with the Maintenance/Housekeeping Supervisor the following was observed: Resident Rooms 1, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, &18 plus the main dining room and therapy/feed dining rooms had window sills with thick layers of dust. In Resident Rooms 2, 5, 8, 10, 11, 12, 14, 15, 16, 17, & 18, the heater register grids had a thick layer of dust. Resident Rooms 2, 5, 15, 16, 17, & 18 had rust on the heater register grids.</p> <p>In interview with the Maintenance/Housekeeping Supervisor</p>	F0253	<p>F-253 Housekeeping & Maintenance Services It is the policy of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> The Maintenance/Housekeeping Supervisor re-educated the housekeeping staff on dusting procedure on 5-24-12, including the dusting of window sills and heater register grids that are present throughout the facility. An inspection was done on 5-11-12 of the heater register grids that had rust on them. The Maintenance Supervisor has removed the grids, sanded to bare metal and painted each with rust resistant paint. <u>2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?</u> All residents have the potential to be affected by this practice. If the Administrator or other department managers observe dust collecting on any surfaces in the building or any</p>	06/09/2012			

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	<p>on 5/8/12 at 2:00 p.m., he indicated he would take a vacuum and clean the heater grids, have the housekeeper clean all window sills and they would take out the heater grids, sand and repaint them. "The window sills and heater grids are to be cleaned with each day's cleaning. This should be done everyday."</p> <p>On 5/9/12 at 11:05 a.m., another tour with the Maintenance/Housekeeping Supervisor was conducted to re-check the window sills for cleanliness. He indicated the housekeeper had done some of the rooms and we could see if it was done properly. During observation at this time of 4 rooms (Rooms 1, 4, 6, & 7) there was still dust in the window sills and heater grids. The observation was discontinued at this time and he indicated he would go back to the housekeeper to be sure she understood what needed to be done. No other observations were done during this survey.</p> <p>3.1-19(f)</p>		<p>heating register grids that are rusty, the Administrator or Maintenance/Housekeeping Supervisor will make sure that these items are corrected as soon as possible. Once that is done, the Administrator or Maintenance/Housekeeping Supervisor will re-train staff involved and render progressive disciplinary action for continued noncompliance. <u>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> The Maintenance Supervisor has added the checking of the heater grids for rust to the monthly Preventive Maintenance log – they will be checked monthly on a routine basis. The housekeeper dusts the grids daily and if rust is noted in between the PM checks they will notify the Maintenance Supervisor immediately. The Administrator or Designee will make rounds at least 5 times a week for 30 days to assess accuracy of dusting and to assess grids for rust. Any issues that are noted will be addressed as indicated in question #2. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the rounds to the monthly QA&A meeting for review and recommendations. After the 30</p>		

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			days is finished, the QA&A committee can change the frequency of the rounds or can discontinue the rounds when 100% compliance is achieved. Even when the specific rounds are discontinued, the Administrator and department managers will continue to check for collected dust and heater grid rust as part of their routine rounds that will be done on an ongoing basis. Date of Compliance: 6/9/12	

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the base legs on a mechanical lift and the brakes on a wheelchair were locked prior to transfer of residents. This deficient practice affected 2 of 2 residents in a supplemental sample of 2. (Residents # 22, # 16)</p> <p>Findings include:</p> <p>1. On 5/09/12, at 3:15 p.m., Resident #22 was observed being brought to Resident #22's room to be assisted with ADL's (Activities of Daily Living). After a Hoyer sling was placed under Resident #22, CNA #1 and CNA #2 attached the straps to the Hoyer. CNA#1 then raised Resident #22 above the Geri-Chair. The base legs were not locked. Resident #22 was then lifted over to the resident's bed, and lowered down, again without the base legs locked. The Hoyer was moved out of the way for care to be done for Resident # 22.</p> <p>After ADL's were completed, CNA # 1</p>	F0323	<p>F-323 Free of Accident Hazards/Supervision/Devices <u>It is the policy of this facility that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents including the proper use of mechanical lifts. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> The Director of Nursing re-educated nursing staff 5-24-12 on the proper use of the mechanical lifts during resident transfers. 2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by this practice. There have been no other resident affected by this practice. If any staff is observed not to follow the facility policies and procedures regarding mechanical lifts and resident transfers the DON will stop that person at that time and make</p>	06/09/2012

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	<p>brought the Hoyer back over the top of Resident #22's bed, lowering it down to the bed, and re-hooked the straps. Again it was observed that the Hoyer base legs were not locked. CNA#1 then transferred Resident #22 back over to the Geri-Chair, again not locking the base legs on the Hoyer.</p> <p>Record Review on 5/10/12, at 7:15 p.m., of the facility's Nursing Policy and Procedure, provided by the Director of Nursing (DON), issue date of February 2004, revised 9/04, and 6/06, stated on page 1 of 2 under "Guidelines: Before lifting or transferring the resident, the base legs must be locked in the OPEN position for optimum stability and safety".</p> <p>During an interview with CNA #1 on 5/10/12 at 1:30 p.m., when questioned about the procedure for using the Hoyer lift and the locking of the base legs, CNA # 1 indicated she thought the legs should be locked. In an interview with LPN # 1 on 5/10/12 at 1:45 p.m., regarding if the legs for the Hoyer should be locked, the LPN replied, "Yes of course."</p> <p>2. On 5/10/12, at 10:25 a.m., Resident # 16 was observed being wheeled into the bathroom after requesting toileting assistance. CNA # 3 was observed lining the wheelchair up to the grab bar for</p>		<p>sure that the resident is safe. Once that is done, she will retrain staff involved on the policy and procedure. Progressive disciplinary action will be given for continued lack of compliance.</p> <p><u>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> Every certified nursing assistant and licensed nurse will be educated on the facility policy/procedure related to mechanical lift and wheelchair transfer and will complete a satisfactory documented return demonstration using the lift in the next 30 days. The DON or designee will perform random rounds to observe staff performance at least 5 days a week to assess accurate/safe mechanical lift and wheelchair transfers by staff. The results of those rounds by the DON or designee will be documented on the QA form "F323". Any issues or concerns identified at that time will be addressed as indicated in question #2. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of the QA audit to the interdisciplinary team morning meeting 5 days per week, the weekly Standards of Care meeting, and the monthly QA&A Committee meeting for</p>				

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	<p>Resident # 16 to use to pull self up and to maneuver onto the toilet. It was observed the wheelchair brakes were not applied. Observation of Resident # 16 after toileting, the resident was again observed to pull up on the grab bar, assisted with clothing by CNA # 3, and turned around to sit in the wheelchair. The brakes were still not in the locked position.</p> <p>Upon record review at 05/10/12 at 7:30 p.m., of the facility's "Safety/Handling of Wheelchairs" policy, provided by the DON on 5/10/12, at 2:04 p.m., on page 18, Transferring To and From Other Seats, it states under "WARNING: Also be certain that the wheel locks are engaged to help prevent the wheels from moving" Under "CAUTION" on page 18, it states "Engage wheel locks."</p> <p>3.1-45(a)(2)</p>		<p>review and recommendations. The QA audit will be done 5 days a week for 30 days. After that time the audit tool will continue at a frequency determined by the QA&A committee, and can be discontinued by the QA&A committee when 100% compliance is achieved. Even when the written QA audit is discontinued, the Administrator, DON, or designee will continue observations of staff performance using the mechanical lift for resident transfers as part of their regular rounds during each tour of duty. Date of compliance: 6/9/12 Auditor's Name: _____ Date: _____</p>		

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review,</p>	F0441	F-441 Infection Control, Prevent Spread, Linens It is the	06/09/2012

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	<p>the facility failed to ensure soiled linens were handled to prevent cross contamination and soiled gloves were removed after potential contamination during 1 of 2 observations of care in a supplemental sample of 2. (Resident # 22)</p> <p>Findings include:</p> <p>On 5/9/12, at 3:15 p.m., CNA # 1 was observed performing incontinence care with gloved hands to Resident # 22 with the assistance of CNA # 2 who also was wearing gloves. After CNA # 1 finished cleaning Resident #22, the CNA placed the soiled wash cloths on the blanket at the foot of Resident # 22's bed. CNA # 1 and CNA # 2 were observed to keep the soiled gloves on their hands.</p> <p>CNA # 2 was observed picking up a clean brief that had fallen onto the floor, and CNA # 2 and CNA #1 proceeded to place and secure it on Resident # 22.</p> <p>CNA #1 was then observed placing her soiled gloved hand into her uniform pocket and pulling out a plastic bag, giving it to CNA # 2 to place Resident #22's soiled linens into it. CNA # 2 pushed Resident # 22 in his geri chair towards the door, stopped and removed her soiled gloves and threw soiled gloves in trash can. CNA # 2 pushed Resident #</p>		<p>policy of this facility to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection including the proper use of gloves and the separation of clean and dirty linen. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> The Director of Nursing re-educated nursing staff on 5-24-12 on infection control including, proper glove use, hand washing and clean linen handling. <u>2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?</u> All residents have the potential to be affected by this practice. If any staff is observed not to follow the facility policies and procedures regarding glove use, hand washing and clean linen handling the DON will stop that person at that time, and retrain them on the policy and procedure. Progressive disciplinary action will be given for continued lack of compliance. <u>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> The DON or designee will perform</p>				

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	<p>22 in his geri chair to the front hall in front of the birdcage. CNA # 2 then removed alcohol gel from her pocket and put alcohol gel in her hands to cleanse. CNA # 2 was not observed to wash her hands at any time during or after care. CNA # 1 was observed to remove her soiled gloves and wash her hands prior to leaving the resident's room.</p> <p>Review of Nursing Policy and Procedure related to Linen Handling at 5/10/12 at 8:00 p.m., received from DON on 5/10/12, at 2:04 p.m. revised 4/07, states "POLICY: All linens shall be handled in such a way as to prevent cross contamination." "Remove soiled linen from the room immediately by placing in hamper."</p> <p>3.1-18(l) 3.1-18(j)</p>		<p>random rounds 5 days a week for 30 days to assess accuracy of proper glove use, hand washing and clean linen handling. If any issues are observed, the DON will proceed as indicated in question #2. Rounds by the DON or designee will be documented on the QA form "F441" and the results will be brought to the interdisciplinary team meeting at the next scheduled morning management meeting for review.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of QA audit to the interdisciplinary team meeting at least 5 days per week, the weekly Standards of Care meeting, and the monthly QA&A Committee meeting for review and recommendations. The QA audit will be done 5 days a week for 30 days. At that time the audit tool will continue at a frequency determined by the QA&A committee, and can be discontinued by the QA&A committee when 100% compliance is achieved. Even when the written QA audit is discontinued, the Administrator, DON, or designee will continue observations of staff performance as part of their regular rounds during each tour of duty. Date of compliance: 6/9/12</p>		

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