

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155692	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2014
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NAME OF PROVIDER OR SUPPLIER  HERITAGE OF HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1180 W 500 N HUNTINGTON, IN 46750
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 22, 23,24, 27, 28 and 29, 2014</p> <p>Facility number: 002910 Provider number: 155692 AIM number: 200345390</p> <p>Survey team: Angela Selleck, RN TC Shelley Reed, RN Karen Koeberlein, RN (January 22, 23, 24, 28, and 29, 2014) Jason Mench, RN</p> <p>Census bed type: SNF: 17 SNF/NF: 43 Residential: 48 Total: 108</p> <p>Census payor type: Medicare: 15 Medicaid: 16 Other: 77 Total: 108</p> <p>Residential sample: 8</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC</p>	F000000	This plan of correction constitutes my written allegation of compliances for the deficiency cited. This plan of correction is submitted to meet requirements established by state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	16.2.  Quality review completed by Debora Barth, RN.			

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure personal</p>	F000441	This Plan of Correction is submitted as required under	02/07/2014			

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	<p>protective equipment was provided to visitors and staff prior to entering a residents room when the resident was in isolation. (Resident #91). This had the potential to affect 12 of 12 residents residing on the rehabilitation unit.</p> <p>Findings include:</p> <p>During an observation on 1/24/14 at 11:00 a.m., Resident #91 had a sign on the door indicating the need to "see nurse before entering." No personal protective equipment (gloves, gowns) were observed at the entrance to Resident #91's room at this time.</p> <p>During an observation on 1/28/14 at 8:55 a.m., the sign remained on Resident #91's door indicating the need to see the nurse before entering the room. No personal protective equipment was observed at the entrance to Resident's #91's door at this time.</p> <p>During an interview on 1/28/14 at 9:18 a.m., RN #3 indicated Resident #91 was on isolation contact precautions for a MRSA (Methicillin Resistant Staph aureus) infection. RN #3 indicated there was personal protective equipment, (gloves,</p>		<p>Federal and State regulation and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility; and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings or conclusions constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The Heritage of Huntington respectfully requests paper compliance. Plan of Correction: 1) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?a. Resident #91 was reviewed and Contact Precautions were discontinued on 1/30/14. Resident #91 continues on Standard Precautions to prevent the further transmission of infection related to the MRSA infection of the left leg. 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? a. All residents that will be admitted to the facility or those with a known infection will be reviewed by DON or designee for the potential to transmit infection. Standard precautions will continue to be used by the facility for all</p>				

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	<p>gowns) just inside the door. An additional observation at this same time found no gloves or gowns available at the entrance to Resident #91's room.</p> <p>During an observation on 1/29/14 at 2:27 p.m., a small wooden cabinet had been placed at the entrance to Resident #91's door. The cabinet contained gloves and gowns. The sign indicating to see nurse before entering was still visible on the door.</p> <p>During an interview on 1/29/14 at 2:30 p.m., CNA #4 indicated the small cabinet was placed there to provide personal protective equipment prior to entering Resident #91's room. CNA #4 indicated that prior to the cabinet being placed at Resident #91's door, an individual would obtain personal protective equipment by walking through Resident #91's room and into the bathroom.</p> <p>A policy titled " Management of the Resident with Resistant Organisms" obtained from the DON on 1/28/14 at 10:00 a.m., indicated the following:</p> <p>"Precautions will be followed, including the use of contact</p>		<p>residents. Further interventions will be applied if it is determined a need exists within accordance to CDC and CMS guidelines.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?a. All residents deemed to require more than Standard Precautions to prevent the spread of infection will be assessed by the DON or designee prior to admission to determine appropriate measures to be taken. b. Facility staff will be educated on varying types of precautions as well as the policy and procedure pertaining to the correct measures to be taken to prevent the spread of infection with a focus on Multi-drug Resistant Organisms. (See Exhibit A-1 &amp; A-2) 4) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?a. DON or designee will complete a monthly Infection Control Quality Assurance tool to monitor that the deficient practice will not reoccur and report those findings to the Quality Assurance Committee at the quarterly meeting. (See Exhibit B-1) 5) February 7th, 2014. The facility respectfully requests informal dispute resolution for Tag 441 and respectfully maintains that it was and is in substantial compliance</p>				



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	<p>properly implemented for 1 of 5 residents observed during medication administration. (Resident I)</p> <p>Findings include:</p> <p>During medication administration observation on 1/29/14 at 11:35 a.m., Resident (I) was given Tylenol 500mg, crushed and placed into pudding for her noon medication. Resident (I) indicated she had a 2:00 p.m. appointment and would like to take her 2:00 p.m. Tramadol (opioid analgesic) with her to take to her appointment in case she was not back in time. LPN #1 indicated she could crush up the medication and send it with her. Resident (I) provided LPN #1 with a condiment container with a lid and indicated other staff had sent medication with her in the container.</p> <p>LPN #1 returned to the medication cart and removed two Tramadol 50 mg tablets, crushed them and placed them into the container with pudding. LPN #1 returned to Resident (I)'s room and gave the container of medication to the resident.</p> <p>During record review on 1/29/14 at</p>		<p>established by state and federal law. POLICY @ TIME OF SURVEY: It is the Policy of the Heritage of Huntington to recognize that each resident has the right to self administer medications if the IDT deems it safe and appropriate. If upon admission, a resident wishes to self administer medications, then the Medication Self Administration Assessment is completed and the IDT reviews the assessment and deems the resident safe to self administer medications. Upon admission, Resident #1 who was and is alert and oriented, opted on her service plan to have the nurse administer her medications. This decision was made by resident #1 due to arthritis making it difficult to manage medication preparation. Resident #1 keeps a current list of medications and dosages in her room and can state each medication she takes, the time it is due, and what it is for. Resident # 1 also reorders her own prescription from the pharmacy and keeps track of when they need refilled. When the medications arrive at the facility, the nurse checks the medications with the orders, MAR and TAR and stores the medications in the medication cart. Resident # 1 previously made an appointment on 1/29/13 and called and scheduled the HAT Van to transport her to the appointment. Resident #1</p>				

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	<p>2:10 p.m., the clinical record indicated Resident (I)'s service plan, dated 10/31/13, indicated Resident (I) did not self-administer medication and staff provided all administration of medication.</p> <p>During an interview on 1/29/14 at 2:30 p.m., the Assistant Director of Nursing (ADoN) indicated staff had a copy of the self-administration sheets. She provided no additional information.</p> <p>Review of a current facility policy titled "Medication Self Administration", which was provided by the ADoN on 1/29/14 at 2:30 p.m., indicated the following:</p> <p>"Policy: It is the policy of the Heritage of Huntington to recognize that each Resident has the right to self administer medications if the interdisciplinary team deems it safe and appropriate.</p> <p>Procedure: 1. If, upon admission, a Resident wishes to self-administer medications, then the MEDICATION SELF ADMINISTRATION ASSESSMENT is completed."</p>		<p>informed the nurse that she would be leaving for a scheduled appointment and she would like to take her routine "2:00 Tramadol" with her to her appointment. Resident #1 does have a current order from her doctor that she may go LOA with friends and family and take medications. Corrective actions have been put into place for the residents affected by the alleged deficient practice R216, Evaluation Non-Compliance. The Policy and Procedure for Medication Self Administration was revised on 2/7/14 stating that every resident upon admission will have a Medication Self Administration Assessment done. The assessment will be reviewed Bi-annually by nursing staff to ensure that the resident is still able to accurately and safely self-administer medications. No resident will be given medication to take with them without a current SELF-ADMINISTRATION OF MEDICATION assessment in place noting the resident is safe to administer medications. EXHIBIT-A Each resident that resides in assisted living having the potential to be affected by the deficient practice has been identified and the charts have been audited. Each resident that has been identified as having the potential to be affected by the deficient practice has had the MEDICATION SELF ADMINISTRATION</p>		

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			ASSESSMENT completed. The Service Plan now state s under MEDICATIONS AND TREATMENTS: Every resident upon admission will have a MEDICATION SELF ADMINISTRATION assessment completed. EXHIBIT-BMeasures put into place to ensure that the deficient practice does not reoccur have been added to the SERVICE PLAN bi-annual review: A check box has been added to the review to assure that the Bi-annual and Significant change MEDICATION SELF-ADMINISTRATION assessment is current. EXHIBIT-CA Service plan Quality Assurance tool has been put into place to monitor that the deficient practice will not reoccur. This Quality assurance tool will be completed each month, (using a random sample of 5 residents) by the Director of Nursing, Assistant Director of Nursing, or Executive Director/Administrator of this facility. EXHIBIT-D Each nurse has been in-serviced on these changes on the facility's Policy and Procedures for the SERVICE PLAN and MEDICATION SELF-ADMINISTRATION assessment. The systemic changes will be completed by 2/10/14	