

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  03/08/2012
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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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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 5, 6, 7, and 8, 2012</p> <p>Facility number: 000117 Provider number: 155210 AIM number: 100266460</p> <p>Survey team: Janie Faulkner, RN TC Cheryl Fielden, RN (March 7 and 8, 2012) Jill Ross, RN Diana Sidell, RN</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census payor type: Medicare: 4 Medicaid: 44 Other: 22 Total: 70</p> <p>Sample: 15 Supplemental sample: 1</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Please accept this Plan of Correction as our credible allegations of compliance for the deficiencies noted in the 2567 for Heritage House of Greensburg. In respectfully submitting the required Plan of Correction our facility is not admitting to the allegations of non-compliance contained within. We are alleging compliance by April 6, 2012 and requests a paper compliance review if possible.</p>	

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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	Quality review completed 3/15/12 Cathy Emswiller RN				

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to intervene after a resident had a greater than 10% weight loss in one month. This affected 1 resident (Resident #38) out of 7 in a sample of 15 reviewed for weight loss.</p> <p>Findings include:</p> <p>Resident #38's record was reviewed on 3-6-12 at 11:45 a.m. The record indicated this resident was admitted with diagnoses that included, but not limited to, depression, CHF (congestive heart failure), diabetes, high blood pressure, morbid obesity, respiratory failure and right hemiplegia (complete paralysis of one side).</p> <p>On 3-6-12 at 11:45 a.m., the weight chart indicated there was a weight of 246 lbs (pounds) in January, 2012, 245.8 lbs in February and 227.2 lbs in March. There</p>	F0325	<p>F 325 Maintain Nutritional Status 1. Resident #38's weight loss was reviewed by the health care plan team. The resident's physician, family, and the Registered Dietician were notified per policy and procedure. Resident number 38's care plan was adjusted to include interventions to prevent further weight loss. 2. All residents have the potential to be affected by this practice. All resident weights have been reviewed, and any residents with significant weight loss have been identified and care plans reviewed and updated as needed. 3. To ensure the deficient practice does not reoccur all new admissions will be weighed weekly for 4 weeks and monitored. Once a stable weight has been established residents will be weighed monthly. Any significant weight loss will be reported to the attending physician, responsible party, Registered Dietician, and added to the SWAT (Skin Weight</p>	04/06/2012	

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	<p>were no notes from the physician, nurses notes or dietary notes addressing this issue. In interview with the DON (Director of Nursing) at this time she indicated she was not aware of this weight loss. She indicated she would have the resident re-weighed and follow through as needed.</p> <p>A care plan reviewed on 3-6-12 at 11:45 a.m., indicated on 8-4-11 there had been a weight loss in the last 30 days. The goal was, "Resident will have no significant weight change thru next review." The intervention for this was "Monitor weight weekly. Meds as ordered." There is a review date of 2-27-12 for this problem.</p> <p>In interview with the DON on 3-7-12 at 9:40 a.m., she indicated they will be re-weighing [Resident #38] due to the big change in her weight. "She has been seen by the Dietician, Psychologist, Dietary Manager to try to get her to eat better. She refuses to let staff feed her. She just seems very depressed. The doctor has changed her meds (medications) to try to improve her appetite."</p> <p>Review of the nurses notes on 3-7-12 at 11:05 a.m. failed to include the weight loss but did address the fact that this resident was not eating well. During the month of February the food intake log</p>		<p>Assessment Team) committee meeting to be monitored weekly thru aggressive dietary and/or clinical interventions. These interventions will be added to the care plan. All nursing staff and the dietary manager will be inserviced on the Resident Weight Policy and Procedure by March 30, 2012. 4. The corrective action will be monitored by the Director of Nursing or designee as follows: The Quality Assurance tool "Weight Loss Audit Sheet" (see ATTACHMENT 1) will be completed weekly for 6 weeks then monthly thereafter. Corrective actions will be implemented if problems occur. The results from this audit tool will be reviewed at the Quality Assurance Committee meeting for recommendations. 5. Completion date April 6, 2012</p>		

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	<p>indicated this resident had no intake at meals 14 times. There were only 3 times during February that the resident ate 90 or 100% of her meals. All other meal intake documentation indicated she was only eating 5 - 50% of her meals.</p> <p>Review of the weight chart for Resident #38 on 3-7-12 at 11:05 a.m. the re-weight showed a weight of 225.2 lbs. This was a 20.8 lb weight loss in 2 months and 1 week. The DON had notified the doctor and received an order for Megase 800 mg (this is a medication to increase appetite) by mouth twice a day.</p> <p>Resident #38 was alert and oriented but not interviewable due to aphasia (inability to speak or to speak clearly). In review of the dietary notes on 3-6-12 at 11:45 a.m., they indicated the "resident is fed by staff...Consuming 25-50% of most meals." This entry was dated 2-27-12.</p> <p>There was no update on the care plan for the weight loss as of 11:15 a.m. on 3-8-12.</p> <p>3.1-46(a)(1)</p>				

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure staff used proper hand hygiene and glove use during food preparation in that staff touched door handles and other contaminated items and went back to food serving or preparing without changing their gloves or washing their hands. This occurred during 2 of 4 observations of food preparation. This deficient practice had the potential to affect 68 out of 68 residents who received meals prepared in the facility kitchen.</p> <p>Findings include:</p> <p>During filling of food trays for residents on 3-5-12 at 11:45 a.m., Dietary Aide #1 was observed as she went from putting silverware, drinks and covers over the plates on food trays, to pushing a cart, to opening a refrigerator, and then back to serving trays again without changing her gloves or washing her hands.</p> <p>During interview on 3-5-12 at 3:45 p.m.,</p>	F0371	<p>371 Food Storage Preparation1. No residents were affected by this deficient practice. The dietary staff werere-educated on proper hand hygiene and glove use. Dietary assistant #1 and cook #2 were re-educated immediately.2. All residents have potential to be affected by this practice. All dietary staff will be observed for proper hand hygiene and proper glove use. Should there be anyevidence that staff fail to comply with the facility policy and Infection Control Programs, they will immediately be re-educated and progressive discipline will be initiated if additional action is required.3. All dietary staff will be inserviced on proper hand hygiene and glove use by March 30, 2012. This inservice will have emphasis on cross contamination related to glove use.4. The dietary manager or designee will observe dietary staff using the "Dining Room/Food Service Audit Tool" (see ATTACHMENT 2) weekly for 6 weeks, then monthly for 3 months, then quarterly thereafter on proper hand hygiene and proper glove use. The results of the audit will be</p>	04/06/2012			

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	<p>Cook #2 indicated she was going to puree food for 10 residents for the evening meal. Cook #2 was observed as she went from pureeing food, to the refrigerator, got milk out, poured milk and put it back in the refrigerator, and back to pureeing food without changing gloves or washing hands.</p> <p>In review of the handwashing policy received on 3-6-12 at 9:05 a.m., from the Dietary Manager, indicated: "Policy: Hands will be washed regularly according to procedure to help minimize risk of cross contamination to foods for resident/staff consumption...When to wash hands...6) after handling soiled surfaces, equipment or utensils 7) between tasks that may result in cross contamination..."</p> <p>In review of Proper Use of Gloves received on 3-6-12 at 9:05 a.m., from the Dietary Manager, indicated: "Policy: Gloves are to be worn over washed hands and can only be used for a single task. Procedure: 1) Wash hands according to proper procedure. 2) Single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food. 3) Gloves are to be discarded when damaged or soiled, or when interruptions occur in the operation..."</p>		<p>reviewed by the Quarterly Quality Assurance Committee and recommendations made will be followed.5. Completion Date: April 6, 2012</p>				

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	3.1-21(i)(3)				

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F0387 SS=D	<p>483.40(c)(1)-(2) FREQUENCY &amp; TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on interview and record review, the facility failed to ensure physician visits were conducted every 60 days. This affected 2 of 13 residents reviewed for timeliness of physician visits in a sample of 15. (Residents #49 and 61)</p> <p>Findings include:</p> <p>1. Resident #49's record was reviewed on 3/6/12 at 3:30 p.m. The record indicated Resident #49 was admitted with diagnoses that included, but were not limited to, stroke with left sided weakness, difficulty swallowing, high blood pressure, insulin dependent diabetes, and peripheral artery disease.</p> <p>Physician progress notes indicated the physician visited on 8/8/2011, then did not visit until 11/16/11, which resulted in 100 days between physician visits.</p> <p>During an interview on 3/8/12 at 6:25 p.m., the Director of Nursing indicated</p>	F0387	F 387 Timeliness of Physician Visits 1. There were no negative outcomes from the deficient practices. Residents #49 and #61 are current with their physician visits at this time. 2. All residents have the potential to be affected by this deficient practice. All resident records have been reviewed to ensure residents have been seen timely by their physician. Physicians with any delinquent visits were notified immediately. Any residents that were identified will be seen by their attending physician no later than March 30, 2012. 3. A letter will be sent to physicians that follow residents at this facility to remind them of the timeliness of physician visits. The Medical Director will see the resident if the attending physician is unable to see residents per policy and procedure. All attending physicians will be re-educated on timeliness of physician visits related to regulations by March 30, 2012. 4. This action will be monitored by the medical records designee weekly for 6 weeks then	04/06/2012			

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	<p>she could not locate any other documentation that indicated the physician had visited between those dates.</p> <p>2. Resident # 61's record was reviewed on 3/7/12 at 9:50 a.m. The record indicated Resident #61 was admitted with diagnoses that included, but were not limited to, depression, end stage Huntington's disease, inability to talk, and constipation.</p> <p>Physician's progress notes indicated the physician visited on 4/6/11, then did not visit again until 6/29/11, which resulted in 84 days between physician visits.</p> <p>Physician's progress notes indicated the physician's next visit was on 9/22/11 which resulted in 85 days between physician visits.</p> <p>During an interview on 3/8/12 at 6:25 p.m., the Director of Nursing indicated she could not locate any other documentation that indicated the physician had visited between those dates.</p> <p>A policy and procedure for "Physician Visits", with a last review date of 2/02/12, was provided by the Director of Nursing on 3/8/12. The policy indicated, but was not limited to: "Policy: This facility shall monitor physician visits to ensure</p>		<p>monthly thereafter using the "Physician Visit Timeliness Tool" see ATTACHMENT 3). These audits will be reviewed at the Quality Assurance Committee meetings for recommendations.</p> <p>5. These systematic changes will be completed by April 6, 2012.</p>				

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	<p>regulatory compliance with the following requirements: The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required...."</p> <p>3.1-22(d)(1) 3.1-22(d)(2)</p>			

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F0441 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>A. Based on observation, the facility failed to serve beverages in a sanitary</p>	F0441	F 441 Infection Control - Prevent Spread 1. To correct this	04/06/2012	

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	<p>manner in that staff touched the rims of the glasses as they were served during 1 of 2 observations of 3 of 3 staff members [CNAS' # 3, # 4, # 5]</p> <p>B. Based on observation, record review and interview, the facility failed to ensure that infection control practices were followed in that a urinal with urine, a pitcher for liquid and an adaptive drinking glass were sitting on the back of a commode in one of one bathrooms used by residents in the physical therapy department.</p> <p>C. Based on record review and interview, the facility failed to ensure monthly infection control logs were complete. This deficient practice had the potential to affect 17 of 26 residents that were documented on the infection control logs.</p> <p>Findings include:</p> <p>A. Upon observation during the meal serving observation on 3-5-12 between 12:15 p.m. and 12:35 p.m., CNAs #3, #4 and #5 picked up drinks, without covers, by the rim as they were serving trays to the residents in the main dining room. This occurred each time these staff members served drinks during this observation.</p>		<p>deficient practice, Certified Nursing Assistants #3, 4, and 5 were re-educated on the proper handling of drinking glasses. The therapy department staff were re-educated on proper storage of urinals, pitchers, and drinking glasses. The infection control nurse was also re-educated on completing the infection control logs. 2. All residents have the potential to be affected by this practice. All staff and therapy will be inserviced on proper infection control practices with an emphasis placed on proper handling of drinking glasses and proper storage of urinals, pitchers, glasses, and cups. The infection control nurse also has been inserviced on completing the infection control form by March 30, 2012. 3. The corrective action will be monitored by the Director of Nursing or designee using the quality assurance tool "General Infection Control Tour/Tool" (see ATTACHMENT 4) weekly for 6 weeks then monthly thereafter. The results of the QA tool audit will be reviewed by the Quality Assurance Committee and recommendations will be followed. 4. These systematic changes will be in place by April 6, 2012.</p>		

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	<p>B. During the environmental tour conducted on 3/7/2012 from 09:15 a.m. to 10:00 a.m. with the Administrator a clear plastic rectangle container was observed on the tank of the commode used by residents in the physical therapy department. In this clear rectangle container was a plastic pitcher for liquids, a urinal with urine and an adaptive drinking glass.</p> <p>In an interview with the Administrator during the observation, she indicated she had an issue with the items on the back of the commode.</p> <p>Upon interview during the environmental tour the Physical Therapy Assistant (PTA) indicated that the items have always been there. The urinal belongs to a resident that receives physical therapy but he was not in the physical therapy department at that time, the pitcher for liquids might be used to fill a hydroculator (A hydroculator is a sort of quilted device filled with a clay-like substance used for pain management and in physical therapy). No reasons were given for the adaptive drinking cup. The PTA immediately removed the items. A document entitled Standard precautions for all departments was provided by the Administrator on 3/8/2012 at 6:25 p.m. The document indicates, "...facility</p>			

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  03/08/2012	
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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	<p>considers all body fluids...to be potentially harmful..."</p> <p>C. The "Monthly Infection Logs" for February 2012 were provided by the Director of Nursing on 3/7/12 at 10:17 a.m. Review of these logs indicated a total of 26 residents listed on the logs and the following areas not completed:</p> <ul style="list-style-type: none"> <li>- 2 residents did not have the site of the infection identified</li> <li>- 23 residents lacked completion of the column to indicate if the infection was Nosomocial (acquired in the facility), Community acquired, or Chronic (same infection for three months)</li> <li>- 3 residents lacked an admission date</li> <li>- 13 residents lacked the onset date of the symptoms</li> <li>- 15 residents lacked the sign/symptoms</li> <li>- all 26 residents lacked risk factors</li> <li>- 14 residents lacked culture results and the date</li> <li>- 2 residents lacked treatment documented in the treatment/comments column</li> </ul> <p>On the "Monthly Infection Log", the line under the columns to be filled out indicated "Form to be completed on last working day each month."</p> <p>A policy and procedure for "Infection Surveillance Program", with a last review date of 2/2/12, was provided by the</p>						

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	<p>Director of Nursing on 3/7/12 at 11:20 a.m. The policy indicated, but was not limited to: "A. Purpose: 1. To provide an accurate and complete data collection process relative to an infection; to assist in compiling statistical data for the Quality Assurance Committee. Establish an infection control and prevention process for residents during the admission process and ongoing during stay...B. Procedure: 1. The Infection Control Surveillance Report Form is to be completed by Nurse Designee when a resident is placed on an antibiotic. A resident may be placed on an antibiotic with or without a culture. 2. The completed form is to be maintained and reviewed by the Infection Control Coordinator at least bi-monthly...."</p> <p>During an interview on 3/8/12 at 4:43 p.m., the Director of Nursing indicated she could not answer as to why the logs were not completed and that the Infection Control Nurse had left for the day.</p> <p>3.1-18(a) 3.1-18(b)(1) 3.1-18(l)</p>			

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