STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155442	A. BUILDING 00 B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT FRANKLIN	580 LEMLEY STREET FRANKLIN, IN 46131

(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 IN00416222. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00416222 - Federal/State deficiencies related to the allegations are cited at F880. Survey date: September 27, 2023 Facility number: 000352 Provider number: 155442 AIM number: 100290720 Census Bed Type: SNF/NF: 33 Total: 33 Census Payor Type: Medicaid: 23 Other: 10 Total: 33 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 2, 2023.	F 0000		
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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Spall	HFA	10/11/2023

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.

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	§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; §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			

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	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. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure infection control practices implemented to mitigate the spread of COVID-19 for 2 of 3 residents reviewed for infection control. A staff member entered a resident's room with droplet precautions without eye protection and 2 staff members where observed not wearing a facemask inside the facility as indicated on the sign posted at each entrance to the facility. (Resident B, CNA 1, CNA 2, Maintenance Director) Finding includes: 1. On 9/27/23 at 9:00 a.m., observed the Maintenance Director walk through a hallway approximately 4 feet from multiple residents sitting in the hallway without a facemask on.	F 0880	Submission of this Plan of Correction for Hickory Creek at Franklin is not an admission to the citation listed on the CMS 2567 or any statement or finding that forms on the basis of the alleged citation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: "Resident B" no longer COVID+ or in transmission-based precautions.	10/21/2023

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	On 9/27/23 at 1:12 p.m., observed CNA 2 in a resident room with both residents in the room. CNA 2 was kneeling between the 2 beds approximately five feet from each resident. CNA 2 was not wearing a facemask. CNA 2 picked up a clear garbage bag that contained a soiled brief then walked out of the room. At that time, CNA 2 indicated she should have re-applied the facemask after the resident pulled it off of her face. CNA 2 pulled an intact, folded, face mask out of her pocket and put the mask on her face. During an interview on 9/27/23 at 1:17 p.m., the Maintenance Director indicated a facemask was required while in the facility. 2. During an interview on 9/27/23 at 9:45 a.m., CNA 1 (Certified Nursing Aide) indicated Resident B was in isolation precautions for testing positive for COVID-19. At that time, the door to Resident B's room was closed. There was a red sign on Resident B's door that indicated droplet/contact precautions and a gown, gloves, N95 mask, and eye protection were required to enter Resident B's room. Observed CNA 1 knock on Resident B's door and open the door. CNA 1 walked into the room and walked toward Resident B's roommate but within 4 feet of Resident B. Resident B was not wearing a face mask and the privacy curtain was not fully pulled to separate the room. Then CNA 1 exited the room. At that time, CNA 1 indicated eye protection was required to enter the room and she should have worn a face shield into the room. The clinical record for Resident B was reviewed on 9/27/23 at 11:37 a.m. The diagnoses included, but were not limited to, COVID-19, diabetes, and morbid obesity.		**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 have the potential to be affected by the alleged deficient practice. Facility no longer has any residents on transmission-based precautions for COVID-19. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be educated on COVID-19 Infection Prevention, Education & Vaccination and Donning and Doffing PPE by October 21, 2023 by DNS/IP or designee. Daily observational rounds will continue until compliance is achieved and reviewed in QAPI by the IP/designee.	

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	An Admission MDS (Minimum Data Set) assessment, dated 9/12/23, indicated Resident B was cognitively intact. A progress note, dated 9/25/23 at 12:08 p.m., indicated exposure testing took place. Resident B tested positive with a point of care antigen test. Resident B was noted to have a cough, congestion, fatigue, and shortness of breath. Resident B was placed in droplet/contact isolation for 10 days. A physicians order initiated on 9/25/23, indicated Resident B droplet/contact isolation due to a highly transmissible pathogen, related to COVID-19. On 9/27/23 at 9:27 a.m., the Administrator provided a copy of a facility policy, titled COVID-19 Policy, dated 7/2023, and indicated this was the current policy used by the facility. A review of the policy indicated this community will implement infection control practices to reduce the risk of transmission of COVID-19. Residents and staff that reside or work on a unit or area of the facility experiencing a COVID-19 outbreak when the source of COVID-19 cannot be determined through contact tracing. This Federal tag relates to Complaint IN00416222. 3.1-18(b)(1)		**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:** · PPE Observational tool will be completed daily by IP/designee x6 weeks and until compliance is maintained. · The IP/designee will be responsible for reviewing the PPE Observational Tool and 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. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	