STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155228	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for the Investigation of Complaint IN00101250 and Complaint IN00101861. This visit was conducted in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00100773 completed on December 8, 2011. Complaint IN00101250 -- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00101861 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F425 and F441. Unrelated deficiencies are cited. Survey dates: January 9, 10, and 11, 2012 Facility number: 000133 Provider number: 155228 AIM number: 100266080 Survey team: Penny Marlatt, RN Census bed type: SNF/NF: 48 Total: 48	F0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Please accept this Plan of Correction as Credible Allegations of Compliance.	

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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	Census payor type: Medicare: 4 Medicaid: 34 Other: 10 Total: 48 Sample: 3 Supplemental Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 1/18/12 by Suzanne Williams, RN			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to administer the correct pain medication for 1 of 3 residents in a sample of 3 reviewed for proper medication administration and failed to administer a medication ordered to be given with meals in that manner during 1 of 2 medication pass observations for 1 of 12 residents observed. (Residents #A and #I) Findings include: A. In an interview with the Director of Nursing (DON) on 1-9-12 at 2:20 p.m., she indicated Resident #A had a medication error earlier that morning. She indicated Resident #A had, "received the wrong pain medicine." She indicated the physician and family had been notified of the error and the resident was being monitored closely. The Administrator provided a copy of a document entitled, "Medication Error Report," on 1-10-12 at 8:50 a.m. This document indicated LPN #4 had administered one Norco 7.5/10 milligrams (mg) on 1-9-12 at 5:00 a.m. The "Reason For Error" indicated on the document was "just didn't take time."	F0282	F 282 - Services by Qualified Person/Per Care Plan It is the practice of this facilty that services are provided or arranged by this facility are provided by qualified persons in accordnce with each resident's written plan of care. No harm was noted to the resident who received the wrong pain medication. The physician was called with no new orders and family was notified. Both employees, LPN 3 and 4, were given a teaching counseling, and in-serviced on the general procedure for medication administrationa nd preventing medication errors. No ill effects were noted to the resident who received medication without food. All residents have the potential to be affected, all resident were reviewed for the proper times for medications to be given with meal, and no other medication errors were made. All nurses and qmas will be in-serviced on general procedures for medication administration, and preventing medication errors. All new nurses and qmas will be in-serviced upon hire and annually thereafter. All nurses and qmas will be observed on a medication pass by the D.O.N. or her designee. This will also be done for all new nurses and qmas upon hire. Will continue to	02/10/2012

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	The clinical record of Resident #A was reviewed on 1-9-12 at 5:30 p.m. Her diagnoses included, but were not limited to depression, high blood pressure, history of hip fracture, neurogenic bladder and coronary artery disease. Review of her physician-ordered medications indicated she did not have a routine order for Norco, a combination product of hydrocodone and acetaminophen. However, she did have an order for Percocet 5/325 mg. (a combination product of oxycodone and acetaminophen) one tablet twice daily by mouth. She did not receive this dose of Percocet on 1-9-12 at 5:00 a.m. The "Medication Error Report," indicated LPN #4 and LPN # 5 found the error and reported it to the physician at 6:30 a.m. on 1-9-12. B. During a medication pass observation on 1-9-12 at 4:08 p.m., LPN #3 was observed to prepare medications for administration to Resident #I. LPN #3 was observed to then administer the following medications to Resident #I: Lactase Fast 9000 units, Hydroco/APAP 5.325 milligrams, Baclofen 10 mg. and Calcium 500 mg with Vitamin D 200 international units. Review of the clinical record on 1-9-12 at		monitor medication pass by observing 6 x wk for 1 month, 5 x wk for 1 month, 4 x wk for 1 month, 3 x wk for 1 month, 2 x wk for 1 month, 1 x wk for 1 month. To be reviewed monthly in QA meeting for 6 months and then quarterly unless trends are identified. If errors continue or trends are identified the QA monitoring will continue monthly until resolved, and then added to quarterly reviews. Date of completion: February 10, 2012	

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	5:28 p.m. indicated the physician order for the Lactase indicated the following: Lactase Fast 9000 units, one tablet by mouth three times daily with meals for lactose intolerance. The resident's meal was observed to be served in his room at 4:50 p.m. In interview with LPN #3 on 1-9-12 at 4:12 p.m., she indicated, "I normally give the Lactase before his meals with his other medications." 3.1-35(g)(2)			

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F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on observation, interview and record review, the facility failed to administer the correct pain medication for 1 of 3 residents in a sample of 3 reviewed for proper medication administration. (Resident #A) Findings include: In an interview with the Director of Nursing (DON) on 1-9-12 at 2:20 p.m., she indicated Resident #A had a medication error earlier that morning. She indicated Resident #A had, "received the wrong pain medicine." She indicated the physician and family had been notified of the error and the resident was being monitored closely. The Administrator provided a copy of a document entitled, "Medication Error Report," on 1-10-12 at 8:50 a.m. This document indicated LPN #4 had administered one Norco 7.5/10 milligrams (mg) on 1-9-12 at 5:00 a.m. The "Reason For Error" indicated on the document was "just didn't take time." The clinical record of Resident #A was reviewed on 1-9-12 at 5:30 p.m. Her diagnoses included, but were not limited	F0333	F 333 - Residents Free of Significant Med Errors It is the practice of this facility to ensure that residents are free of any significant medication errors. No harm was noted to the resident who received the wrong pain medication. The physician was called and no new orders were received, family was notified. The employee was given a teaching counseling and in-serviced on the general procedure for medication administration and preventing medication errors. All other residents have the potential to be affected, but no other residents were noted to have a medication error. All nurses and qmas will be in-serviced on preventing medication errors. All nurses and qmas will also be observed on a medication pass by the D.O. N. or her designee. All new nurses and qmas will be in-serviced upon hire and annually thereafter. Will continue to monitor medication pass by observing 6 x wk for 1 month, 5 x wk for 1 month, 4 x wk for 1 month, 3 x wk for 1 month, 2 x wk for 1 month, 1 x wk for 1 month. To be reviewed monthly in QA meeting for 6 months and then quarterly unless trends are identified. If errors continue or trends are identified the QA monitoring will continue monthly until resolved, and then added to quarterly QA reviews. Date	02/10/2012

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	to depression, high blood pressure, history of hip fracture, neurogenic bladder and coronary artery disease. Review of her physician-ordered medications indicated she did not have a routine order for Norco, a combination product of hydrocodone and acetaminophen. However, she did have an order for Percocet 5/325 mg. (a combination product of oxycodone and acetaminophen) one tablet twice daily by mouth. She did not receive this dose of Percocet on 1-9-12 at 5:00 a.m. The "Medication Error Report," indicated LPN #4 and LPN # 5 found the error and reported it to the physician at 6:30 a.m. on 1-9-12. Nursing notes for 1-9-12 indicated Resident #A complained of "generalized not feeling well" at 10:00 a.m. At 1:12 p.m. notes indicated she was ambulating with the restorative nursing staff. At 6:00 p.m., it indicated she did not eat supper. At 9:00 p.m., nursing notes indicated she had been offered the alternative supper food selection and ate only a few bites and drank only a few sips of milk. The notes indicated she declined all snack offerings, but did drink 125 milliliters of water and 125 milliliters of a liquid supplement. In interview with Resident #A on 1-9-12 at 3:20 p.m., she indicated her stomach had hurt off and on all day. She indicated she		of completion: February 10, 2012	

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	had attempted to eat tomato soup earlier, but it did not taste good to her. At the time of the interview, the resident was lying down in bed. The resident was observed on 1-9-12 at 5:15 p.m. to be seated in her wheelchair in the dining room. She indicated she had just begun to eat her supper. She was observed at 5:52 p.m. to have eaten less than 10% of her meal. On 1-10-12 at 1:55 p.m., Resident #A was observed to be visiting with a family member while sitting up in a chair in her room. She was observed to be alert, cheerful and talkative. 3.1-25(b)(9) 3.1-48(c)(2)			

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F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure a medication dropped on the floor was not administered, medications were given as ordered by the physician and medications were documented in the Medication Administration Record properly for 3 of 12 residents during 1 of 2 medication pass observations and during a dining observation. (Residents #G, #H, #I) Findings include: A. During a dining observation on 1-9-12 at 5:12 p.m., LPN #2 was observed to take a cup of medications to Resident #G. LPN #2 was observed to speak to the resident prior to handing her the cup of	F0425	F 425 - Pharmaceutical SVC - Accurate Procedures, RPH It is the practice of the facility to provide pharmaceutical services that assure the accurate acquiring, receiving. dispensing and administering of all drugs and biologicals to meet the needs of each resident. No harm was noted to the resident who received a pill that was dropped on the floor nor was any noted to the resident that was given medication that was to be given with food. All residents have the potential to be affected, at no other time was it noted that a pill had been dropped on the floor and then given to a resident, all other residents were reviewed for the proper times for medications to be given with meals. All	02/10/2012

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	medications. Resident #G was observed to take the medications with one white pill falling from her mouth, down onto her shirt and roll onto the floor, near the right side of her wheelchair. LPN #2 was observed to pick up the white pill, speak to the resident and then place the white pill into her mouth. LPN #2 then left the dining area. On 1-9-12 at 5:15 p.m., Resident #G indicated she had dropped a pill while taking them by nodding her head to indicate, "yes." She indicated LPN #2 had picked up the same pill from the floor and gave it to her. She indicated this occurred by again nodding her head to indicate, "yes." In interview with the Director of Nursing on 1-9-12 at 6:35 p.m., she indicated the facility does not have a policy to indicate one should not administer pills dropped on the floor. She indicated that such things, "should be common sense." B. During a medication pass observation on 1-9-12 at 4:08 p.m., LPN #3 was observed to prepare medications for administration to Resident #I. LPN #3 was observed to then administer the following medications to Resident #I: Lactase Fast 9000 units, Hydroco/APAP 5.325 milligrams, Baclofen 10 mg. and		nurses and qmas will be in-serviced on the general procedures for medication administration, and preventing medication errors. All nurses and qmas will also be observed doing a medication pass by the D.O.N. or her designee. New nurses and qmas will be in-servied upon hire and annually thereafter. Will continue to monitor by observing medication pass 6 x wk for 1 month, 5 x wk for 1 month, 4 x wk for 1 month, 3 x wk for 1 month, 2 x wk for 1 month, 1 x wk for 1 month. To be reviewed monthly in QA for 6 months and then quarterly unless trends are identified. If errors continue or trends identified the QA monitoring will continue monthly resolved, and then added to quarterly reviews.	

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	Calcium 500 mg with Vitamin D 200 international units. Review of the clinical record on 1-9-12 at 5:28 p.m. indicated the physician order for the Lactase indicated the following: Lactase Fast 9000 units, one tablet by mouth three times daily with meals for lactose intolerance. The resident's meal was observed to be served in his room at 4:50 p.m. In interview with LPN #3 on 1-9-12 at 4:12 p.m., she indicated, "I normally give the Lactase before his meals with his other medications." C. During a medication pass observation with LPN #2 on 1-9-12 at 3:35 p.m., he was observed to document the medications onto the Medication Administration Record (MAR) as given or administered as he was preparing the medications. This documentation was observed to be conducted prior to administration of the medications for Resident #H. In interview with LPN #2 on 1-9-12 at 3:46 p.m., he indicated, "I mark my meds [off of the MAR] as I pull the meds." In interview with the Director of Nursing on 1-11-12 at 1:10 p.m., she indicated she had spoken with LPN #2. She indicated			

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	he thought that he was supposed to mark off the medications as they were being prepared for administration. The Director of Nursing provided a policy entitled, "General Procedures To Follow For All Medications," on 1-10-12 at 1:00 p.m. This policy had no activation date provided. This policy indicated, "Read medication label three (3) times before pouring...After administration, return to cart and document administration in Medication Administration Record (MAR-Form 2)..." This Federal tag relates to Complaint IN00101861. 3.1-25(b)(1) 3.1-25(b)(3)			

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F0441 SS=E	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F0441		
	Based on observation, interview and record review, the facility failed to ensure a medication dropped on the floor was not administered, routine handwashing was		F 441 - Infection Control, Prevent Spread, Linen Handwashing and Glove-Non Sterile policy and procedures were reviewed to ensure that the facility is assisting	02/10/2012

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	conducted between residents during medication administration and appropriate use of gloves for resident care and opening of medications for 5 of 12 residents observed during 1 of 2 medication pass observations and during a dining observation. (Residents #C, #G, #H, #I and #J) Findings include: A. During a dining observation on 1-9-12 at 5:12 p.m., LPN #2 was observed to take a cup of medications to Resident #G. LPN #2 was observed to speak to the resident prior to handing her the cup of medications. Resident #G was observed to take the medications with one white pill falling from her mouth, down onto her shirt and roll onto the floor, near the right side of her wheelchair. LPN #2 was observed to pick up the white pill, speak to the resident and then place the white pill into her mouth. LPN #2 then left the dining area. On 1-9-12 at 5:15 p.m., Resident #G indicated she had dropped a pill while taking them by nodding her head to indicate, "yes." She indicated LPN #2 had picked up the same pill from the floor and gave it to her. She indicated this occurred by again nodding her head to indicate, "yes."		to help prevent the transmission of infection. No harm was noted to the resident who received a pill that had been dropped on floor, no harm was noted to the resident when the nurse gave the g - tube medications without wearing gloves, no harm came to the resident when nurse opened the seal of the medication by pushing ungloved finger through seal, nor was any harm noted to the resident when the nurse prepared medications for a resident without washing her hands. All residents have the potential to be affected, but no ill effects were noted to any. All nurses and qmas will be in-serviced on infection control practices to include hadwashing, glove use, proper medication handling and g - tube medication administration. All employees will be in-serviced on proper handwashing and glove use. All employees will have to do a return demonstration on proper handwashing. Thiss will be monitored by observing g-tube medication pass 3 x week for 2 months, 2 x wk for 2 months, and 1x wk for 2 months.. Oral medication pass will be 6 x wk for 1 month, 5 x wk for 1 month, 4 x wk for 1 month, 3 x wk for 1 month, 2 x wk for 1 month, 1 x wk for 1 month. To be reviewed monthly in QA and then quarterly unless trends are identified. If errors continue or trends are identified the QA monitoring will	

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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF RICHMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 2070 CHESTER BLVD RICHMOND, IN 47374	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	In interview with the Director of Nursing on 1-9-12 at 6:35 p.m., she indicated the facility does not have a policy to indicate one should not administer pills dropped on the floor. She indicated that such things, "should be common sense." B. During a medication pass observation on 1-9-12 at 3:35 p.m. with LPN #2, he was observed to prepare medications to administer to Resident #H via the resident's gastric tube. LPN #2 was not observed to wear gloves during the administration of the medications via the resident's gastic tube. C. During a medication pass observation on 1-9-12 between 4:08 p.m. and 4:49 p.m. with LPN #3, she was observed to not wash her hands with soap and water or use hand sanitizer between Residents #I and #J; after administration of medications to Resident #J and prior to preparing medications for Resident #C. D. During a medication pass observation on 1-9-12 at 3:35 p.m. with LPN #2, he was observed to prepare medications to administer to Resident #H. LPN #2 was observed to obtain an unopened and sealed bottle of docusate sodium (also known as Colace, a stool softener.) He was observed to open the seal by pushing		continue monthly until resolved, and then added to quarterly QA reviews. Date of completion: February 10, 2012	

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	his ungloved, bare right index finger through the seal of the bottle and then prepare the appropriate dose of medication. A policy entitled, "Handwashing Procedure," was provided by the MDS Coordinator on 1-11-12 at 8:50 a.m. This policy did not have an activation date provided. This policy indicated, "Handwashing is the single most important measure for preventing the spread of infection...Following are instances when handwashing MUST [sic] be done...before and after caring for each Resident...after contact with Resident blood or body secretions...after removing gloves." A policy entitled, "Gloves, Non-Sterile," was provided by the MDS Coordinator on 1-11-12 at 8:50 a.m. this policy did not have an activation date provided. This policy indicated, "Disposable gloves are worn to protect the hands when health care personnel are likely to be exposed to blood or bodily fluids....Health care personnel shall wear gloves when there is anticipated hand contact with blood or other potentially infectious material." The policy indicated to wash hands prior to putting the gloves on and upon removal of the gloves.			

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	The Centers for Disease Control (CDC) "Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" (2007, page 50) indicates, "Gloves can protect both patients and healthcare personnel from exposure to infectious material that may be carried on hands." This Federal tag relates to Complaint IN00101861. 3.1-18(l)			