

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/07/2016
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
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(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
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00206325.</p> <p>Complaint IN00206325 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309.</p> <p>Survey date: September 7, 2016.</p> <p>Facility number: 000117 Provider number: 155210 AIM number: 100266460</p> <p>Census bed type: SNF/NF: 58 Total: 58</p> <p>Census payor type: Medicare: 3 Medicaid: 31 Other: 24 Total: 58</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 34233 on September 8, 2016.</p>	F 0000	<p>F 0000 Please accept this Plan of Correction as our credible allegation of compliance for the deficiency noted in the 2567 for Heritage House of Greensburg. In respectfully submitting the required Plan of Correction, we are alleging compliance by October 7, 2016 and request a paper compliance review if applicable.</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 0309 SS=D Bldg. 00	<p>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.</p> <p>Based on interview and record review, the facility failed to appropriately assess a resident following an unwitnessed fall for 1 of 3 residents reviewed for falls. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 09/07/2016 at 10:30 A.M. The resident's Quarterly MDS (Minimum Data Set) assessment, dated 06/17/2016, indicated the resident was moderately cognitively impaired with a BIMS (Brief Interview for Mental Status) of 10. The resident's diagnoses included, but were not limited to, depression, hereditary ataxia, and insomnia.</p> <p>Resident #B's "Occurrence Initial Assessment" indicated on 07/28/2016 the resident had an unwitnessed fall. Resident #B was found on the floor by his/her bed and</p>	F 0309	<p>F 0309 LPN # 2 caring for this resident was inserviced on 09/14/2016 on Policy and Procedure for "Neurological Assessments"(see Attachment A). The resident # B had no negative outcome from this deficient practice.</p> <p>All residents have the potential to be affected by this deficient practice. An inservice was held to review the "Neurological Assessment" Policy (see Attachment B). Nurses were educated of the need for neurological assessments on any unwitnessed falls. Nurses were informed that any nurse that deviates from the policy will be re-educated and disciplined as needed.</p> <p>The DON or her designee will review all falls daily. Any residents with an unwitnessed fall would require neuro-checks. These results of the neuro-checks will be documented on the "Neurological Assessment Flowsheet" (see Attachment C) and become part of the residents' permanent record.</p>	10/07/2016			

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	<p>"denies hitting [his/her] head." The assessment further indicated, "...Neuro [neurological] checks started due to hitting head or unwitnessed fall..." and was answered "No."</p> <p>During an interview on 09/07/2016 at 12:04 P.M., LPN #2 indicated Resident #B's fall had been unwitnessed. She further indicated she did not complete neurological checks because the resident did not have any apparent injury during his/her head to toe assessment and denied hitting his/her head.</p> <p>During an interview on 09/07/2016 at 11:19 A.M., RN (Registered Nurse) #1 indicated neurological checks were automatically started for any unwitnessed fall.</p> <p>During an interview on 09/07/2016 at 12:23 P.M., RN #3 indicated when a resident had an unwitnessed fall neurological checks were always completed.</p> <p>This Federal tag relates to Complaint IN00206325.</p> <p>3.1-37(a)</p>		<p>All falls witnessed and unwitnessed will be discussed at the next quarterly Quality Assurance Meeting. Any Nurse found to be non-compliant will be re-educated and progressively disciplined. The results of the audits will be reviewed by the Quality Assurance Committee and any recommendations made will be followed.</p> <p>Audits will be conducted weekly over the next 4 weeks to ensure neuro-check assessments have been completed on unwitnessed falls, then monthly for 3 months, then quarterly thereafter, until 100% compliant (see Attachment D).</p>	