

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155402	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/22/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 15, 16, 20, 21, and 22, 2015.</p> <p>Facility number: 000271 Provider number: 155402 AIM number: 100291260</p> <p>Survey Team: Bobette Messman, RN-TC Maria Pantaleo, RN Rita Mullen, RN</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 20 Medicaid: 52 Other: 6 Total: 78</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on January 28, 2015.</p>	F000000		

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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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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, record review and interview, the facility failed to ensure a safe and free from harm environment for 3 of 30 rooms observed for a safe environment . (Residents #27, #30, # 77 and #84). This deficient practice had the potential to impact 4 of 78 residents utilizing rooms in the facility.</p> <p>Findings include:</p> <p>1. During resident room observations on 1/15/2015 the following were observed:</p> <p>a) Room 167 1/15/2015 at 2:26 p.m., the vent in the bathroom, near the floor had sharp edges which were exposed.</p> <p>Resident #27 needed assistance with all ADL's (activities of daily living) and used a Hoyer lift for bathroom utilization.</p> <p>b.) Room 169 1/15/2014 at 2:52 p.m., the vent in the bathroom, near the floor, was broken and had sharp edges exposed.</p> <p>Residents # 30 was ambulatory and</p>	F000323	<p>F 323 Free of Accident Hazards/Supervision/Devices</p> <p>1. Corrective action for the residents affected by the alleged deficient practice: Room #167 and #169 (residents #27, #30, #77 and #84) have had the vents removed from their rooms. The door has been fixed on Room #116 to ensure it latches shut properly and has been fixed so there is no chipping or peeling on the front of door.</p> <p>2. Corrective action taken for those residents having the potential to be affected: Facility rooms will be checked for unsafe vents and to ensure they have doors that latch properly and doors with chipped paint prior to the compliance date of 2/20/15.</p> <p>3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: Staff Development Coordinator/Designee will inservice staff on the policy and procedure of how to use the work request System for maintenance requests on resident rooms prior to date of compliance.</p> <p>4. Corrective actions will be monitored to ensure the alleged</p>	02/20/2015			

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	<p>utilized the bathroom facilities.</p> <p>Resident # 77 needed assistance for mobility and used the bathroom facilities.</p> <p>2.) During the environmental tour, on 1/20/2015 at 1:55 p.m., with the Administrator, Maintenance Supervisor and Housekeeping Supervisor, the following was observed:</p> <p>a.) Room 116 a, the entry door did not properly shut and was chipped and peeling.</p> <p>Resident # 84 was ambulatory and utilized the door for safety in case of fire or other facility hazard.</p> <p>During the environmental tour on 1/20/2015 at 1:48 p.m., with the Administrator, Housekeeping Supervisor and Maintenance Supervisor, the Administrator indicated a " Work Request System" was in place and all staff were oriented to the policy.</p> <p>The Maintenance Supervisor indicated he was not aware the resident rooms needed repair, and the work request system did not include these rooms.</p> <p>3.1-45(1)</p>		<p>deficient practice does not re occur by: Maintenance Director/Designee will inspect 10 rooms weekly x 4 weeks, then 5 rooms weekly x 4 weeks and then monthly until 95% compliance is achieved. Any negative patterns will be presented to PI monthly for review and or recommendations.</p>				

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F000371 SS=E	<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 Based on observation and interview, the facility failed to ensure staff washed their hands during the food service in 1 of 1 kitchen. This affected 76 of 78 residents that received food from the kitchen.</p> <p>Findings include:</p> <p>During the kitchen observation on 1/15/15 at 12:05 p.m., the Dietary Manager dropped a hot pad on the kitchen floor. The Dietary Manager was observed picking up the hot pad from the kitchen floor and returned to serving food without washing her hands.</p> <p>During an interview on 1/22/2015 at 1:10 p.m., with the Dietary Manager , she indicated she should have washed her hands after picking the hot pad off the kitchen floor.</p> <p>3.1-21(i)(3)</p>	F000371	<p>F 371 Food Procure, Store/Prepare/Serve- Sanitary 1. Corrective action for the residents affected by the alleged deficient practice: Dietary Manager was educated on handwashing policy and a competency check completed by the Staff Development Coordinator. 2. Corrective action taken for those residents having the potential to be affected: Residents that reside in the facility have the potential to be affected by this alleged deficient practice however no known negative outcomes have been noted. Staff will be inserviced prior to the compliance date on Hand washing policy and procedure, emphasizing policy while in kitchen or serving food. 3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: Staff Development coordinator/Designee to inservice staff on Hand washing policy and procedure prior to the compliance date. SDC to perform competency checks on Dietary</p>	02/20/2015	

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F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 1 of 2 nursing station, resident lounge/ common area, 1 of 4 resident hallways (Earhart Hall), 7 of 30 resident rooms (walls, floors, doors, bathroom fixtures and furniture), (Room's #, 105, 115, 116 a and b, 155, 166, 167, and 169) and 1 of 30 resident rooms observed for odors, (Room # 116). This deficient practice had the potential to impact 10 of 78 residents utilizing rooms in the facility and 64 out of 78 utilizing the resident lounge/ common area.	F000465	staff by date of compliance. 4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: Staff Development coordinator/designee will complete audit tool "Hand washing" weekly x 4weeks, then bi-weekly x 4 weeks, then monthly until 95% compliance is achieved on facility staff. Any negative patterns will be presented to PI monthly for review and or recommendations. F 465 Safe Functional Sanitary Comfortable Environment 1. Corrective action for the residents affected by the alleged deficient practice: The overhead lights at the nurses station were cleaned while surveyors were here; the Earhart hallway carpet was cleaned and approved air filters were added while surveyors were here; Room #105 Bathroom door to be repaired and towel dispenser replaced; Room #115 the wall will be painted; Room#116 was deep cleaned and mattress cleaned while surveyors were here and plaster under window to be fixed; Room #155 has been cleaned to remove cobwebs, Room #166	02/20/2015			

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	<p>Findings include:</p> <p>1. During the initial tour on 1/15/2015 at 9:30 a.m., the following was observed:</p> <p>a.) The electrical cord to the overhead lights at the nursing station, lounge/ common area were covered in dust and debris.</p> <p>b.) The Earhart hallway entering from common area had a urine odor.</p> <p>2. During resident room observations on 1/15/2015, 1/16/2015, and 1/20/2015, the following were observed:</p> <p>a.) Room 105 1/16/2015 at 9:45 a.m., the bathroom door was chipped, peeling, marred, and scratched and the bathroom towel dispenser was peeling and rusty.</p> <p>b.) Room 115 1/16/2015 at 2:10 p.m., the room wall was wet and water spots were observed near the door and light switch.</p> <p>c.) Room 116 1/16/2015 at 1:18 p.m., the room had a urine odor and the plaster under the window was crumbling.</p> <p>d.) Room 155 1/16/2015 at 11:27 a.m., the bathroom vent/fan in ceiling was dusty and had debris, cobwebs were on the ceiling and in the corners of the room.</p>		<p>entry door to be repaired; Room #167 Bathroom sink to be repaired, towel dispenser to be replaced and vent removed; Room #169 the bathroom floor tile will be replaced around toilet and the vent to be removed. All repairs not already completed will be completed prior to compliance date.</p> <p>2. Corrective action taken for those residents having the potential to be affected: Facility rooms and common areas have been audited to ensure Safe, Functional, Sanitary, Comfortable environment. Staff will be inserviced prior to the compliance date on "Maintenance Work Request" policy and procedure, as well as looking at rooms for homelike environment.</p> <p>3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: Staff Development coordinator/Designee to inservice staff on "Maintenance Work Request" and procedure prior to the compliance date. Department heads to tour building daily to audit for odors and report to housekeeping/nursing any findings. Work requests and environmental concerns will be addressed during morning meeting to ensure follow up has occurred.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re</p>				

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	<p>f.) Room 166 1/15/2015 at 11:17 a.m., entry door was chipped, peeling, marred, and scratched.</p> <p>g.) Room 167 1/15/2015 at 2:26 p.m., the bathroom sink edges were separating from the sink, the bathroom towel dispenser was chipped and rusty, and the vent in the bathroom had sharp edges which were exposed.</p> <p>h.) Room 169 1/15/2014 at 2:52 p.m., the floor tile in the bathroom and around the toilet seat were cracked and rusted, the vent in the bathroom was broken and had sharp edges exposed.</p> <p>3. During the environmental tour, on 1/20/2015 at 1:55 p.m., with the Administrator, Maintenance Supervisor and Housekeeping Supervisor, the following were observed:</p> <p>a.) Room 116 a, the entry door did not shut and the paint was chipped and peeling.</p> <p>b.) Earhart hallway entering from common area continued to have an odor.</p> <p>c.) The electrical cord to the overhead lights at nursing station, lounge/ common area were covered in dust and debris.</p>		<p>occur by: Maintenance Director/designee will complete audit tool "Resident Room Inspection" weekly x 4weeks, then bi-weekly x 4 weeks, then monthly until 95% compliance is achieved. Housekeeping will complete audit tool "Daily Room cleaning" weekly x 4weeks, then bi-weekly x 4 weeks, then monthly until 95% compliance is achieved. Any negative patterns will be presented to PI monthly for review and or recommendations.</p>				

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	<p>d.) Room 116 had a urine odor.</p> <p>During the environmental tour on 1/20/2015 at 1:48 p.m., with the Administrator, Housekeeping Supervisor and Maintenance Supervisor, the Administrator indicated a " Work Request System" was in place and all staff were oriented to the policy.</p> <p>The Maintenance Supervisor indicated he was not aware the resident rooms needed repair, and the work request system did not include these rooms.</p> <p>The Housekeeping Supervisor was not aware Earhart hallway and room #116 had urine odors.</p> <p>During an interview, on 1/20/2014 at 3:45 p.m., with the Administrator, he indicated the facility had been working on fixing the urine odor on Earhart Hall, but nothing tried had worked.</p> <p>3.1-19(f)</p>						