STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155332		01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTH CARE CENTEI	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 IN00190569. Complaint IN00190569-Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F514. Survey dates: January 19 and 21, 2016 Facility number: 000225 Provider number: 155332 AIM number: 100267670 Census bed type: SNF/NF: 87 Total: 87 Census payor type: Medicare: 10 Medicaid: 65 Other: 12 Total: 87 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 30576 on January 23, 2016	F 0000	F 0000The creation and submission of this plan does not constitute an admission by this provider of any set forth in the statement of deficiencies or any violation of regulations. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review in lieu of a post survey on or after 6/20/2016.	

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 determined that other safegaurds 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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F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a visitor's voiced concerns to the licensed nursing staff, regarding a resident's level of consciousness and breathing, were promptly assessed by the licensed nursing staff for 1 of 3 residents reviewed for resident assessments in a sample of 3. (Resident #B) Findings include: In an interview with a friend of Resident #B on 1-19-16 at 11:00 a.m., she indicated on the afternoon of 1-3-16, she had found the resident to be unresponsive to her talking to her and her breathing seemed "fast and gurgling," with her abdomen appearing enlarged to her. She indicated she then went to share her concerns with the nurse on duty. She	F 0309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEINGEach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B passed away at facilityHow will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? DNS and ED reviewed the Facility Event Summary Report and identified ten (10) residents with like criteria of nasal drainage, congestion and diminished breathing in the month of January	02/20/2016

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	indicated the nurse's response was, "Oh, she's just out of it. That's how she is sometimes." She indicated the nurse repeated that statement several times. She indicated the nurse, "Also told me her nose was full of snot. She never once went over to check on her and she was right there close [to the nurse's station] in the lounge. She didn't even attempt to go check on her while I was there. I felt like she was just blowing me off." She indicated the resident passed away not long after these events, the same afternoon. In an interview with LPN #1 on 1-19-16 at 7:48 p.m., she indicated she was the nurse on duty on the early afternoon of 1-3-16. She indicated she had provided care for Resident #B on that date. She indicated there did not appear to be anything out of the ordinary for the resident. She recalled after lunch, she obtained the monthly vital signs for Resident #B and, although she could not recall the exact values, she recalled her vital signs were within a normal range. She indicated around 2:00 p.m., to 2:30 p.m., she provided the resident her scheduled medication. She recalled the resident was asleep, seated in her wheelchair, in the TV room. She recalled, "It took me a few minutes to get her awake, but once I got her awake, she		1-22-2016. All ten (10) residents were assessed and documented on by a licensed nurse. The ED reviewed past six (6) months Reports of Concerns and none identified a complaint of a nurse not responding to a concern, The DNS or designee will review assessments and documentation of LPN #1 times 3 months and provide education and up to disciplinary action if needed to ensure polices/procedures are followed. All nurses will be in-serviced on Resident Concern Policy and to report immediately any voiced concerns from visitors to ED.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed Nurses will be in-serviced February 11, 2016 by DNS/ED on Care Values--Attentiveness Assessment--Resident Change of Condition Policy Documentation Guidelines for Nursing Policy Resident Concerns and Grievance Policy/Reporting Visitor Concerns to ED All new nurses will be in-serviced by the CEC/designee at orientation.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? Change on Condition CQI tool will be completed by DNS/designee weekly x weeks, monthly x6 months, and then quarterly until continued	

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	took the medicine okay...she drank 3 cups of cranberry juice and was talking to me." She recalled the resident sounded congested to her, so she listened to [auscultated] the resident's lungs and found them to be clear. She indicated the congestion,"Seemed to be mostly just nasal congestion." She indicated after this interaction, she went to the nurse's station to chart [document]. She indicated about 15 minutes after assisting Resident #B with her medication, "These 2 ladies came up to the desk and asked how [name of Resident #B] was doing. They may have said something about her breathing. I can't remember exactly what they said, I don't recall it sounding urgent. I remember being able to hear her [Resident #B] breathing real loud and congested-sounding and being able to hear her at the desk [nurse's station] from the TV room. I recall I assured them she was okay. Looking back, I should have told them I had just been with her and checked her out because things can change in a short amount of time. And I did use the term, 'boogers.' Probably not the best term, but it is a street term most people understand. The ladies, to me, just sounded like they were just wanting to know how she was doing. I should have gotten up and gone and checked on her right then." She indicated she did have an unnamed CNA go to assist the		compliance is maintained for 2 consecutive quarters. Results will be reported to the Continuous Quality Improvement Committee overseen by the Executive Director, monthly. If a threshold of 100% is not achieved, an action plan will be developed to ensure compliance.By what date the systemic changes will be completed Completion for 309 2/20/2016/	

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	resident with blowing her nose and the CNA did as requested. She indicated she clocked out for the day around 3:00 p.m. In an interview with CNA #2 on 1-21-16 at 10:56 a.m., she indicated on 1-3-16 at around 2:40 p.m., LPN #1 requested for her to assist Resident #B with blowing her nose because the resident was congested. She indicated she did as requested, but informed LPN #1 it was not very helpful. She indicated the nasal discharge was clear. She indicated Resident #B had bouts with congestion, on an off and on basis, "but not real bad." She indicated the resident's nose "tended to run a lot." She indicated around 2:55 p.m., another CNA requested assistance in repositioning Resident #B in her wheelchair, and she provided assistance. She recalled Resident #B at that time was nonverbal, which she recalled was not unusual, but alert and "looked and acted her normal self." She indicated she clocked out for the day around 3:00 p.m. In an interview with RN #3 on 1-19-16 at 1:50 p.m., she indicated she was not working on the day Resident #3 had passed away. She recalled in the month prior to her death, the resident had an increase in the number and type of behaviors, such as yelling out, crying and often not being able to share why she was			

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	upset. She indicated around the time of the resident's death, she had been receiving treatments for an UTI [urinary tract infection] or for an upper respiratory infection. In an interview with CNA #4 on 1-19-16 at 2:10 p.m., she recalled on 1-3-16, she had started her shift around 3:00 p.m. She recalled seeing Resident #B between 3:00 p.m., and 4:00 p.m., seated in her wheelchair in the TV lounge. She recalled she did not notice anything unusual about the resident's appearance. She indicated she had taken a short break, somewhere between 4:00 p.m., and 4:30 p.m. She indicated upon return to the unit, the resident had already passed away. She recalled it was fairly common for Resident #B to have a runny nose and to sound a little bit congested. In an interview with a family member of Resident #B on 1-19-16 at 3:45 p.m., she indicated she had cared for the resident at home until her care needs became greater than she could perform. She indicated she was aware of the resident was declining and had more hallucinations in the recent past. "Still, shocked she went so fast." She indicated, "After our friends were here and told the nurse on duty she was breathing funny and she couldn't wake her up, the nurse just didn't go			

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	check on her. Just told her she was out of it and had boogers in her nose. You don't talk that way and you have an obligation to go check the patient out. She didn't. That really hurts me as a [family member] and as a nurse." Resident #B's clinical record was reviewed on 1-19-16 at 9:45 a.m. It indicated her diagnoses included, but were not limited to, advanced Parkinson's disease, tremors, bronchitis, arthritis, functional quadriplegia and anxiety. Her most recent Minimum Data Set (MDS) assessment, dated,11-2-15, indicated she was cognitively intact, required extensive assistance of 2 or more persons for transfers and toileting, was unable to walk, used a wheelchair for mobility in and about the facility, required extensive assistance of one person with dressing and was dependent with the assistance of one person for bathing. The resident code status was listed as "DNR," [do not resuscitate] which was signed by the resident on 7-28-15 and acknowledged by the attending physician on 7-31-15. Review of the nursing progress notes for Resident #B indicated in the month prior to her death on 1-3-16, she had multiple documentation's of auditory and visual hallucinations, paranoia and falls. A nine pound weight loss in a 30 day period was			

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	noted on 12-18-15 related to a variable appetite. The resident was seen by psychiatric services on 12-17-15 with her antidepressant changed from Prozac to Cymbalta related to a possible untoward interaction with other medications she received. On 12-21-15, a urinalysis was obtained related to the recent increase in behaviors. This resulted in the resident being placed on an antibiotic for an urinary tract infection. The nursing progress notes did not include the documentation of a lung assessment conducted by LPN #1 on 1-3-16. It did not include any reference to the resident's nasal congestion referred to by LPN #1. It did indicate her vitals signs were documented for 1-3-16 with her vitals signs within normal range. The only documentation in the nursing progress notes for 1-3-16 indicated at 3:55 p.m., LPN #5 was called to the TV lounge by staff. "Noted resident up in w/c [wheelchair] facing TV with head downward like usual. Color ashen and skin slightly cool to touch. Radial [wrist] pulse absent. Transferred into bed with 3 assist[s]. Called out resident's name with no response. Apical heart beat and respirations are absent per [name of staff member] RN and this writer." It indicated the nurse practitioner and the family were notified of the resident's			

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	death at 4:00 p.m. On 1-21-16 at 10:50 a.m., the Director of Nursing (DON) provided a copy of a document entitled, "Employee Coaching & Counseling." This document indicated LPN #1 displayed, "Lack of response to a visitor's concern related to a resident." It indicated LPN #1 had been counseled regarding, "Education provided in response to customer concern to always go to the resident in question and assess the situation regardless of last time checked as a resident's condition may change rapidly. Chart Vital Signs and any assessment done." Attached to this form was educational material entitled, "Head to Toe Assessment in 5 Minutes Or More." The DON indicated the resident referenced in this document was Resident #B and the events of 1-3-16. In an interview with the DON on 1-19-16 at 4:15 p.m., she indicated, "My expectations are that when a nurse is asked to check on a resident, she should do it." In an interview with the Executive Director on 1-31-16 at 11:00 a.m., she indicated she was unaware of the situation regarding the visitor addressing LPN #1 with concerns regarding Resident #B's breathing and lack of response until			

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	about one week after the resident's death. She indicated a family member of Resident #B brought it to her attention and the investigation was initiated at that time. This Federal tag relates to Complaint IN00190569. 3.1-37(a)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure accurate documentation of a physical assessment related to a resident's respiratory status and mental status for 1 of 3 residents reviewed for resident assessments in a sample of 3. (Resident #B)	F 0514	F 514 RECORDS-COMPLETED/ACCURATE/ACCESSIBLEThe Facility must maintain clinical records on each resident that are complete; accurate; accessible; and systematically organized.What corrective action (s) will be accomplished for those residents found to have been affected by	02/20/2016

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	Findings include: In an interview with a friend of Resident #B on 1-19-16 at 11:00 a.m., she indicated on the afternoon of 1-3-16, she had found the resident to be unresponsive to her talking to her and her breathing seemed "fast and gurgling," with her abdomen appearing enlarged to her. She indicated she then went to share her concerns with the nurse on duty. She indicated the nurse's response was, "Oh, she's just out of it. That's how she is sometimes." She indicated the nurse repeated that statement several times. She indicated the nurse, "Also told me her nose was full of snot. She never once went over to check on her and she was right there close [to the nurse's station] in the lounge. She didn't even attempt to go check on her while I was there. I felt like she was just blowing me off." She indicated the resident passed away not long after these events, the same afternoon. In an interview with LPN #1 on 1-19-16 at 7:48 p.m., she indicated she was the nurse on duty on the early afternoon of 1-3-16. She indicated she had provided care for Resident #B on that date. She indicated there did not appear to be anything out of the ordinary for the resident. She recalled after lunch, she		the deficient practice? Resident #B passed away at the facility.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 by the alleged deficient practice. DNS and ED reviewed the Facility Event Summary Report and identified ten (10) residents with symptoms of nasal drainage, congestion, and diminished breathing for the month of January 1-22, 2016. All ten (10) residents charts were reviewed and showed assessment and accurate documentation. CEC/designee will review the Facility Event Summary Report daily to review event documentation and assessments to ensure completion. If not completed DNS will follow up with nurse and provide necessary education/discipline action if indicated. DNS will review assessments and documentation of LPN#1 times 3 months and provide any needed education and up to disciplinary action if needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed Nurses will be in-serviced on February 11, 2016 by the DNS and ED on Care Values Assessments--Resident Change in Condition	

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	obtained the monthly vital signs for Resident #B and, although she could not recall the exact values, she recalled her vital signs were within a normal range. She indicated around 2:00 p.m. to 2:30 p.m., she provided the resident her scheduled medication. She recalled the resident was asleep, seated in her wheelchair, in the TV room. She recalled, "It took me a few minutes to get her awake, but once I got her awake, she took the medicine okay...she drank 3 cups of cranberry juice and was talking to me." She recalled the resident sounded congested to her, so she listened to [auscultated] the resident's lungs and found them to be clear. She indicated the congestion,"Seemed to be mostly just nasal congestion." She indicated after this interaction, she went to the nurse's station to chart [document]. She indicated about 15 minutes after assisting Resident #B with her medication, "These 2 ladies came up to the desk and asked how [name of Resident #B] was doing. They may have said something about her breathing. I can't remember exactly what they said, I don't recall it sounding urgent. I remember being able to hear her [Resident #B] breathing real loud and congested-sounding and being able to hear her at the desk [nurse's station] from the TV room. I recall I assured them she was okay. Looking back, I should have		Policy Documentation Guidelines for Nursing PolicyAll new nurses will be in-serviced by the CEC/designee at orientation.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? Facility Activity Report/Event Hot Charting CQI tool will be completed by the DNS/designee weekly x 4 weeks, monthly x6 months, and then quarterly until compliance is maintained for 2 consecutive quarters. Results will be reported to the Continuous Quality Improvement Committee overseen by the Executive Director, monthly. If a threshold of 100% is not achieved, an action plan will be developed to ensure compliance.By what date the systemic changes will be completed. Completion date for Tag F 514 2/20/2016.	

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	told them I had just been with her and checked her out because things can change in a short amount of time. And I did use the term, 'boogers.' Probably not the best term, but it is a street term most people understand. The ladies, to me, just sounded like they were just wanting to know how she was doing. I should have gotten up and gone and checked on her right then." She indicated she did have an unnamed CNA go to assist the resident with blowing her nose and the CNA did as requested. She indicated she clocked out for the day around 3:00 p.m. Resident #B's clinical record was reviewed on 1-19-16 at 9:45 a.m. It indicated her diagnoses included, but were not limited to, advanced Parkinson's disease, tremors, bronchitis, arthritis, functional quadriplegia and anxiety. Her most recent Minimum Data Set (MDS) assessment, dated,11-2-15, indicated she was cognitively intact, required extensive assistance of 2 or more persons for transfers and toileting, was unable to walk, used a wheelchair for mobility in and about the facility, required extensive assistance of one person with dressing and was dependent with the assistance of one person for bathing. The resident code status was listed as "DNR," [do not resuscitate] which was signed by the resident on 7-28-15 and acknowledged by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTH CARE CENTEI	281 S CR 200 E CONNERSVILLE, IN 47331

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	the attending physician on 7-31-15. The nursing progress notes did not include the documentation of a lung assessment conducted by LPN #1 on 1-3-16. It did not include any reference to the resident's nasal congestion referred to by LPN #1. It did indicate her vitals signs were documented for 1-3-16 with her vitals signs within normal range. The only documentation in the nursing progress notes for 1-3-16 indicated at 3:55 p.m., LPN #5 was called to the TV lounge by staff. "Noted resident up in w/c [wheelchair] facing TV with head downward like usual. Color ashen and skin slightly cool to touch. Radial [wrist] pulse absent. Transferred into bed with 3 assist[s]. Called out resident's name with no response. Apical heart beat and respirations are absent per [name of staff member] RN and this writer." It indicated the nurse practitioner and the family were notified of the resident's death at 4:00 p.m. On 1-21-16 at 10:50 a.m., the Director of Nursing (DON) provided a copy of a document entitled, "Employee Coaching & Counseling." This document indicated LPN #1 displayed, "Lack of response to a visitor's concern related to a resident." It indicated LPN #1 had been counseled regarding, "Education provided in			

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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE REHABILITATION & HEALTH CARE CENTEI		STREET ADDRESS, CITY, STATE, ZIP CODE 281 S CR 200 E CONNERSVILLE, IN 47331	

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	response to customer concern to always go to the resident in question and assess the situation regardless of last time checked as a resident's condition may change rapidly. Chart Vital Signs and any assessment done." Attached to this form was educational material entitled, "Head to Toe Assessment in 5 Minutes Or More." The DON indicated the resident referenced in this document was Resident #B and the events of 1-3-16. This Federal tag relates to Complaint IN00190569. 3.1-50(a)(1) 3.1-50(a)(2)			