| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155406 | A. BUILDING 00<br>B. WING | 08/04/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| HICKORY CREEK AT PERU | 390 W BOULEVARD<br>PERU, IN 46970 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00379975.<br><br>Complaint IN00379975 - Substantiated. No deficiencies related to the allegations were cited.<br><br>Survey dates: August 1, 2, 3, and 4, 2022.<br><br>Facility number: 000475<br>Provider number: 155406<br>AIM number: 100290540<br><br>Census Bed Type:<br>SNF/NF: 32<br>Total: 32<br><br>Census Payor Type:<br>Medicare: 0<br>Medicaid: 32<br>Other:0<br>Total: 32<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed August 5, 2022 | F 0000 | | |
| F 0880<br>SS=D<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>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. | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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| | §483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility | | | |

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| | 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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>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 ensure PPE was worn and hand hygiene performed during medication pass for 1 of 1 observations.<br><br>Findings include:<br><br>During an initial medication administration observation on 8/3/22 at 8:28 AM, LPN 2 was observed dispensing tablets from the medication pack into her bare hand then placed them into a medication cup. LPN 2 was observed to do this several times. ABHS (alcohol based hand sanitizer) was not utilized between obtaining each resident's medication. LPN 2 also was observed touching the computer to chart, the top of the medication cart, and the narcotic record. on the | F 0880 | /p><br>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 8/22/22.<br>/p><br>**F 880**<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>**How other residents having the potential to be affected by the** | 08/22/2022 |

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| | medication cart. ABHS was not utilized prior to touching items on the medication cart and dispensing medications into her hand. LPN 2 then opened up the medication cart, obtained a liquid medication bottle (inside a plastic bag) with small plastic syringe. LPN 2 was observed placing the plastic syringe into the liquid medication bottle and drew some medication out. She then placed the plastic syringe (with the medication inside) directly on top of the medication cart without covering it. LPN 2 then picked up a log book, wrote in it, then put the book away, picked up the plastic syringe and emptied the liquid medication into a medication cup. LPN 2 placed the syringe back into the bag with the medication bottle and placed the bag in the medication cart. LPN 2 was observed to clean some of the liquid medication residue from the top of the cart with tissues, then used ABHS. LPN 2 was observed to go in front of her medication cart, obtain some tissues and blow her nose. LPN 2 then placed the tissue inside the trash can next to the medication cart. LPN 2 locked the medication cart, picked up the medication cups and proceeded to walk toward a residents room. LPN 2 did not her wash hands or use ABHS after blowing her nose. LPN 2 then walked into residents room, gave the medication cup to resident then adjust the resident's straw. LPN 2 did not don or doff gloves during the observation.<br><br>During an observation on 8/3/22 at 8:38 AM, LPN 2 was observed dispensing medication tablets from a medication pack into her bare hands before placing then into medication cup. LPN 2 did not use ABHS in between obtaining medications.<br><br>During an observation on 8/3/22 at 11:46 AM, LPN 2 explained she would be giving Insulin Aspart 15 units injectable pen. LPN 2 obtained a disposable needle, cleaned around the insulin hub | | **same deficient practice will be identified and what corrective action(s) will be taken:**<br>· No residents were identified as being affected by the alleged deficient practice<br>· All residents have the potential to be affected by the alleged deficient practice.<br>· The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, post-test, observation, and QA tools.<br>·All staff have been re-educated regarding infection control practices during medication pass, hand hygiene, and ppe use during med pass<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>·A Root Cause Analysis will be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause.<br>·The IP Consultant will provide education and training to the IP/DNS/ED and IDT including | |

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| | with an alcohol pad then twisted the disposable needle onto the insulin pen. LPN 2 gathered the rest of the supplies, turned to the cart next to her, and donned 2 disposable gloves. She walked through the hallway with the gloves on. LPN 2 knocked on the door with her gloves on. LPN 2 then cleaned the site, gave the insulin, then took one glove off and left the other one while holding the disposable needle inside. LPN2 Walked back through the hallway to her medication cart and placed the disposable needle inside the sharps container with a gloved hand. LPN 2 did not perform hand hygiene after the insulin administration.<br><br>In an interview on 08/03/22 at 12:27 PM LPN 1 indicated when giving medications, the orders should be checked in the computer, the correct dose verified, as well as date, type of medication, and route reviewed. Then supplies are obtained, hand hyginene performed, and gloves donned. After medication is given, gloves would be doffed, hand hygiene performed, and charting completed in the computer. If insulin is to be given, hand hygiene would be performed, the pen prepped, correct dose verified, prep the resident's skin with alcohol, and insulin would be administered. When handling resident's oral medications, hand hygiene would be performed first, then the medications would be placed into the medication container without touching the medications.<br><br>In an interview on 8/3/22 at 12:38 PM, the Director of Nursing indicated the facility expected the nurses, during a medication administration, to follow the five rights and perform hand hygiene.<br><br>A current facility policy, Hand Hygiene Policy, dated 12/21, was provided by the Director of | | providing all education, in-service materials, observation, and QA tools.<br>· The facility LTC Infection Control Self-Assessment will be reviewed with the consultant IP to determine accuracy<br>·All staff have been re-educated regarding infection control practices during medication pass, hand hygiene, and ppe use during med pass<br><br>· Daily observational rounds will be conducted on all shifts for 6 weeks until compliance is maintained by the IP/designee using the observational rounds tool to observe for (proper infection control practices during medication pass). Any noted concerns with compliance will be addressed immediately with staff and noted on the daily infection control monitoring form. Daily monitoring forms will be turned into the Administrator as proof of ongoing compliance.<br>· The consultant IP will provide ongoing training, oversight, resources and competencies as needed based on the Observation Rounds Audit and QA tools identifying on-going areas of concern or not meeting threshold.<br>· The facility IP Nurse or designee will complete hand hygiene skills competency training and hand hygiene observations.<br>· Observations will be | |

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| | Nursing on 8/3/22 at 1:34 PM. The policy indicated..." To provide a standardized approach to Hand hygiene to reduce or minimize the transmission of infection from potential microorganism on the hands of all employees...5 moments of hand hygiene-term that describes the hand hygiene opportunities that prevent infection transmission lined to healthcare activities. Before touching a resident. Before clean/aseptic procedure. After body fluid exposure risk. After touching a resident. After touching resident surroundings...."<br><br>A current facility policy, Medication Administration, dated 3/17, was provided by the Director of Nursing on 8/3/22 at 1:34 PM. The policy indicated..." Proper hand hygiene is performed before and after and examination gloves worn for administration of topical, ophthalmic, injections, eneteral, rectal, and vaginal medications...."<br><br>3.1-18(a) | | reviewed monthly in QA (QAPI)<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:**<br>· The IP/DNS/Designee will monitor each solution/systemic change identified in the RCA daily or more often as necessary for 6 weeks and until compliance is maintained.<br>· (The proper infection control practices during medication pass tool will be completed daily by IP/designee x6 weeks and until compliance is maintained.<br>· The IP/designee will be responsible for the completion of the (infection control practices during medication pass) QA Tool weekly x 4, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director.<br>· If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.<br>· The facility will review, update and make changes to the DPOC as needed with input and oversight from the Consultant Infection Preventionist for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee | |

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| | | | will re-evaluate the continued need for the audit.<br>.<br>**By what date the systemic changes will be completed:**<br>Completion Date: 8/22/22 | |