STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155210		06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 24, 25, 26, 27, 31, June 1, and 2, 2016 Facility number: 000117 Provider number: 155210 AIM number: 100266460 Census bed type: SNF/NF: 64 Total: 64 Census payor type: Medicare: 6 Medicaid: 30 Other: 28 Total: 64 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on June 4, 2016.	F 0000	F 000 Please accept this Plan of Correction as our credible allegation of compliance for the deficiencies noted in the 2567 for Heritage House of Greensburg. We are alleging compliance by July 2, 2016 and request a paper compliance review if applicable.	
F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES			

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.

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 06/02/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240	

(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
	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 environment was free of hazards related to improperly disposed of sharps and unsecured chemicals. This had the potential to affect 16 of 22 independently mobile residents who resided in the locked dementia unit. Findings include: 1. During an observation of the locked dementia unit on 05/24/2016 at 10:15 A.M., the central bathing room was unlocked with the door open. There were no residents or staff in or around the bathing room. There was a used, disposable razor sitting on top of the right shower half-wall. During an interview on 06/02/2016 at 11:06 A.M., RN (Registered Nurse) #1 indicated disposable razors were considered sharps and were to be disposed of in the sharps containers. The current facility policy, titled "Sharps, Disposal of", was provided by the Administrator on 06/02/2016 at 11:50 A.M. and was reviewed at that time. The	F 0323	F 323 There were no negative outcomes from this deficient practice. Staff members on the dementia unit were inserviced on ensuring the janitor door is locked and sharps are disposed of properly. All residents residing on the dementia unit have the potential to be affected by this practice. The door knob on the janitor door was immediately replaced with a self-locking lock. The razor was immediately disposed of into the sharps container. All staff, housekeeping and nursing staff will be inserviced on proper disposable of sharp objects and to ensure that janitor doors are closed and locked when unattended. A automatic door closure and also an electronic keypad door lock is on order to be installed on the shower room door of the dementia unit to ensure increased safety of the environment. Director of Nursing or designee will do daily rounds when working to ensure the janitor doors are locked and disposable razors are removed from the shower rooms and disposed of properly. This will be monitored daily when working for one month then weekly for 4 weeks then monthly for 3 months then quarterly until compliance is	07/02/2016

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 06/02/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240	

(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
	policy indicated, "...Place all used ...in ...sharps disposable container after use..." 2. During an observation of the locked dementia unit on 05/27/2016 at 12:22 P.M., the janitor room door was unlocked. There were unsecured chemicals including, but not limited to, one bottle of bleach, one can of Clorox disinfecting spray, one can of baseboard stripper, one can of shaving cream, one spray bottle of "heavy duty cleaning solution", and one bottle of disinfectant deodorizer inside the unlocked janitor room. During an interview on 05/27/2016 at 12:40 P.M., the DON (Director of Nursing) indicated the janitor closet should always be locked. During an interview on 06/02/2016 at 11:06 A.M., RN #1 indicated supply and storage rooms were to be kept locked. The current facility policy, titled "Hazardous Chemicals", was provided by the Administrator on 06/02/2016 at 11:50 A.M. and was reviewed at that time. The policy indicated, "...All hazardous chemicals must be behind locked doors or under...direct supervision..." 3.1-45(a)(1)		100%.See Attachment A. Any staff member found not to follow procedure will be counseled and re-educated. The results of the audits will be reviewed by the QA Committee and any recommendations will be followed.	

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 06/02/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240	

(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
F 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 2 medication errors out of 32 opportunities for error, resulting in a 5.9% error rate. This affected 2 of 8 residents observed for medication pass. (Resident #12 and #57) Findings include: 1. During an observation of medication administration on 05/31/2016 at 1:28 P.M., RN (Registered Nurse) #1 administered Ketotif 0.025% eye drops, one drop, to Resident #12's right eye. During an interview on 06/01/2016 at 9:51 A.M., RN #1 indicated Resident #12's eye drops were supposed to be administered to both eyes. The clinical record for Resident #12 was reviewed on 06/01/2016 at 9:31 A.M. The current physician orders for Resident #12 indicated Ketotif eye drops, instill	F 0332	F 332 Resident Numbers 12 and 57 suffered no adverse reactions due to the medication error. The physician was notified. RN #1 was inserviced 6/1/16 on the medication administration policy. All residents that are administered medications have the potential to be affected by this practice. No other residents have been identified through the medication pass observation to have been affected. All licensed Nurses and QMAs will be re-inserviced on the proper medication pass procedure. This will also be done for all new hires as part of the orientation process. A "Medication Pass Procedure" tool (see attachment B) has been developed and all licensed nurses and QMAs will be "checked off". The DON or designee will have all licensed nurses and QMAs "checked off" on the medication pass procedure with in one month, then random audits will be conducted monthly for 3 months then quarterly thereafter. Any staff member found not to be following proper procedure will be re-educated. The results of the audits will be reviewed by the QA	07/02/2016

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 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

(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
	one drop into both eyes three times daily. 2. During an observation of medication administration on 05/31/2016 at 1:40 P.M., RN #1 administered UTI-Stat to resident #57. During an interview on 06/01/2016 at 8:44 A.M., the DON (Director of Nursing) indicated she could not find a current order for the UTI-Stat. She further indicated she did not know if an order was necessary for the medication because it was basically thick, concentrated cranberry juice. The clinical record for Resident #57 was reviewed on 06/01/2016 at 8:29 A.M. The current physician orders for Resident #57 did not include an order for UTI-Stat. The UTI-Stat bottle was reviewed on 06/01/2016 at 8:53 A.M. and indicated the medication was to be used under medical supervision with the intake to be determined by a healthcare provider. The current facility policy, titled "Medication Administration", was provided by the Administrator on 06/02/2016 at 11:20 A.M. and was reviewed at that time. The policy indicated, "...Read medication label three (3) times before administration...Pour the		Committee and any recommendations will be followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155210		06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

(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
	correct number of tablets/capsules into the medication cup, checking the MAR against the medication in the resident's drawer to ensure accuracy..." 3.1-25(b)(9) 3.1-48(c)(1)			
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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			

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 06/02/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240	

(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
	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. Based on observation, interview and record review, the facility failed to ensure proper infection control measures were maintained related to linen storage and handling. This had the potential to affect 60 of 64 residents who had personal clothing laundered by the facility. Findings include: During an observation on 05/24/2016 at 11:54 A.M., a laundry cart of resident clothing was sitting unattended in the hallway of the locked dementia unit with the front cover on top of the cart and the clothing left exposed. Laundry Aide #3 returned to the cart, removed clothing from the cart and took the clothing to a resident's room, leaving the laundry cart open. The Laundry Aide then moved the cart down the hallway with the front flap still open and continued distributing clothing to resident rooms. During an observation on 05/24/2016 at 12:13 P.M., Laundry Aide #3 was	F 0441	F 441 No residents were known to be affected by this deficient practice related to infection control by exposing the clean linen cart during delivery of personal clothing. Laundry Aide # 3 was immediately re-inserviced on 6-1 to cover the linen cart. All other laundry employees were also re-inserviced on the need to keep flap down to ensure the linen cart is covered to prevent and control the spread of infection by using proper linen storage and handling. New hires will also be trained on this procedure as part of their orientation process. Should there be any evidence that the staff fail to comply with the procedure to keep the linen cart covered, they will be immediately re-educated, and progressive discipline will be initiated if additional actions are required.See Attachment A. Laundry Supervisor or designee will monitor to observe linen carts are covered when a cart is unsupervised or while being transported through the hallways weekly for 4 weeks then monthly for 3 months then quarterly	07/02/2016

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 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

(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
	delivering clothing to multiple rooms on the #4 Hall. The laundry cart, with resident clothing hanging inside, was left open while the Laundry Aide walked in and out of several rooms. There were multiple residents who walked past the cart while it was open and unsupervised. During an observation on 05/27/2016 at 12:01 P.M., a laundry cart of resident clothing was sitting in the hall of the locked dementia unit unattended. The cart was uncovered on the front with the flap sitting on top of the cart. Laundry Aide #3 was removing clothing and delivering it to resident rooms. The cart was left open while clothing was being delivered. The Laundry Aide then moved the cart down the hall with the cover still open. During an interview and observation on 05/24/2016 at 12:23 P.M., Laundry Aide #3 indicated she was not aware the cart had a cover. Following the interview, the Laundry Aide left the front of the cart open and continued down the hall. During an interview on 05/27/2016 at 12:25 P.M., Laundry Aide #3 indicated the laundry carts were supposed to be covered when moved down the hall. During an interview on 06/01/2016 at		thereafter. Results of the findings will be reviewed by the Quality Assurance Committee and any recommendations will be followed.	

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 06/02/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240	

(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
	11:35 A.M., RN (Registered Nurse) #2 indicated linen carts should be covered in the halls, including carts of resident clothing. During an interview on 06/02/2016 at 11:06 A.M., RN #1 indicated clean linen carts were to be covered at all times. The current facility policy, titled "Laundry Instructions" and dated 7/22/04, was provided by the Administrator on 06/02/2016 at 11:50 A.M., and was reviewed at that time. The policy indicated, "...All clean linen is to be transported...with a cover over the linens at all times..." 3.1-19(g)			