STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 6, 7, 8, 9, and 10, 2023 Facility number: 000244 Provider number: 155353 AIM number: 100288790 Census Bed Type: SNF/NF: 30 Total: 30 Census Payor Type: Medicare: 2 Medicaid: 24 Other: 4 Total: 30 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 15, 2023.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiency, or any violation of regulation. The provider respectfully requests that this 2567 Plan of Correction be considered for Letter of Credible Allegations of Compliance and requests a desk review in lieu of a post survey review on or after September 10, 2023.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record	F 0684	**1)**	09/10/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brooke	Thies	08/30/2023

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	review, the facility failed to complete neurological assessments after a fall for 1 of 4 residents reviewed for accidents. (Resident 22) Findings include: During an observation on 08/08/23 at 9:59 A.M., Resident 22 was in his wheelchair. A staff member was assisting the resident to go outside for some fresh air. A Quarterly MDS (Minimum Data Set) assessment, dated 07/14/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, hypertension, non-Alzheimer's dementia, hemiplegia or hemiparesis, and depression. The resident required extensive assistance of two or more staff members with bed mobility and transfers. A Fall Event, dated 02/02/23, indicated the resident had an unwitnessed fall at 9:30 P.M. He was found lying on the floor face up on his back. The resident indicated he had leaned too far off the bed and fell on his back. The resident was assessed with no injuries. His vital signs were stable and neurological checks were initiated. A Neurological Assessment, dated 02/02/23, lacked documentation to indicate the resident's neurological checks were completed on the following dates and times: - 02/02/23 at 9:45 P.M., 10:00 P.M., 10:15 P.M., 11:15 P.M., 11:45 P.M., and - 02/03/23 at 1:15 A.M., 2:15 A.M., 3:15 A.M. During an interview on 08/09/23 at 1:51 P.M., LPN (Licensed Practical Nurse) 2 indicated the resident		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #22 fall event 2/2/23 was reviewed on 8/30/32 at which time the physician was contacted and notified of the missed neurological assessments on 2/2/23 at 9:45am, 10:00pm, 10:15pm, 11:15pm, 11:45pm and on 2/3/23 at 1:15am, 2:15am, 3:15pm. **2) How other residents having the potential to be affected by t he same deficient practice will be identified and what corrective action(s) will be taken.** All residents having falls have the potential to be affected. A fall audit was completed on all residents who fell in the last 30 days to ensure neurological assessments were completed per schedule. The DNS/designee will re-educate the facility nurses on Fall Management Policy and Neurological Assessment procedure on 9/6/23 **3) What measures will be put into place or what systemic change s will be made to ensure that th e deficient practice does not re cur?** The DNS/designee will re-educate facility nurses on the Fall Management Policy and	

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	currently had used a mechanical lift for transfers due to some recent falls. If a resident had an unwitnessed fall the nurse was to assess the resident, obtain their vitals, and assist the resident up. If the fall was not witnessed the nurse should initiate neurological checks. The neurological checks were completed on paper. Once they were complete, she would file them in the resident's file or put them in the DON's box. The current facility policy titled, "Fall Management", with a revised date of 8/2022, was provided by the DON on 08/09/23 at 3:34 P.M. The policy indicated, "...to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls...Post fall...any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided. A neurological assessment will be initiated on all un-witnessed falls..." A current, undated, "Neurological Assessment" procedure form was provided by the DON on 08/09/23 at 3:34 P.M. The form indicated neurological assessment documentation should included, "...Date ...Time...Q [every] 15 min [minutes] x [times] 1 hr [hour]...Q 30 min x 2 hr...Q 1 hr x 4 hr...Every eight hours x 72 hours..." 3.1-37(a)		Neurological Assessment. When a resident has an unwitnessed fall a neurological assessment will be initiated. The oncoming nurse will review the fall event and continue the neurological assessments per the schedule. If there are missing neurological assessments, the nurse will contact the physician. The DNS/designee will complete a review of the neurological assessments schedule during the daily clinical meeting. **4)** **How the corrective action(s) wil l be monitored to ensure the de ficient practice will not recur, i.e. what quality assurance pro gram will be put into place?** To ensure compliance the DNS/Designee will complete Fall Management CQI Tool weekly x 4 weeks, monthly x 6 months, then quarterly for 6 months. If a 100% threshold is not achieved, a different action plan will be developed to ensure compliance. Results will be reported to QAPI committee.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with			

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	professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure appropriate interventions were in place for a resident at risk for pressure ulcers that currently had a pressure ulcer for 1 of 2 residents reviewed for pressure ulcers. (Resident 25) Findings include: Resident 25 was observed in her room in bed on 08/06/23 at 1:15 P.M. The resident was wearing a pressure reducing boot on her right foot. The resident was not wearing a boot on her left foot. The resident's left foot was not elevated, and her heel was resting on the mattress. On 08/07/23 at 9:36 A.M., the resident was observed in a common area. The resident was sitting in a broda (positioning wheelchair) chair. A pressure reducing boot was on the resident's right foot. The resident was wearing a nonskid sock on her left foot. Her left heel was resting on the chair footrest. On 08/08/23 at 9:50 A.M., the resident was observed in her room in her chair. The chair was in a reclined position, with the resident's legs extended and her feet up on the footrest. The resident was wearing a pressure reducing boot on her right foot and a non-skid sock on her left. The	F 0686	**1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #25 pressure ulcer interventions were reviewed on 8/30/23 by the IDT team with new intervention/order added, 8/30/23 to wear bilateral heel boots at all times as resident will allow. **2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents with risk for pressure ulcers had the potential to be affected. A review of interventions was completed on 8/30/23 for all residents at high risk for pressure ulcers to ensure appropriate interventions are in place. The DNS/designee will re-educate facility nurses on the facility Skin Management Program on 9/6/23. **3)** **What measures will be put into**	09/10/2023

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	resident's left heel was in contact with the chair footrest. On 08/08/23 at 10:54 A.M., the resident's right heel wound was observed with the ADON (Assistant Director of Nursing). The resident was in her room in her chair. The chair was reclined, with the resident's legs extended and her feet were up on the footrest. The resident was wearing a pressure reducing boot on the right foot and a non-skid sock on the left. The resident's left heel was in contact with the chair footrest. The ADON removed the boot and sock from the resident's right heel. A golf ball sized wound was observed on the resident's right heel. The wound bed was dry and dark brown in color. There was no drainage or signs of infection. During an interview on 08/08/23 at 10:55 A.M., the ADON indicated the resident has had the wound on the right heel for less than two months. The wound started out as intact blister. The resident did not wear pressure reducing boots before the wound developed. The ADON indicated she was the facility wound nurse. The resident was to wear the boot while she was up in her chair. The resident's left heel was resting on the footrest of the chair. The resident was not wearing a pressure reducing boot on the left foot. She was not sure why she wasn't wearing a boot on the left foot. She had looked before, and couldn't find another boot in the resident's room, she thought it might have been in the laundry. A Significant Change MDS (Minimum Data Set) assessment, dated 06/21/23, indicated the resident was severely cognitively impaired. The resident required extensive to total staff assistance for all ADLs (Activities of Daily Living). The resident's diagnoses included, but were not limited to,		**place or what systemic changes will be made to ensur e that the deficient practice does not recur?** The DNS/designee will re-educate facility nurses on the Skin Management Program. in-serviced nursing staff on proper and appropriate interventions for residents at risk for pressure ulcers. When a resident is identified as at risk for pressure ulcers, interventions will be initiated to prevent injury. The DNS/designee will review the Facility Activity Report daily to identify any change in condition and ensure appropriate interventions are initiated during the daily clinical meeting. DNS/designee will round each shift to ensure pressure reducing interventions are in place per plan of care. **4) How the corrective action(s) wil l be monitored to ensure the de ficient practice will not recur, i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete Skin Management CQI Tool weekly x 4 weeks, monthly x 6 months, then quarterly for 6 months. If a 100% threshold is not achieved, a different action plan will be developed to ensure compliance. Results will be reported to QAPI	

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	stroke, dysphagia, hemiplegia, malnutrition, and depression. The resident was at risk for pressure ulcers and had one, unhealed Stage 2 (Partial-thickness skin loss with exposed dermis, presenting as a shallow open ulcer. The wound bed was viable, pink, or red, moist, and may also present as an intact or open/ruptured blister) pressure ulcer at the time of the assessment. The resident received hospice services. On 08/09/23 at 8:49 A.M., the resident was observed in her room in her chair. The chair was in a reclined position, with the resident's legs extended and her feet up on the footrest. The resident was wearing a pressure reducing boot on her right foot and a non-skid sock on her left. The resident's left heel was in contact with the chair footrest. On 08/09/23 at 10:10 A.M., the resident was observed in her room in her chair. The chair was reclined, with the resident's legs extended and her feet up on the footrest. The resident was wearing a pressure reducing boot on her right foot and a non-skid sock on her left. The resident's left heel was in contact with the chair footrest. On 08/09/23 at 1:29 P.M., the resident was observed in the common area near the television. The resident's chair was reclined, with the resident's legs extended and her feet up on the footrest. The resident was wearing a pressure reducing boot on her right foot and a non-skid sock on her left. The resident's left heel was in contact with the chair footrest. On 08/09/23 at 2:09 P.M., the resident was observed in the common area near the television. The resident's chair was reclined, with the resident's legs extended and her feet up on the		committee.	

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	footrest. The resident was wearing a pressure reducing boot on her right foot and a non-skid sock on her left. The resident's left heel was in contact with the chair footrest. On 08/10/23 at 9:20 A.M., the resident was observed in her room in her chair. The chair was reclined, with the resident's legs extended and her feet up on the footrest. The resident was wearing a pressure reducing boot on her right foot and a non-skid sock on her left. The resident's left heel was in contact with the chair footrest. A Wound Management Detail Report indicated the resident's Stage 2 pressure wound was first observed on 06/27/23 at 11:23 A.M. The wound measured 4 cm (centimeters) x 3.5 cm. The depth could not be measured. The comments section indicated the wound was an intact blister on the resident's right heel that was pale in color and firm to touch. A liquid skin protectant treatment was ordered to be administered twice a day and the resident was to wear pressure reducing boots to both heels while in bed. The resident's Plan of Care was reviewed on 08/08/23 at 11:40 A.M., and included a Risk for Skin Breakdown Care Plan, with a start date of 05/22/23. The interventions included, but were not limited to, the following: - Foam boots to bilateral feet while in bed, with a start date of 06/27/23, and - Foam boot to right heel at all times, with a start date of 07/27/23. The current MD orders included, but were not limited to the following:			

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	- An open-ended order, with a start date of 06/26/23, to float the resident's heels as much as she tolerates, - An open-ended order, with a start date of 07/06/23, for the resident to wear foam boots on both feet while in bed, and - An open-ended order, with a start date of 07/27/23, for a foam boot to be in place on her right heel at all times. During an interview on 08/10/23 at 1:36 P.M., the DON (Director of Nursing) indicated the interventions in place for the resident included the foam boots that started on 06/27/23. One boot stayed on her heel at all times. The resident was to wear both of them when she was in bed. Sometimes she kicked the boot off. If a resident refused to wear boots, nursing staff should document the refusal in the resident's record. It would not hurt to have the boot on the left foot while she was up in the chair. The resident's clinical record lacked documentation the resident refused to wear the pressure reducing boots. During an interview on 08/10/23 at 2:59 P.M., CNA (Certified Nurse Aide) 5 indicated she worked second shift and was familiar with the resident. She assisted the resident into bed. Pressure reducing interventions they had implemented for the resident included turning and repositioning the resident every 2 hours. The resident liked to lean on her left side, so they tried to keep pressure off that side. The resident wore a pressure reducing boot on her right foot because she had a pressure ulcer on her right heel. They did not put a pressure reducing boot on her left foot, and she			

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	didn't wear a pressure reducing boot on her left foot when she was in bed. There were two boots in her room, but they were both for the right foot in case one of them was soiled. The current facility policy, titled "SKIN MANAGEMENT PROGRAM", with a most recent revision date of 05/22, was provided by the DON on 08/10/23 at 2:24 P.M. The policy indicated, "...a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing..." 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the identified fall intervention, of a trapeze bar, was accessible for 1 of 4 residents reviewed for accident hazards. (Resident 22) Findings include: The clinical record for Resident 22 was reviewed on 08/09/23 at 2:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/14/23,	F 0689	**1) What corrective action will be accomplished for those residents found to have been af fected by the deficient practice?** Resident #22's trapeze bar was assessed on 8/10/23 and is within reach and accessible. **2) How other residents having th e potential to be affected by th**	09/10/2023

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	indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, hypertension, non-Alzheimer's dementia, hemiplegia or hemiparesis, and depression. The resident required extensive assistance of two or more staff members with bed mobility and transfers. A Fall Event, dated 07/04/23 at 12:55 P.M., indicated the resident had an unwitnessed fall. The resident was found sitting on the floor next to the bed. The resident stated he was trying to scoot himself up in bed. An IDT (Interdisciplinary Team) Note, dated 07/05/23 at 12:41 P.M., indicated the resident had an unwitnessed fall, he was observed sitting beside the bed. The resident was trying to scoot back in the bed and slid out of the bed. An intervention was put into place for a trapeze bar to assist in positioning. An at-risk fall Care Plan, with a start date of 10/24/22 and a revised date of 08/09/23, indicated the intervention, with a start date of 07/05/23, was for the resident to have a trapeze bar to assist the resident with positioning himself in bed. During an observation on 08/09/23 at 2:25 P.M., the resident was lying in bed on his back. The triangle trapeze grab bar over the resident's bed was hung to high and not accessible by the resident. During an observation on 08/10/23 at 10:03 A.M., the resident was lying in bed on his back. The triangle trapeze grab bar over the resident's bed was hung to high and not accessible by the resident.		**e same deficient practice will b e identified and what correctiv e action(s) will be taken.** All residents having falls have the potential to be affected. Care profiles have been reviewed x1 for all residents to ensure all plan of care interventions are in fact in place. All nursing staff will be re-educate regarding ensuring fall interventions are in place per Fall Management Policy on 9/6/23. **3)** **What measures will be put into place or what systemic change s will be made to ensure that th e deficient practice does not recu r?** All nursing staff will be re-educated on the Fall Management Policy ensuring fall interventions are in place per the resident care sheets and care plan. When providing care to a resident, CNAs and nurses will ensure fall interventions are in place per the resident care sheets and the care plan. The department head team will complete care companion rounds ensuring fall interventions are in place for their assigned residents. The DNS/designee will round each shift to ensure fall interventions are in place per plan of care. **4)** **How the corrective action(s)**	

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	During an interview and observation on 08/10/23 at 10:43 A.M., CNA (Certified Nurse Aide) 4 indicated the resident was able to stand when he first came to the facility. He had recently not been able to stand. A trapeze bar was added to his bed a couple of days ago to help him position himself. She confirmed that the trapeze bar was not down at that time to be accessible by the resident. During an observation and interview on 08/10/23 at 10:46 A.M., Resident 22 was lying in bed. He indicated he was able to reposition himself with the trapeze bar when it was down, but the staff left it up and he couldn't reach it. The current facility policy titled, "Fall Management", with a revised date of 8/2022, was provided by the DON on 08/09/23 at 3:34 P.M. The policy indicated, "...to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls...Residents who are categorized as moderate to high risk should have fall interventions implemented based on resident specific risk factors...The resident care specific requirements will be communicated to the assigned caregiver utilizing resident profile or CNA assignment sheet..." 3.1-45(a)(2)		**will be monitored to ensure the** **deficient practice will not recur** **,** **i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete Fall Management CQI Tool weekly x 4 weeks, monthly x 6 months, then quarterly for 6 months. If a 100% threshold is not achieved, a different action plan will be developed to ensure compliance. Results will be reported to QAPI committee.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to administer medications for a Urinary Tract Infection for 1 of 14 residents reviewed. (Resident 17) Findings include: During an observation and interview on 08/06/23 at 11:32 A.M., Resident 17 was sitting on the side of her bed. The resident indicated she has had a lot of UTI's (urinary tract infections).	F 0690	**1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #17's EMAR was reviewed on 8/30/23 and physician was notified of the missed antibiotic medication dates on 2/19/23 at 7:00am, 2/21/23 at 11:00pm, and 2/22/23 at 11:00pm. **2)** **How other residents having the**	09/10/2023

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	155353	A. BUILDING 00 B. WING	08/10/2023

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	A Significant Change MDS (Minimum Data Set) assessment, dated 06/21/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anemia, hypertension, renal insufficiency, diabetes, depression, and bipolar. A Progress Note, dated 02/16/23 at 11:03 A.M., indicated the resident had a new order for cephalexin (an antibiotic) for a UTI. A Urine Culture, dated 02/14/23, indicated the resident's urine culture organism contained Escherichia Coli (E.coli). A physician's order, dated 02/16/23 through 02/23/23, indicated the staff were to administer the resident's cephalexin 500 mg (milligrams) every 8 hours. The February 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had not received the antibiotic medication on the following dates and times: - 02/19/23 at 7:00 A.M., - 02/21/23 at 11:00 P.M., and - 02/22/23 at 11:00 P.M. A UTI Care Plan, dated 02/16/23, indicated staff were to administer the resident's antibiotics as ordered. A Progress Note, dated 03/09/23 at 8:28 A.M., indicated the resident had a new order for amoxicillin 500 mg, three times a day, for a UTI with E.coli. A physician's order, dated 03/09/23 through		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents having UTIs have the potential to be affected. A audit was completed on all residents who were treated with antibiotics in the last 30 days for a UTI was completed to ensure administration per MD order. The DNS/designee will re-educate the facility nurses on the General Dose Preparation & Medication Administration Policy on 9/6/23. **3)** **What measures will be put into place or what systemic change s will be made to ensure that the deficient practice does not recur?** The DNS/designee will re-educate facility nurses on the General Dose Preparation & Medication Administration Policy. The DNS/designee will review the administration compliance report daily to ensure medication administration during the daily clinical meeting. If an antibiotic dose is missed the MD will be notified and an investigation initiated to identify the cause of the missed antibiotic administration. **4)** **How the corrective action(s) will be monitored to ensure the**	

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	03/15/23, indicated the staff were to administer the resident's amoxicillin 500 mg, three times a day. The March 2023 EMAR/ETAR indicated the resident had not received the antibiotic medication on 03/15/23 at 7:00 A.M. During an interview on 08/10/23 at 10:04 A.M., the ADON (Assistant Director of Nursing) indicated when a medication was given it would have the nurse's initials on the EMAR. During an interview on 08/10/23 at 10:15 A.M., the DON (Director of Nursing) indicated the blank in the EMAR signified a missed medication dose. The current facility policy titled, "General Dose Preparation and Medication Administration", with a revised date of 01/01/22, was provided by the DON on 08/10/23 at 1:10 P.M. The policy indicated, "...should comply with Applicable Law and the State Operations Manual when administering medications...Document necessary medication administration/treatment information [e.g.,...when medications are given...]" 3.1-25(b)(2)		**deficient practice will not recur , i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete Antibiotic Therapy CQI Tool weekly x 4 weeks, monthly x 6 months, then quarterly for 6 months. If a 100% threshold is not achieved, a different action plan will be developed to ensure compliance. Results will be reported to QAPI committee.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to monitor/assess a resident's fistula following dialysis treatments for 1 of 1 resident	F 0698	**1) What corrective action will be accomplished for those resi dents found to have been**	09/10/2023

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	reviewed for dialysis. (Resident 24) Findings include: During an interview on 08/06/23 at 11:21 A.M., Resident 24 indicated he left the facility for dialysis treatments on Mondays, Wednesdays, and Fridays, at around 10:00 A.M. He returned around 2:30 P.M. During an interview on 08/10/23 at 9:21 A.M., the ADON (Assistant Director of Nursing) indicated, for residents who received dialysis treatments outside of the facility, the staff checked their vital signs before they left and when they came back. They were weighed when they came back. The dialysis treatment facility weighed them before and after treatments, but the facility still did their own weight when they come back to ensure it was correct. The resident had a fistula (dialysis access port) in his arm. When he returned from having a dialysis treatment the staff at the facility checked his fistula for a bruit and thrill. They checked the bruit and thrill every day each 12-hour shift, but upon return from dialysis it was checked to make sure it was not bleeding or swollen. They also reviewed his dialysis binder when he returned from treatments. The dialysis center put information in the binder that the facility staff needed to review. Facility staff documented the assessments of the resident before and after dialysis treatments under "Events" in the EHR (Electronic Health Record). The resident had not been sent out to the hospital in the last three months. The facility did not fill out any paper on the post dialysis assessment. The post dialysis assessments were in the computer. During an interview on 08/10/23 at 9:36 A.M., the DON (Director of Nursing) indicated there should		**affected by the deficient practic e?** Resident #24's fistula site is monitored and assessed following dialysis treatments. Resident 24's MD was notified of the missed dialysis events on 8/30/23. **2)** **How other residents having the potential to be affected by t he** **same deficient practice will be identified and what corrective action(s) will be taken.** All dialysis residents admitted had the potential to be affected. A dialysis event audit will be completed for the last 30 days to ensure fistula monitoring is being completed. The DNS/designee will re-educate the facility nurses on the Dialysis Care policy on 9/6/23. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DNS/designee will re-educate facility nurses on the Dialysis Care policy. Prior to a resident leaving for dialysis a dialysis event will be initiated with completion upon return from dialysis to include fistula site monitoring. The DNS/designee will review dialysis event completion during the daily clinical meeting.	

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	be a dialysis Event for every day the resident received dialysis treatments. The Event History document was provided by the ADON on 08/10/23 at 9:39 A.M.. The record lacked a post dialysis assessment for the following dates: - 07/28/23, - 07/19/23, - 07/17/23, - 07/12/23, - 07/05/23, - 07/03/23, - 06/30/23, - 06/19/23, and - 06/16/23. The Progress Notes were provided by the DON on 08/10/23 at 10:28 A.M., and included, but were not limited to, the following: - A note, dated 06/23/23 at 2:07 P.M., indicated the resident had returned from the dialysis center early due to his fistula infiltrating during his session. His left lower forearm was noted with slight swelling from the infiltration. The resident's clinical record lacked a nursing assessment post dialysis of shunt cite after the resident returned to the facility after receiving dialysis on the above listed dates that he had received treatments. The facility provided the dialysis center's post vitals, however the resident's clinical record lacked a facility document shunt assessment once the resident arrived back at the facility. During an interview on 08/10/23 at 10:36 A.M., the		**4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete Dialysis Care CQI Tool weekly x 4 weeks, monthly x 6 months, then quarterly for 6 months. If a 100% threshold is not achieved, a different action plan will be developed to ensure compliance. Results will be reported to QAPI committee.	

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	DON indicated on 06/23/23, the Dialysis center had sent back paperwork indicating the resident's fistula had infiltrated and the staff here at the facility were to monitor the fistula site. The resident had a port in his chest they had used for dialysis treatments prior to him getting the fistula in his arm. They had tried to place a fistula in his arm before and it had been unsuccessful, so they had continued to use the port in his chest for a while. He had gotten a new fistula in his arm this year. On 06/23/23 the fistula was in his arm, the same fistula they were currently using. She had not seen the fistula when it had infiltrated. The clinical record was reviewed on 08/07/23 at 1:51 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/24/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, obstructive uropathy, and renal insufficiency. The resident received dialysis treatments. The current "Dialysis Care" policy, with a reviewed date of 11/2017, was provided by the DON on 08/10/23 at 10:28 A.M. The policy indicated, "...For...residents receiving dialysis at a certified dialysis facility:...An assessment of the resident will be completed upon return from each dialysis visit to include vital signs and assessment of the site including bruit and thrill (if applicable), drainage, and general condition...A dialysis event will be initiated in EMR [Electronic Medical Record] to include time of transfer and completed on return to the unit..." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs			

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	§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to follow the physician's order to discontinue a medication after a pharmacy recommendation for 1 of 5 residents reviewed for unnecessary medications. (Resident 21) Findings include: Resident 21's clinical record was reviewed on 08/09/23 at 1:48 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/12/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, renal insufficiency, and diabetes with diabetic kidney complication. A Pharmacy Consultation Report, dated 06/19/23,	F 0757	**1)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident #21 physician was contacted and notified on 8/10/23 of pharmacy recommendations not being followed related to resident discontinue of Farxiga 10mg on 6/23/23. New order received and noted 8/10/23 to discontinue Farxiga. **2)** **How other residents having the potential to be affected by t**	09/10/2023

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	indicated the resident received Farxiga (a diabetic medication)10 mg (milligrams) daily. The resident had an eGFR (estimated glomerular filtration rate, a test that measured kidney function) of 44 ml/min (milliliters per minute). The manufacturer stated to avoid this medication in patients with an eGFR of less than 45. The pharmacist recommended considering discontinuing the medication. The physician response indicated the MD accepted the recommendation to discontinue the medication on 06/23/23. The resident's current medication orders included, but were not limited to, an open ended order, with a start date of 04/19/23, to administer Farxiga 10 mg once a day. The June, July, and August 2023 EMAR (Electronic Medication Administration Record) indicated the resident received the medication every day. During an interview on 08/09/23 at 2:50 P.M., the DON (Director of Nursing) indicated the medication should have been discontinued when the MD accepted the pharmacy recommendation, and it was not discontinued. The resident continued to receive the medication daily. The current facility policy, titled "Medication Regimen Reviews and Pharmacy Recommendations", dated 10/2018, was provided by the DON on 08/09/23 at 2:57 P.M. The policy indicated, "...Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving..." The current facility policy, titled "MatrixCare Physician Orders Policy", with a most recent revision date of 02/14/22, was provided by the DON on 08/09/23 at 12:12 P.M. The policy indicated, "...orders will be entered into		**he** **same deficient practice will be identified and what corrective action(s) will be taken.** All residents having pharmacy recommendations have the potential to be affected. A review was completed on all residents receiving pharmacy recommendations in the last 30 days to ensure completion per MD order. The DNS/designee will re-educate the facility nurses on the MatrixCare Physician Order Policy on 9/6/23 **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DNS/designee will re-educate facility nurses on the Matrix Care Physician Order policy. Pharmacy recommendations will be given to the MD for review upon receiving, with new orders being initiated as appropriate. The DNS/ designee will review all pharmacy recommendations daily during the clinical meeting. **4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** To ensure compliance the	

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	MatrixCare Physician Orders by the Nurse receiving the order..." 3.1-48(a)(5)		DNS/Designee will complete the Pharmacy Services and Recommendations CQI Tool weekly x 4 weeks, monthly x 6 months, then quarterly for 6 months. If a 100% threshold is not achieved, a different action plan will be developed to ensure compliance. Results will be reported to QAPI committee.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to store dry foods in a sanitary manner related to the dry storage room. This deficient practice had the potential to affect	F 0812	**1)** **What corrective action will be accomplished for those residents found to have been**	09/10/2023

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	all 30 residents who reside in the facility. Findings include: During an initial kitchen and dry storage observation on 08/06/23 at 10:42 A.M., the following was observed: - a watermelon sat inside a plastic container that contained ranch dressing packets, - a cardboard box of disposable lids and a cardboard box of plastic bowls sat on the floor under the middle rack, and - there was a white powdered substance along the back wall behind the middle rack of dry goods that measured approximately 3-4 feet long and 6 inches wide, and - 4 small Styrofoam bowls, a tea bag, a clear plastic bowl, and a coffee creamer were laying on the floor under the storage racks. - two rodent traps with no visible rodent droppings. On 08/06/23 at 11:24 A.M., The Daily Cleaning Schedule for the kitchen were reviewed with Dietary Aide 6 , the August 2023 cleaning logs lacked documentation that the dry storage room was cleaned on 08/04/23, 08/05/23 and 08/006/23. It was noted a copy of the schedule was needed. The Daily Cleaning Schedule was reviewed on 08/06/23 at 1:34 P.M., with Cook 7, the logs were now signed with a staff member's initials to indicated the Dry Storage Room was cleaned on 08/04/23, 08/05/23, and 08/06/23. During a dry storage observation on 08/06/23 at 1:41 P.M., the following was observed: - a cardboard box of disposable lids and a		**affected by the deficient practic e?** No residents suffered any ill affects from the alleged deficient practice. On 8/10/23 dry storage cleaned and inspected per daily cleaning schedule. On 8/10/23, dietary staff re-educated on Daily Cleaning Schedule. **2)** **How other residents having the potential to be affected by t he** **same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. A review of the Daily Cleaning Schedule will be completed for the last 30 days. The DSM/designee will re-educate dietary staff on the Cleaning Schedule Policy on 9/6/23. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DSM/designee will re-educate dietary staff on the Cleaning Schedule Policy. The dietary staff will complete daily cleaning per cleaning schedule by initialing daily. DSM/designee will check cleaning schedule daily to ensure completion, and spot check dry	

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	cardboard box of plastic bowls sat on the floor under the middle rack, and - there was a white powdered substance along the back wall behind the middle rack of dry goods that measured approximately 3-4 feet long and 6 inches wide, and - 4 small Styrofoam bowls, a tea bag, a clear plastic bowl, and a coffee creamer were laying on the floor under the storage racks. - two rodent traps with no visible rodent droppings. During an observation and interview of the dry storage room with the Social Services Director on 08/08/23 at 9:20 A.M., the following was observed: - a cardboard box of plastic bowls sat on the floor under the middle rack, and - there was a white powdered substance along the back wall behind the middle rack of dry goods that measured approximately 3-4 feet long and 6 inches wide, and - 4 small Styrofoam bowls, a tea bag, a clear plastic bowl, and a coffee creamer were laying on the floor between the bread rack and another storage rack. - two rodent traps with no visible rodent droppings. The Social Service Director, who was assisting with managing the kitchen, indicated the dry storage room should be cleaned daily and deep cleaned once a week. The daily cleaning schedule log was observed and indicated the dry storage room had been cleaned, swept, and mopped, daily, since 08/06/23. She indicated the staff should not have signed the log if it had not been cleaned. The current facility policy titled, "Cleaning Schedules" with a revised date of 05/23, was		storage area daily prior to daily clinical meeting. **4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** The DNS/designee will complete the Food Storage CQI audit tool weekly x 4 weeks, monthly x 6 months, and then quarterly for 6 months. If a 100% threshold is not achieved, a different action plan will be developed to ensure compliance. Results will be reported to QAPI committee.	

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	provided by the DON (Director of Nursing) on 08/09/23 at 12:13 P.M. The policy indicated, "...The culinary staff will maintain the sanitation of the culinary department through compliance with a written, comprehensive cleaning schedule...The cleaning schedule will be posted for all cleaning tasks, and employees will initial tasks once completed...The Culinary Manager is responsible to ensure all cleaning tasks are completed timely and thoroughly..." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	155353	A. BUILDING 00 B. WING	08/10/2023

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HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation and interview, the facility failed to follow infection control guidelines for 1 of 2 wound observations (Resident 12) and 1 of 2 insulin administrations (Resident 3). Findings include: 1. During and observation on 08/08/23 at 2:58 P.M., Resident 12 was lying in his bed on his right side. LPN (Licensed Practical Nurse) 2 indicated the resident had just received a shower. The LPN donned gloves from a box, gathered dry wash cloths and placed them directly in the resident's bathroom sink. She wet the cloths with water and applied soap to a few of them. After the cloths were wet, she placed them on a pad at the end of the resident's bed. She removed her gloves and sanitized her hands. The resident was positioned, and the nurse used the cloths to wash and rinse the resident's wound to the bilateral groin area. The wounds showed no signs of infection, and no odor was present. During an interview on 08/10/23 at 11:01 A.M., the DON (Director of Nursing) indicated the resident's wounds were to be washed with soap and water. Staff should have held the wash cloths in their clean gloved hand while wetting them and putting soap on them. Then the staff should have placed them in a bag at the foot of the resident's bed, so they didn't touch anything. Staff should never sit clean wash cloths in the resident's sink to get them wet. During an interview on 08/10/23 at 1:44 P.M., CNA	F 0880	**1)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident 3 and 12 suffered no affects from the alleged deficient practice. LPN 2 has been educated on clean dressing techniques, and proper cleaning of the insulin pen prior to applying the needle. **2)** **How other residents having the potential to be affected by t he same deficient practice will be identified and what corrective action(s) will be taken.** All resident receiving wound treatment/insulin administration have the potential to be affected. An audit will be completed --to identify all residents that receive dressing changes and insulin injection via insulin pen. The DNS/designee will re-educate the facility nurses on Dressing Change Clean Technique, and Insulin pen Administration by 9/6/23. **3)** **What measures will be put into place or what systemic**	09/10/2023

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	(Certified Nurse Aide) 4 indicated when she gave a resident a bath, she would get a bath basin and place wash cloths in it, to get them wet. She would never place clean wash cloths directly in the resident's bathroom sink. The current facility Skills Competency-Nursing Policy & Procedure, titled, "Dressing Change Clean Technique" with a revised date of 06/2021, was provided by the DON on 08/10/23 at 2:24 P.M. The policy indicated, "...Prepare a clean work surface or place a clean barrier such as clean towel or paper towel to ensure easy access to supplies during procedure...Set up clean field with dressing change supplies and other necessary equipment..." 2. During an observation on 08/09/23 at 8:31 A.M., LPN 2 gathered Resident 3's Lispro insulin pen from a medication cart. She removed the pen from a clear reusable plastic bag, removed the cap from the pen, and attached a needle to the pen. She did not cleanse the hub of the pen with alcohol before attaching the needle. She primed the insulin pen and dialed up the dose needed for the resident. She assisted the resident into the bathroom, used an alcohol pad to cleanse the resident's skin, and injected the medication. During an interview on 08/09/23 at 8:43 A.M., LPN 2 indicated she should have cleansed the pen before attaching the needle. During an interview on 08/10/23 at 3:00 P.M., the Regional Director of Clinical Services indicated the insulin pen should have been cleansed with alcohol before the needle was attached. The current facility policy, titled "Insulin Pen Administration", with a reviewed on date of 10/2019, was provided by the DON on 08/10/23 at		**changes will be made to ensur e that the deficient practice does not recur?** The DNS/designee will re-educate facility nurses on the Dressing Change Clean Technique and Insulin Pen administration. All facility nurses will have a dressing change clean technique skill validation and insulin administration skills validation completed by 9/6/23. The DNS/designee will complete 3 dressing change and insulin administration observations weekly per QAPI auditing to ensure compliance. **4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur , i.e. what quality assurance program will be put into place?** The DNS/designee will complete the Infection Control Review CQI audit tool weekly x 4 weeks, monthly x 6 months, and then quarterly for 6 months. If a 100% threshold is not achieved, a different action plan will be developed to ensure compliance. Results will be reported to QAPI committee.	

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	2:24 P.M. The policy indicated, "...wipe top of insulin pen with alcohol swab/pad if instructions indicated..." 3.1-18(b)			