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	09/28/2023

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 the Investigation of Complaint IN00416303. Complaint IN00416303- Federal/State deficiency related to the allegation is cited at F744. Survey dates: September 27 and 28, 2023 Facility number: 000244 Provider number: 155353 AIM number: 100288790 Census Bed Type: SNF/NF: 30 Total: 30 Census Payor Type: Medicare: 1 Medicaid: 26 Other: 3 Total: 30 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 2, 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 the Letter of Credible Allegations of Compliance and requests a desk review in lieu of a post survey review on or before 10/28/23.**	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on interview and record review, the facility failed to implement interventions to address a	F 0744	**F744 - It is standard of this facility to implement**	10/27/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brooke Thies	Executive Director	10/13/2023

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.

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	09/28/2023

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
	resident's dementia care needs related to wandering into other resident's personal space for 1 of 4 residents reviewed for dementia care. (Resident C) Findings include: A progress note, dated 08/28/23 at 6:00 P.M., indicated a nursing staff member entered Resident B's room and observed Resident C touching Resident B inappropriately. The residents were immediately separated. Resident B was assessed and there were no injuries observed. The resident's family, physician, and police were notified. The clinical record for Resident B was reviewed on 09/27/23 at 10:30 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/21/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, diabetes, Alzheimer's disease, anxiety, and depression. During an interview on 09/27/23 at 9:52 A.M., LPN (Licensed Practical Nurse) 2 indicated on 08/28/23 she went to Resident B's room to check her blood sugar and give the resident her evening medications. The door was closed to the room. She knocked, no one answered, so she cracked the door open. Resident B was laying on her bed and her shirt was pulled up to her neck. Resident C was standing next to the bed and he had his hands on Resident B's bare breasts. Both residents just froze when they saw her. She escorted Resident C out of the room and had another staff member take him to his own room. She conducted a head to toe assessment on Resident B and asked her if she was okay. The resident did not seem upset about what		**interventions to address a resident's dementia care needs related to wandering into other resident's personal space.** **1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** All residents with the diagnosis of dementia with behavioral disturbances care plans were reviewed by the IDT team. A care plan for potential to wander into others personal space was added with individualized interventions by the IDT team. Resident C no longer resides in the facility. **2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All Residents have the potential to be affected. SSD/IDT will review behavior care plans upon admission, quarterly, and with any new/worsening behavior and as needed. The IDT team will ensure education is provided to the staff, update and completing care plans that are person centered and include appropriate interventions. **3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur?** Review of Behavior Care plan	

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	09/28/2023

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
	happened. Resident C was upset, he denied he did anything and couldn't understand why LPN 2 asked him to go to his room. LPN 2 indicated they had to keep an eye on Resident C. In the last week or so leading up to the incident, he had been going into Resident B's room and Resident B had been sharing her snacks with him. Staff would escort him out of the room when they caught him in there. Before this incident, Resident C had gone into Resident D's room and made her uncomfortable. This started within a day or two of his admission to the facility. Resident D and Resident G shared a room. He had been asked to stay out of their room. He was trying to be friendly with Resident D, but it was making her uncomfortable. He had been making inappropriate suggestions. Resident G would turn on the call light to get staff into the room and tell Resident D to tell staff what Resident C said to her. Resident C needed frequent redirection. The Administrator, Social Services Director, and DON (Director of Nursing) all talked to him about it. It lasted a few weeks, but then he stopped going in their room, it seemed like he got the hint that Resident D wasn't interested. The clinical record for Resident C was reviewed on 09/27/23 at 9:30 A.M. An Admission MDS assessment, dated 07/12/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, non-Alzheimer's dementia, seizure disorder, and depression. The resident exhibited wandering behavior during the assessment review period. Resident C's admission records, that included, but were not limited to, a psychiatric evaluation follow up, dated 05/15/23, were provided by the Administrator on 09/28/23 at 1:30 P.M. The evaluation indicated staff reported the resident		during initial IDT review of new admission, any new/worsening behaviors will be reviewed by IDT during clinical meeting, reviewed during MDS assessment period and monthly during behavior review meeting. All care plans will be developed and implemented based on the new and worsening behavior with individualized interventions. IDT will be educated regarding dementia care needs related to wandering into other resident's personal space by SSD/designee on 10/19/23. **4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** SSD/designee will complete Behavior Management QAPI tool weekly x 4, monthly x 6 and then Quarterly thereafter. If 95% is not achieved an action plan will be developed. Results will be reviewed during the monthly QAPI meeting.	

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	09/28/2023

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
	has had some difficulty with making sexual remarks towards females but he had not been physical with anyone. Staff also reported the resident had increased confusion in the evening which appeared to be sundowning. The medication review indicated the resident received 10 mg (Milligrams) of Provera daily for sexual aggression. An IDT (Interdisciplinary Team) Behavior Review Note, dated 07/10/23 at 3:14 P.M., indicated Resident C was wandering into peers' rooms. The resident was redirected. The root cause of the resident's behavior expression was determined to be related to their dementia. The resident's care plan was updated, and preventative interventions included, but were not limited to, the following: redirect the resident, offer an activity of interest, ensure basic needs were met, and engage in conversation. During an interview on 09/28/23 at 1:50 P.M., Residents D and G indicated there were times that a resident might wander in their room, but they would eventually leave, it wasn't a big deal. Resident G indicated Resident D did have a problem with a male resident a few months ago, but the resident was no longer in the facility. Resident D indicated a male resident would come into her room. He was inappropriate with her. She told a nurse about it, and they handled it. During an interview on 09/28/23 at 2:17 P.M., the Administrator indicated Resident C went back to the facility he was at before he was admitted here. She was unaware of any issues with Resident C and Resident B before the incident occurred. She was unaware of any incidents with Resident C and any other residents in the facility.			

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	09/28/2023

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
	The current facility policy, titled Behavior Management, with a revision date of 08/22, was provided by the Administrator on 09/28/23 at 1:51 P.M. The policy indicated, "...It is the policy...to provide behavior interventions for residents with problematic or distressing behaviors..." This Federal tag relates to Complaint IN00416303. 3.1-37(a)			