| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155442 | A. BUILDING 00<br>B. WING | 05/19/2023 |

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| HICKORY CREEK AT FRANKLIN | 580 LEMLEY STREET<br>FRANKLIN, IN 46131 |

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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 IN00408332. This survey resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy.<br><br>Complaint IN00408332 - No deficiencies related to the allegations were cited.<br><br>Survey dates: May 15, 16, 17, 18, and 19, 2023<br><br>Facility number: 000352<br>Provider number: 155442<br>AIM number: 100290720<br><br>Census Bed Type:<br>SNF/NF: 33<br>Total: 33<br><br>Census Payor Type:<br>Medicare: 2<br>Medicaid: 27<br>Other: 4<br>Total: 33<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed May 23, 2023. | F 0000 | | |
| F 0689<br>SS=J<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Amanda Spall | HFA | 05/31/2023 |

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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| | remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview, and record, the facility failed to provide supervision to prevent elopement 1 of 1 residents reviewed. A resident was able to exit the facility with a delivery person. The resident was found by a family member on a in the turn lane of a heavily traveled highway. (Resident 20)<br><br>This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 5/15/23 at approximately 10:30 a.m., when the facility failed to provide supervision to prevent elopement. The resident was found walking in the turn lane of a highly traveled highway. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy on 5/16/23 at 4:30 p.m. The Immediate Jeopardy was removed on 5/17/23 at 2:15 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm but potential for more than minimal harm that is not Immediate Jeopardy.<br><br>Finding includes:<br><br>During an interview on 5/16/23 at 10:40 a.m., the Administrator indicated Resident 20 had eloped from the facility yesterday (5/15/23). She indicated they suspected a flower delivery person that was in the facility at approximately 10:30 a.m., left the facility and Resident 20 exited the building at that time. Resident 20's parents take him to their house every evening for dinner. Resident 20 will stand by the door waiting for his parents to pick him up. The facility was unaware Resident 20 had exited | F 0689 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·Resident 20 was placed 1 on 1 with staff at return to facility<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents at risk for elopement have the potential to be affected by this deficient practice.<br>·Sign on entry door updated to notify visitors and vendors not to assist anyone out the door<br>·Wanderguard system installed<br>·Letter sent to all families and common venders educating on not allowing anyone out of the facility<br>·All staff educated on elopement policy, vendor sign in, and wanderguard system<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>·Sign on entry door updated to notify visitors and vendors not to assist anyone out the door<br>·Wanderguard system installed | 05/31/2023 |

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| | the facility until his parents called the facility and reported they saw him walking outside at 10:40 a.m.<br><br>On 5/16/23 at 10:50 a.m., the Administrator provided a written interview with RN 3, who had indicated she had last seen Resident 20 at 10:21 a.m. on 5/15/23.<br><br>During an interview on 5/16/23 at 11:04 a.m., the DON indicated Resident 20 usually stood at the door. That was where his parents picked him up. The staff was unaware Resident 20 had went out the facility door until his parents called and reported it.<br><br>During an interview on 5/16/23 at 11:39 a.m., CNA 2 indicated Resident 20 liked to stand by the door and wait for his parents to come and get him for dinner.<br><br>During an interview on 5/16/23 at 1:20 p.m., the Administrator indicated the code to open the doors was posted above the key pad.<br><br>On 5/16/23 at 1:30 p.m., the key pad at the front door and the side doors were observed. The key pads had a visible taped on paper on the top of the key pad. The paper indicated "*(next mm [month]current yy[year])" was posted on the paper on top of the key pad.<br><br>During an interview on 5/16/23 at 3:09 p.m., Resident 20's mother indicated Resident 20's father was on driving on State Road 31 on the morning of 5/15/23. His father observed Resident 20 walking south in the median, on the heavily traveled high way, approximately 0.25 - 0.5 miles away from the facility. At that time, Resident 20 was attempting to walk back across the | | ·Letter sent to all families and common venders educating on not allowing anyone out of the facility<br>·All staff educated on elopement policy, vendor sign in, and wanderguard system<br>**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?**<br>·The Missing Resident/Elopement QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 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 | |

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| | northbound lanes of State Road 31 and was in the turn lane on the southbound side. A semi truck was driving close to the area Resident 20 was standing in. Resident 20 was observed in the turn lane with during a heavy traffic time. Resident 20's father pulled over and redirected Resident 20 into his car.<br><br>On 5/16/23 at 3:30 p.m., Resident 20's clinical record was reviewed. The diagnosis included, but was not limited to, diffuse traumatic brain injury.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 3/17/23, indicated Resident 20's cognitive status was severely impaired.<br><br>A care plan, dated 4/7/23 and current through 7/7/23, indicated Resident 20 was at risk for elopement per the Elopement Risk Assessment due to impaired cognition, ability to ambulate independently, and a history of intrusive wandering and waiting by exit doors. The interventions included, but was not limited to, all facility exits secured.<br><br>A Interdisciplinary Progress Note, dated 5/16/23 at 8:59 a.m., indicated Resident 20 exited the building.<br><br>During an observation on 5/17/23 at 8:10 a.m., the outside of the facility was observed. The facility was observed to be on the east side of State Road 31, approximately one half block from the highway, on the northbound side.<br><br>During an interview on 5/17/23 at 10:30 a.m., Resident 20's father indicated on 5/15/23 he was driving south bound on State Road 31. He observed his son walking south bound in the turn lane of State Road 31. Resident 20's father was | | | |

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| | afraid his son was going to cross back over the north bound lane into heavy traffic. Resident 20's father pulled over and told his son to stay where he was. Resident 20's father approached his son and redirected him to his car. He drove Resident 20 to his mothers house. Resident 20's mother immediately called and informed the facility of the incident.<br><br>On 5/16/23 at 3:00 p.m., the Administrator provided a policy titled Elopement Prevention and Response Program, dated October 2013, and indicated it was the current policy being used by the facility. A review of the policy indicated "...c. Resident will be identified as an 'Elopement Risk', 'Wanderguard', 'electric monitoring device', 'security bracelet' etc on direct care staff communication method (ie Matrix Profile, resident care sheets, etc).<br><br>The Immediate Jeopardy that began on 5/15/23 was removed on 5/17/23 when the facility inserviced staff, family, and visitors not to let residents out of the facility, but the noncompliance remained at the lower scope and severity level of no harm but potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been implemented to prevent recurrence.<br><br>3.1-45(a)(2) | | | |
| F 0758<br>SS=D<br>Bldg. 00 | 483.45(c)(3)(e)(1)-(5)<br>Free from Unnec Psychotropic Meds/PRN Use<br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in | | | |

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| | the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or | | | |

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| | prescribing practitioner evaluates the resident for the appropriateness of that medication.<br><br>Based on interview and record review, the facility failed to ensure an AIMS (Abnormal Involuntary Movement Scale) was completed for 1 of 5 residents reviewed for unnecessary medications. (Resident 134)<br><br>Finding includes:<br><br>On 5/18/23 at 9:21 a.m., Resident 134's clinical record was reviewed. The diagnoses included, but were not limited to, schizoaffective disorder and bipolar disorder.<br><br>The Physician Orders included, but were not limited to:<br>Zyprexa (an antipsychotic medication), 5 mg (milligrams), one tablet at bedtime for schizoaffective disorder and bipolar disorder, initiated 4/7/23.<br><br>The Pharmacy Consultation Report, dated 4/15/23, indicated "...[Resident 134] receives an antipsychotic, olanzapine 5mg. [at bedtime]...recommendation: please include the following guidance for olanzapine in the interdisciplinary care...ensure the following are monitored and documented in the medical record...perform an assessment for involuntary movements (AIMS) at baseline and then at least every 6 months..." The document was signed by the ADNS (Assistant Director of Nursing) on 4/18/23.<br><br>Resident 134's care plan indicated, Resident is at risk for adverse side effects relate to use of psychotropic medication. The interventions included, but were not limited to, AIMS | F 0758 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·Resident 134 had an AIMS assessment completed<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents receiving antipsychotic medications have the potential to be affected by the alleged deficient practice.<br>·Audit completed of residents on anti-psychotic medications to ensure AIMS assessment was completed at Admission and Quarterly.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>·All new antipsychotic medication orders, including new admission orders, to be reviewed the following business day in clinical meeting with AIMS review.<br>·RDCS to educate nurse managers on psychotropic management policy<br>**How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality** | 06/05/2023 |

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| | assessment two times a year.<br><br>During an interview on 5/19/23 at 9:10 a.m., the facility Corporate Nurse indicated Resident 134's AIMS assessment was not completed until 5/18/23.<br><br>During an interview on 5/19/23 at 9:20 a.m., the Interim DNS (Director of Nursing Services) indicated Resident 134's baseline AIMS assessment should have been completed when Zyprexa was started in April.<br><br>On 5/19/23 at 11:15 a.m., the Interim DNS provided a copy of the Psychotropic Management policy, dated July 2022, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...it is the policy of American Senior Communities to ensure that a resident's psychotropic medication regime helps promote the resident's highest practicable mental, physical, and psychosocial well-being with person centered intervention and assessment. These medications are managed in collaboration with professional services and facility staff to include non-pharmacological interventions, assessment, and reduction as applicable. Definition: a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior: anti-psychotic; anti-depressant...Potential adverse side effects to psychotropic medications will be observed each shift by a license nurse. An AIMS assessment will be completed for residents who are taking antipsychotic medication as a tool to monitor for adverse side effects. The assessment should be completed within 72 hours of a new order..."<br><br>3.1-48(a)(3) | | **assurance program will be put into place?**<br>·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 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 | |

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| F 0812 SS=E Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 3 of 3 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Cook 2 and Dietary Manager)<br><br>Findings include:<br><br>1. During the initial kitchen tour on 5/15/23 from 10:15 a.m. to 10:30 a.m., Cook 2 was observed organizing the lunch meal tickets at the kitchen's center preparation table while the DM (Dietary Manager) was preparing the noon meal at the | F 0812 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·Staff not wearing hair covering-immediately corrected by CDM<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents have the potential to be affected by the alleged deficiencies | 06/05/2023 |

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| | stove and preparation table area. Cook 2 was observed to have multiple loose hairs, approximately 3 inches in length, in front of the ears and at the neck line that were not covered.<br><br>2. During a follow-up kitchen observation on 5/15/23 from 11:45 a.m. to 11:55 a.m., Cook 2 was observed filling the noon meal drink glasses at the kitchen's center preparation table while the DM was recording the starting food temperatures for the noon meal at the stove and preparation table area. Cook 2 was observed to have multiple loose hairs, approximately 3 inches in length, in front of the ears and at the neck line that were not covered.<br><br>3. During a follow-up kitchen observation on 5/15/23 from 12:30 p.m. to 12:40 p.m., the following was observed:<br><br>- Cook 2 was walking through-out the kitchen area where the noon meal had been prepared and served to the residents. Cook 2 was observed to have multiple loose hairs, approximately 3 inches in length, in front of the ears and at the neck line that were not covered.<br><br>- The DM was observed recording the ending noon meal temperatures. The DM was observed to have multiple loose hairs, approximately 3 inches in length, at the neckline that were not covered.<br><br>During an interview on 5/15/23 at 12:45 p.m., the DM indicated staff's hair was to be covered while in the kitchen.<br><br>On 5/15/23 at 1:25 p.m., the Administrator provided a copy of the American Senior Communities Culinary Personal Hygiene policy, | | ·In-service all culinary team members on sanitation expectations for kitchen operation to be completed by 6/5/2023<br>·ED ensured all staff hair was appropriately covered<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>·POC Rounding Tool to be utilized daily and will include auditing hair covering in the kitchen<br>·Mirror added outside kitchen door near hairnets for staff to ensure hair is fully covered prior to entering the kitchen.<br>·Any deficiencies identified during audit will be addressed immediately by ED/designee<br>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?<br>·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 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 | |

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| | dated November 2022, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Employees will maintain good personal hygiene to prevent food contamination...all employees working in the culinary department must wear a clean hair restraint which effectively covers all hair..."<br><br>On 5/15/23 at 3:05 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to wear effectively keep their hair from contacting...exposed food..."<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | | |
| F 0814<br>SS=C<br>Bldg. 00 | 483.60(i)(4)<br>Dispose Garbage and Refuse Properly<br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>Based on observation, interview, and record review, the facility failed to ensure the dumpster side panel door was kept closed when not in use for 1 of 2 dumpster observations.<br><br>Findings include:<br><br>During the initial facility tour with the DM (Dietary Manager) on 5/15/23 from 10:33 a.m. to 10:37 a.m., the facility dumpster area, located adjacent to the facility, was observed. The dumpster container had two side sliding panel doors. The left side panel area lacked a door. Inside the dumpster multiple filled trash bags were observed. No staff were observed in the area. During an interview at that time, the DM indicated the left sliding door had been missing "for quite | F 0814 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·Side sliding door to dumpster was repaired the same day as identification<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents have the potential to be affected by the alleged deficiency<br>·Side sliding door to dumpster | 06/05/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155442 | A. BUILDING 00<br>B. WING | 05/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HICKORY CREEK AT FRANKLIN | 580 LEMLEY STREET<br>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 |
|---|---|---|---|---|
| | some time." The dumpster container was supposed to be kept closed when not in use.<br><br>During an interview on 5/16/23 at 8:55 a.m., the Corporate Director indicated a "make shift" sliding door was installed on the dumpster "yesterday [5/15/23]" and he had observed a "flock of birds" flying near the dumpster container. The Corporate Director indicated the facility did not have a dumpster policy regarding the doors and lids being kept closed.<br><br>During an interview on 5/19/23 at 9:06 a.m., the DM who indicated she was unsure how long the dumpster sliding door had been missing from the dumpster; however, the previous Maintenance Director "who left in mid April" was aware.<br><br>During an interview on 5/19/23 at 10:24 a.m., the Maintenance Supervisor indicated the dumpster's side sliding panel door had been missing "for at least a month."<br><br>On 5/15/23 at 2:00 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are minimized...effective cleaning is facilitated around...the unit..."<br><br>3.1-21(i)(5) | | was repaired the same day as identification<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>·All staff will be educated on notifying of any needed dumpster repairs by 6/5/23.<br>·POC Rounding Tool to be utilized daily and will include auditing dumpster doors<br>**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?**<br>·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 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 | |