

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155095	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/20/2016
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NAME OF PROVIDER OR SUPPLIER  HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: January 12, 13, 14, 15, 19 and 20, 2016</p> <p>Facility Number: 000038</p> <p>Provider Number: 155095</p> <p>AIM Number: 100274830</p> <p>Census Bed Type: SNF: 16 SNF/NF: 141 Residential: 35 Total: 192</p> <p>Census By Payor Type: Medicare: 15 Medicaid: 115 Other: 62 Total: 192</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on January 22, 2016 by 17934.</p>	F 0000	<p>Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employees, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper compliance in lieu of a Post Survey Review on or after</p>	
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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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F 0323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the doors were secured for the shower room, beauty shop and storage room outside the Cottage (a secured Memory Care unit). The facility also failed to ensure a spray protectant and hand sanitizers were secured and out of reach of residents. This deficiency had the potential to affect 4 out of 26 residents in the Cottage (secured unit) and 8 of 131 residents outside the Cottage who were independently mobile and confused.</p> <p>Findings include:</p> <p>1. An observation of the beauty salon on 1-12-2016 at 2:05 p.m., indicated the salon door was open, the room was dark</p>	F 0323	<p>February 5, 2016</p> <p>F-323 It is the practice of this facility to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. However; based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were individually identified to have been affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents living in the facility that are independently mobile with confusion have the</p>	02/05/2016

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	<p>and unattended. The following products were out on top of the counter, two tall jars of barbicide with combs inside, two gallon size pump containers of shampoo with "...keep out of reach of children..." on the labels and a pump container of (brand name) hand sanitizer which was half full with a label that indicated "...keep out of reach of children..."</p> <p>Numerous beauty products were observed in an unlocked cabinet next to each of the 2 shampoo sinks which included but were not limited to the following, a can of mousse, hair spray, (brand name) rinse and color corrector and assorted nail polishes. Further observation indicated a 13 ounce jar of petroleum jelly and a bottle of nail polish remover were stored in an unlocked cabinet with "...keep out of reach of children..." on labels.</p> <p>Further observation of the beauty salon on 1-12-2016 at 2:06 p.m., indicated numerous facility staff walked by the open salon door and no one closed and secured the salon door.</p> <p>An observation of the beauty salon on 1-13-2016 at 1:37 p.m., indicated the beauty shop door was ajar and a resident was observed to be sitting under the hair dryer unattended. Beauty supplies were</p>		<p>potential to be affected by the alleged deficient practice. No residents were found to have been affected by the deficient practice. Beauty Salon: Facility Beauticians have been re-educated by the Acting DNS. Education included but was not limited to no residents to be left unsupervised in the salon, locking up hazardous chemicals to prevent access to residents and locking the door to the shop when leaving the room unattended. Education provided by the Acting DNS by Feb 1, 2015 Storage Room outside Cottage: The Maintenance Director installed a locking mechanism to the storage room door immediately after being made aware the door was not able to be secured Housekeeping Carts: The hand sanitizer was removed from the top of the housekeeping cart and secured in the cart. Housekeepers have been re-educated about securing hazardous chemicals to prevent residents from having access to them. Education included but is not limited to securing all chemicals not being used in the housekeeping cart and locking the cart when leaving it unattended. Education provided by DNS, Acting DNS, ADNS and Clinical Education Co-ordinator by Feb 1, 2016 Medication Cart The skin spray was immediately removed from the top of the cart</p>	

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	<p>out on the counter and accessible.</p> <p>An observation of the beauty salon on 1-13-2016 at 2:20 p.m., indicated the beauty salon door was open and a different resident was sitting in the chair unattended. An interview with the resident indicated the hair stylist took a resident back to their room.</p> <p>2. An observation of the storage room outside the Cottage on 1-12-2016 at 2:15 p.m., indicated the door was not secured. Further observation inside the room indicated boxes were stacked on the floor with one open box containing individually packaged germicidal wipes with a statement on the label, "...causes irreversible eye damage...."</p> <p>An observation of the storage room outside the Cottage on 1-13-2016 at 8:54 a.m., indicated the storage room was accessible, without a locking mechanism on the door handle and the box of germicidal wipes remained in the room.</p> <p>3. An observation in the Cottage on 1-12-2016 at 2:45 p.m., indicated a 4 ounce bottle of hand sanitizer was out on top of a housekeeping cart which was parked by room 402. Housekeeper #2 was observed to leave the cart unattended while going into residents' rooms to</p>		<p>and put in a secured drawer.</p> <p>Shower Rooms The shower room doors were immediately shut and locked. Cabinets in the shower rooms containing chemicals were also immediately secured.</p> <p>Facility staff in all departments have been re-educated regarding the risk of hazardous chemicals being unattended with independently mobile confused residents and facility expectations to prevent accidents. Education to staff includes but is not limited to keeping shower room doors locked at all times, keeping chemicals in the shower room locked in the cabinets provided, keeping storage rooms containing chemicals secured, keeping the beauty shop locked when unattended and not leaving residents unattended in the shop and observing environment for hazardous chemicals being unattended in any area including medication carts and housekeeping carts. Education provided by DNS, Acting DNS, ADNS, Clinical Education Co-ordinator/Designee by Feb 1, 2016 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Facility Beauticians have been re-educated by the Acting DNS. Education included but was not limited to no residents to be left unsupervised in the salon, locking up</p>		

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	<p>clean. A resident was observed to propel his wheelchair independently in the hallway near the housekeeping cart.</p> <p>Further observation of the housekeeping cart in the Cottage on 1-12-2016 at 2:48 p.m., indicated a resident walked down the hall independently by the unattended housekeeping cart with the hand sanitizer out on top of the cart. The resident was observed to enter another resident's room.</p> <p>An observation of the housekeeping cart in the Cottage on 1-12-2016 at 2:55 p.m., indicated Housekeeper #2 used the container of hand sanitizer and replaced the container of hand sanitizer on top of the housekeeping cart.</p> <p>An observation of the unattended housekeeping cart in the Cottage on 1-13-2016 at 9:02 a.m., indicated the cart was parked outside rooms 409 and 410 with the 4 ounce bottle of hand sanitizer on top of the cart.</p> <p>An observation of the unattended housekeeping cart in the Cottage on 1-13-2016 at 10:54 a.m., indicated the cart was parked outside room 407 with a 4 ounce bottle of hand sanitizer on top of the cart. A resident in a wheelchair was observed to be sitting right next to the housekeeping cart unattended. Another</p>		<p>hazardous chemicals to prevent access to residents and locking the door to the shop when leaving the room unattended. Education provided by the Acting DNS by Feb 1, 2015 Housekeepers have been re-educated about securing hazardous chemicals to prevent residents from having access to them. Education included but is not limited to securing all chemicals not being used in the housekeeping cart and locking the cart when leaving it unattended. Education provided by DNS, Acting DNS, ADNS and Clinical Education Co-ordinator by Feb 1, 2016 Facility staff in all departments have been re-educated regarding the risk of hazardous chemicals being unattended with independently mobile confused residents and facility expectations to prevent accidents. Education to staff includes but is not limited to keeping shower room doors locked at all times, keeping chemicals in the shower room locked in the cabinets provided, keeping storage rooms containing chemicals secured, keeping the beauty shop locked when unattended and not leaving residents unattended in the shop and observing environment for hazardous chemicals being unattended on any surface including medication carts and housekeeping carts. Education provided by DNS, Acting DNS, ADNS, Clinical Education</p>		

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	<p>unattended resident in a wheelchair was observed to self propel the wheelchair in the hallway toward the housekeeping cart. Further observation of the unattended housekeeping cart in the Cottage, indicated an unattended, ambulatory resident walked down the hall and Housekeeper #2 came out of a room. Housekeeper #2 was observed to use the hand sanitizer while the ambulatory resident was standing by the housekeeping cart. Housekeeper #2 was observed to place the hand sanitizer back on top of the housekeeping cart and left the cart unattended while the ambulatory resident was observed to push the housekeeping cart down the hall.</p> <p>4. An observation of an unattended housekeeping cart on 1-13-2015 at 8:51 a.m., indicated a 4 ounce container of hand sanitizer was observed on top of the cart. The housekeeping cart was parked by the biohazard room door across from the unattended nurse station for the 100 hall.</p> <p>An observation of an unattended housekeeping cart on 1-14-2016 at 9:58 a.m., indicated a (brand name) 1 ounce container of hand sanitizer was out on top of the cart. The cart was parked by the unattended 100 hall nurse station. with a resident observed to walk by the cart and</p>		<p>Co-ordinator/Designee by Feb 1, 2016. The facility Safety Committee will make daily rounds x 30 days and is responsible for compliance. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur: A CQI Monitoring Tool titled "Environmental Safety " will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>	

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	<p>another resident self propelling their wheelchair by the cart.</p> <p>5. An observation of an unattended medication cart parked across from the Nalani Lane (300 hall) dining room on 1-15-2016 at 8:56 a.m., indicated a 28 ml (milliliter) bottle of (brand name) skin spray was left out on top of the cart.</p> <p>During a walk around with the Executive Director, the Acting DON (Director of Nursing) and the Maintenance Director on 1-15-2016 at 12:28 p.m., the following was observed:</p> <p>The storage room door outside the Cottage was not locked. Inside the storage room were 3 full boxes of the germicidal wipes stored in an open box. An interview with the Maintenance Director indicated the door could be locked and it was observed he was unable to lock the door because there was not a locking mechanism. The Maintenance Director indicated the door handle had to have been recently changed. Further interview with the Executive Director, Acting DON and the Maintenance Director indicated they were not aware the door handle could not be locked and they were unaware of the germicidal wipes stored in the room.</p> <p>An interview with the Executive Director</p>			

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	<p>on 1-15-2016 at 12:41 p.m., indicated, "those doors should have been locked."</p> <p>An interview with the Executive Director on 1-19-2016 at 8:40 a.m., indicated the facility did not have a policy for the storage of chemicals.</p> <p>An interview with Housekeeper #1 on 1-19-2016 at 9:45 a.m., indicated hand sanitizer should not be left out on top of the housekeeping cart.</p> <p>An interview with the Memory Care Coordinator on 1-19-2016 at 9:58 a.m., indicated there were 4 independently mobile and confused residents of 26 who resided in the Cottage.</p> <p>An interview with the Director of Social Services #3 and #4 on 1-19-2016 at 10:08 a.m., indicated there were 8 independently mobile and confused residents of the 131 residents who resided outside of the Cottage.</p> <p>A MSDS (Material Safety Data Sheet) was provided by the Executive Director on 1-19-2016 at 8:40 a.m., for the for the (Brand name) Germicidal Wipe dated 3-27-2015 and indicated "...serious eye damage...call a poison control center or doctor for treatment advice...not a skin wipe...wear appropriate personal</p>			

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	<p>protective equipment...wash thoroughly after handling...."</p> <p>A MSDS was provided by the Executive Director on 1-19-2016 at 8:40 a.m., for the (brand name) Array Instant Hand Sanitizer dated 9-8-2015 and indicated "...if swallowed...do not induce vomiting...contact physician or poison control center...store away from reach of small children...."</p> <p>A MSDS was provided by the Executive Director on 1-19-2016 at 8:40 a.m., for the barbicide concentrate dated 3-6-2015 and indicated "...if swallowed: immediately call a poison center/physician...containers should be clearly identified...accessible only to authorized personnel...."</p> <p>A MSDS was provided by the Executive Director on 1-19-2016 at 8:40 a.m., for the (brand name) Hand Sanitizer Aloe Gel dated 3-18-2015 and indicated "...causes serious eye irritation...if swallowed, do not induce vomiting...get medical attention...."</p> <p>A MSDS was provided by the Executive Director on 1-19-2016 at 8:40 a.m., for the (brand name) Control Mousse dated 5-20-2010 and indicated "...keep out of reach of children...."</p>			

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	<p>A MSDS was provided by the Executive Director on 1-19-2016 at 8:40 a.m., for the (brand name) Hair Spray Ultra Fine Mist dated 8-22-2008 and indicated "...keep out of reach of children...."</p> <p>A MSDS was provided by the Executive Director on 1-19-2016 at 8:40 a.m., for the (brand name) rinse and color correctors dated 2-9-2005 and indicated "...may cause eye irritation...."</p> <p>A MSDS was provided by the Executive Director on 1-19-2016 at 8:40 a.m., for the nail polish remover dated 12/2001 and indicated for ingestion "...call physician or poison control center...."</p> <p>A MSDS was provided by the Executive Director on 1-19-2016 at 8:40 a.m., for the petroleum jelly dated 11-4-2011 and indicated for ingestion "...do not induce vomiting without medical advice...."</p> <p>A MSDS was provided by the Executive Director on 1-19-2016 at 8:40 a.m., for the (brand name) skin protectant dated 5-30-2015 and indicated "...if swallowed, call a physician immediately...rinse mouth and throat thoroughly with water...."</p> <p>A copy of the nail polish label was</p>			

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	<p>provided by the Executive Director on 1-19-2016 at 8:40 a.m., and indicated "...keep away from small children...."</p> <p>A copy of the (brand name) hand sanitizer label was provided by the Executive Director on 1-19-2016 at 8:40 a.m., and indicated " ...keep out of reach of small children...if swallowed, get medical help...contact a Poison Control Center right away.... "</p> <p>A copy of the (brand name) Shampoo and (brand name) Shampoo labels were provided by the Executive Director on 1-19-2016 at 8:40 a.m., and indicated " ...keep out of reach of children.... "</p> <p>A current policy "Barber/Beauty Shop" dated 2-2012 and provided by LPN #5 on 1-20-2016 at 11:10 a.m., indicated "...chemicals will be secured to prevent misuse or accidents...room/items should be locked or secured when not in use...."</p> <p>6. On 1/13/16 at 9:59 a.m., the Spa room (shower room) in the 700 hall was observed. The entry door was unlocked. Inside the spa room, two closet doors were closed, but not locked. When the closet doors were opened, the following was observed on the shelves: cans of shaving cream, bottles of shampoo, body wash and incontinence wash, PDI</p>			

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	<p>(Professional Disposable International) wipes, tubes of barrier cream (labeled with "Keep out of reach of children"), antiperspirant, mouthwash, lotion, Neutral Quat Disinfectant, denture cleanser tablets and denture adhesive cream.</p> <p>On 1/13/16 at 10:04 a.m., CNA (certified nursing assistant) #6, was observed to enter the 700 hall spa room door without using a key.</p> <p>On 1/13/16 at 1:54 p.m., CNA #7 was observed to open the 700 hall spa room without the use of a key. At 1:56 p.m., CNA #7 was again observed to enter the 700 hall spa room without the use of a key.</p> <p>On 1/14/16 8:41 a.m., the 700 hall spa room was observed to be unlocked. The door was open and the entire locking mechanism was visible on the door frame jam. At 8:47 a.m., the spa room closet doors were again observed to be opened.</p> <p>On 1/15/16 at 10:20 a.m., the 700 hall spa room door was observed to be unlocked.</p> <p>On 1/20/16 at 10:25 a.m., the ADON (Assistant Director of Nursing) provided copies of the following Material Safety</p>			

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	<p>Data Sheets:</p> <p>Cans of (Brand Name) shaving cream indicated: "...precautions to be taken in handling and storing:...keep out of reach of children...."</p> <p>Bottles of (Brand Name) shampoo and body wash indicated: "...hazard statement: causes eye irritation, may be harmful if swallowed...."</p> <p>Bottles of Incontinence Wash indicated: "...if swallowed: Abnormal entry route and may cause diarrhea. Do not induce vomiting. Contact physician or poison control center...store...away from reach of small children...."</p> <p>Supply of PDI wipes indicated: "...Hazard statement...causes serious eye irritation...precautions for safe handing...wash thoroughly after handling...ingestion...call a poison control center...for treatment advice...."</p> <p>Tubes of Barrier Cream indicated: "...first-aid measures...flush with water, if irritation persists, seek medical attention...."</p> <p>Bottles of Antiperspirant indicated: "...other precautions: keep out of reach of children...."</p> <p>Bottles of Mouthwash indicated: "...ingestion...of large amounts may produce signs of stomach irritation...."</p> <p>Bottles of (brand name) lotion indicated: "...hazard information...eye</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/20/2016
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NAME OF PROVIDER OR SUPPLIER  HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>irritation...wash thoroughly after handling...."</p> <p>Two spray bottles of Quat Disinfectant indicated: "...Emergency Overview...Danger. Corrosive to eyes. Causes eye burns and skin irritation. Harmful or fatal if swallowed...handling or storage...avoid ingestion and contact with eyes. Do not taste or swallow...."</p> <p>Package of Denture Cleanser Tablets indicated: "...Health Hazard Data...can cause eye irritation. Wash with copious amounts of water...Ingestion: expected to be slightly toxic by ingestion...call poison control center...."</p> <p>(Brand name) Denture Adhesive Cream indicated: "...Health Hazard Data:...ingestion of large amounts may cause nausea of vomiting. Esophageal blockage could occur in rare cases..may cause transient eye irritation...Avoid contact with eyes...."</p> <p>3.1-45(a)(1)</p>			

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NAME OF PROVIDER OR SUPPLIER  HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805		
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: January 20 &amp; 21, 2016</p> <p>Facility Number: 000038</p> <p>Provider Number: 155095</p> <p>AIM Number: 100274830</p> <p>Census Bed Type: Residential: 35 Total: 35</p> <p>Sample: 8</p> <p>Heritage Park was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000	<p>Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employees, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper compliance in lieu of a Post Survey Review on or after</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2016

FORM APPROVED

OMB NO. 0938-0391

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			February 5, 2016		