

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVE WARREN, IN 46792
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: July 19, 20, 21, 22, 23 and 24, 2015</p> <p>Facility number: 000542 Provider number: 155705 AIM number: 100267380</p> <p>Census bed type: SNF: 6 NF: 132 Residential: 167 Total: 305</p> <p>Census payor type: Medicare: 6 Medicaid: 71 Other: 228 Total: 305</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Heritage Pointe is submitting our facility's Plan of Correction to the deficiencies of the Recertification and State Licensure Survey completed by your department July 19-24, 2015. Our staff would like to compliment the survey team and the site supervisor, Deb Barth, R.N., who performed the ISDH survey this year, for their professionalism and cooperation during the survey process.</p> <p>This letter and Plan of Correction serve as our allegation of compliance that by August 14, 2015 Heritage Pointe will have corrected the cited deficiencies and have all the systemic changes implemented to comply with state and federal regulations. In view of the fact that only two deficiencies were cited, one being an "F" with no substandard quality of care findings on the scope and severity scale, we would like for you to consider accepting the enclosed written paper compliance as evidence of correction to confirm our substantial compliance in lieu of an on-site visit.</p> <p>We heartily thank you and your department for your service. Please contact us with any questions at 260-375-2201 or dsouder@ummh.org.</p>	
F 0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM			

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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Bldg. 00	<p>UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure targeted behavioral symptoms were identified for each psychoactive medication in use for 2 of 5 residents reviewed who met the criteria for unnecessary medication (Residents #110 and #203).</p> <p>Findings include:</p> <p>1. Resident #110's clinical record was reviewed on 7/22/15 at 10:06 a.m.. Resident #110's current diagnoses included, but were not limited to,</p>	F 0329	<p>How other residents were identified for the potential to be affected by the same deficient practice: All residents with physicians orders for any of the following medication classes: antidepressant, hypnotic, antipsychotic, or antianxiety medication were reviewed to identify those residents at risk to be affected. Date Completed: 7-24-15 What corrective actions for residents found to have been affected by the deficient practice were put into place? Assessment built within facility's EMR to enable nursing personnel to accurately assess</p>	08/14/2015			

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	<p>dementia with behavioral disturbances, anxiety, depression and cognitive communication deficit.</p> <p>Resident #110 had current, 7/2015, physician's orders for the following psychoactive medication:</p> <p>a. Seroquel 25 mg (an antipsychotic medication) - take 3, 1/2 tablets to equal (37.5 mg) once daily at 12 noon. This order reflected the medication had been reduced on 7/10/15.</p> <p>b. Seroquel 12.5 mg (1/2 tab) 2 times daily at 7:30 a.m. and 4:30 p.m. This order reflected the medication had been reduced on 7/10/15. This medication coupled with the order for 37.5 mg of Seroquel at 12 noon resulted in the resident receiving varied doses of this medication 3 times daily.</p> <p>c. Ativan 0.5 mg (an anti-anxiety medication) - take 1 tablet daily. This order originated 10/14/14.</p> <p>d. Paxil 20 mg (an anti-depressant medication) - take 1 tablet daily. This order originated 10/24/14.</p> <p>Resident #110 had a current, 6/12/15, quarterly, Minimum Data Set assessment which indicated the resident was severely</p>		<p>Medication for gradual dose reduction appropriateness, specific target behaviors, medication side effects and identification of non-pharmalogical interventions utilized. Attachment A Date Completed 7-27-15 Social Services and Charge nurses reviewing all residents receiving antianxiety, antipsychotic, hypnotic, or antidepressant medication to identify correct/appropriate specific target symptoms as well ensuring the residents care-plan correctly corresponds. Attachment B Date Completed: 8-14-15 All charge nurses completing in-service related to appropriate assessment related to each drug classification: Antidepressant, Antianxiety, Antipsychotic, and Hypnotic medications. Attachment C Date Completed: 8-3-15 All residents currently receiving antidepressant, antianxiety, antipsychotic, and/or hypnotic medication will have an initial assessment with target behaviors for each specific medication completed. Date Completed: 8-11-15 Target behavioral symptoms for the affected drug classes being added to each resident's Medication Administration record for daily monitoring of symptoms. Attachment D Date Completed: 8-7-15 Measures put into place or changes that</p>				

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	<p>cognitively impaired and never or rarely made decisions, was rarely or never understood by others, had both short term and long term memory loss and displayed physical behavioral symptoms 1 to 3 days of the assessment period.</p> <p>Resident #110 had a, 6/9/15, "Psychiatric Progress Note" which indicated, "She seems to be doing better on increased dose of Seroquel will continue to monitor hallucinations and if needed increase Seroquel again at next visit. Unfortunately with her advanced dementia, personal care agitation is likely to continue as she had difficulty understanding what is going on."</p> <p>Resident #110's record lacked any documentation regarding the identified targeted behaviors being treated by her anti-anxiety and anti-depressant medications. Resident #110 most current, 7/1/15, facility "Psychoactive medication review" indicated the resident was receiving the antipsychotic medication Seroquel for the targeted behavior of resistance to care. This targeted behavioral symptom conflicted with the symptoms identified by the psychiatric provider. Resident #110's care plan did not identify targeted behaviors being treated by each individual psychoactive medication.</p>		<p>will be made to prevent re-occurrence. Medication assessments will be automatically scheduled for any new admissions upon admission to the facility. Date Completed: 8-7-15 and then on-going Residents with physicians' orders for the affected medication drug classes will be reviewed quarterly during the residents care-plan session per the administrative nursing personnel including the Director of Nursing to ensure facility established monitoring is completed and correctly corresponds with the residents plan of care. Date Completed: 8-14-15 and then on-going Administrative nursing personnel to complete monthly audits for 6 months (9/14/15-3/14/16) of behavior monitoring documentation to ensure all psychotropic medication(s) have the appropriate monitoring and documentation of target behaviors for those medications indicated. Date Completed: 9/14/15-3/14/16 How corrective actions will be monitored to prevent re-occurrence: Q.A. checks/audits will be completed to ensure all residents have an initial assessment completed. Date Completed: 8-14-15 Monthly audits to be completed per above schedule. The Director of Nursing will be responsible to ensure adherence to instructed</p>		

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	<p>Resident #110 was not observed displaying maladaptive behaviors during any observation day of the survey process 7/20/15, 7/21/15, 7/22/15 and 7/23/15.</p> <p>2. The clinical record for Resident #203 was reviewed on 7/23/15 at 9:07 a.m. Diagnoses for Resident #203 included, but were not limited to dementia with behaviors, dementia with delusions and agitation, and depression.</p> <p>Current physician's orders for Resident #203 included, but were not limited to, the following orders:</p> <p>a. Celexa (an antidepressant medication) 20 milligrams (mg) 1 tablet by mouth once a day.</p> <p>b. Zyprexa (an antipsychotic medication) 2.5 mg 1 tablet by mouth once a day.</p> <p>c. Depakote Sprinkles (a mood stabilizer medication) 125 mg 1 capsule by mouth two times a day.</p> <p>Resident #203 had a current, 6/29/15, admission Minimum Data Set (MDS) assessment which indicated the resident had severe cognitive impairment and never or rarely made decisions. The assessment indicated Resident #203 rejected care and wandered 1 to 3 days</p>		<p>responsibilities related to psychotropic medication monitoring by the nursing staff in accordance with the facility's plan of correction. Any non-compliance will be reported to the Q.A.committee and further action(s) will be determined.</p>	

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	<p>during the assessment period.</p> <p>Resident #203 was not observed displaying any maladaptive behaviors during the survey dates of 7/20/15, 7/21/15, 7/22/15, 7/23/15, and 7/24/15.</p> <p>Resident #203 did have behavioral health care plans. The health care plans did not associate each psychoactive medication with specific targeted behaviors.</p> <p>During an interview on 7/23/15, at 10:45 a.m., the Social Services Director indicated the facility did not break down resident behaviors in a manner to identify which behavioral symptom was being treated by which specific psychoactive medication. She indicated the facility grouped all of the resident's behaviors and all of the resident's psychoactive medications into one area for behavior monitoring, management and care planning. She indicated this method applied to Residents #110 and #203.</p> <p>Review of the current, undated, facility policy, titled "USE OF ANTIPSYCHOTIC DRUGS", provided by the Administrator on 7/23/15 at 3:34 p.m., included, but was not limited to, the following:</p> <p>" ...Procedure: 1. All residents for</p>			

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F 0371 SS=F Bldg. 00	<p>whom antipsychotic drugs are considered necessary must have the disorder and the specific target signs for which the drug is to be used and documented in the clinical record.</p> <p>a. The target signs may be psychiatric [e.g. delusions, hallucinations, incoherent thinking] or behavioral [e.g. kicking, hitting, scratching, biting].... "</p> <p>3.1-48(a)(4)</p> <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, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions. This practice had the potential to impact 136 of 136 residents receiving meals prepared in the main kitchen and 33 of 33 residents served from the Unit 1A kitchenette. Findings include: The initial tour of the main kitchen began</p>	F 0371	<p>How other residents were identified for the potential to be affected by the same deficient practice: All residents reviewed for the potential to be affected by the alleged deficient practice. Infection Control logs reviewed with no food borne illnesses noted within past 6 months. Date Completed: 7-31-15 What corrective actions for residents found to have been affected by the deficient practice were put into place? Hand washing</p>	08/14/2015	

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	<p>on 7/19/15 at 6:31 p.m., with the following concerns observed:</p> <p>1. Upon entering the kitchen, two employees were observed washing metal serving pans in the three compartment sink. Dietary Aide #1 was quickly rinsing the metal pans in the third compartment marked for sanitization and placing them on a rack for drying. Dietary Aide #1 indicated he was not aware of how to test the sanitizing water. Upon locating the Shift Supervisor, the sanitization water was tested, indicating it was 130 degrees Fahrenheit. The Shift Supervisor indicated the water in the compartment should be above 180 degrees Fahrenheit.</p> <p>Review of a policy, titled "...Sanitization of Dishes/Manual Washing", obtained from the Certified Dietary Manager (CDM) on 7/23/15 at 2:32 p.m., dated 9/5/2012, indicated the following: "...For sanitizing using immersion in hot water, water must be maintained at 171 degrees F for 30 seconds...."</p> <p>2. A prep refrigerator in the tray preparation area was found to have fifteen small bowls, each containing one-half cup of applesauce and a piece of</p>		<p>in-service titled "Personal Hygiene" being completed with all dietary staff. Attachment: E Date Completed: 8-14-15</p> <p>Proper storage of leftovers (perishable and non-perishable) in-service being completed with all dietary staff. Attachment: F Date Completed: 8-14-15</p> <p>All dishes will be sanitized utilizing the wash machine. Any dishes that will not fit in the wash machine will be sanitized using the three compartment sink method. Staff in-serviced on proper use and proper temperature of three compartment sink and sanitizing dishes. Attachment: G Date Completed: 8-14-15</p> <p>Dietary stock personnel in-serviced on policy of ensuring all items are used by expiration date or destroyed according to facility policy. Attachment: H Date Completed: 8-3-15</p> <p>Measures put into place or changes that will be made to prevent re-occurrence. Dietician and Dietary Manager to complete on opposite days, Q.A. surveillance <i>food storage and food prep</i> weekly for four weeks (8/4/15-8/25/15) then monthly for 6 months (9/25/15-2/25/16), then quarterly for the next 6 months (5/30/16-8/30/16) to ensure all food is stored appropriately, and stock is used by expiration date or destroyed appropriately per facility policy. Attachment: I Date</p>	

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	<p>garnish, on a tray. One bowl was covered with plastic wrap, but did not have a date on it. Fourteen bowls were uncovered and undated.</p> <p>The cook's prep refrigerator was found to have four small bowls, each containing one-half cup of applesauce and a small piece of garnish, on a tray at the top of a cart. One larger bowl, containing a hard boiled egg, was on the same tray. Each bowl was covered with plastic wrap, but were not dated. A different tray at the bottom of the cart, held 3 metal serving pans, each covered with foil, and marked "F", "AAL", and "H", respectively.</p> <p>Each pan held one cup of yellow liquid, which the Assistant Dietary Manager indicated, "might be egg mix".</p> <p>A shelf, in the walk-in refrigerator used for milk storage, was found to contain 11 cups of strawberry yogurt with an expiration date of 7/9/15. An undated metal pan, covered with plastic wrap and containing 1 cup of cottage cheese, was sitting on top of a plastic milk crate near the door of the refrigerator.</p> <p>Review of a policy, titled "Use of Leftovers", obtained from the CDM on 7/21/15 at 9:32 a.m., indicated the</p>		<p>Completed: 8/14/15-8/30/16 Q.A. surveillance <i>food storage and food prep</i> to be completed every Saturday and Sunday for 3 months (8/8/15-11/8/15) then random weekend checks monthly for 3 months (12/5/15-3/6/16) to ensure compliance on the weekend, to ensure all food is stored appropriately, and stock is used by expiration date or destroyed appropriately per facility policy during weekend hours. Attachment: I Date Completed: 8/8/15-3/6/16 Dietary Managers to perform daily hand washing surveillance daily for four weeks (8/4/15-8/31/15), then weekly for three months (9/1/15-12/1/15), then bi-weekly for 3 months (1/1/16-4/1/16). Attachment: J Date Completed: 8/4/15-3/1/16 How corrective actions will be monitored to prevent re-occurrence: Q.A. checks to be completed per above schedule. Concerns/non-compliance will be reported to the dietary manager as well as to the Q.A. committee to determine further action and potential need for further monitoring.</p>		

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	<p>following:</p> <p>"...2. Leftovers will be covered, labeled, and dated...."</p> <p>3. During an observation of the kitchenette and dining area on Unit 1A, on 7/20/15 at 11:53 a.m., the following concerns were observed:</p> <p>Dietary Aide #2 entered the Unit 1A kitchenette and washed her hands at the sink, without using soap and only running her palms together, for 8 seconds. She began prepping the steam table for the lunch service. Dietary Aide #2 rubbed her left eye with her left hand and continued prepping the stream table. Upon completion of loading the steam table, Dietary Aide #2 then picked up a hot pad from the sink area and wiped the counter near the sink and then wiped the preparation area of the steam table. She then rubbed her forehead with her right hand, turned to the sink, and rinsed her hand with water under the faucet for 3 seconds. After drying her hands, Dietary Aide #2 picked up a stack of trays and placed them at the back of the steam table. She began prepping trays by picking up a tray, placing a plate on it, and placing a piece of bread on the plate</p>			

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	<p>before passing it to another employee.</p> <p>During an interview, on 7/20/15 at 12:21 p.m., Dietary Aide #2 indicated handwashing should be done when entering the kitchenette and if contact occurred with her face or hair. She also indicated that hand washing should be for at least 20 seconds.</p> <p>4. During an observation of the kitchenette and dining area on Unit 1A, on 7/22/15 at 11:47 a.m., the following concerns were observed:</p> <p>Employee #2 entered the 1A kitchenette and washed her hands at the sink by running water over her hands for 6 seconds. She began placing metal trays of food from a cart onto the steam table. She then rubbed the left side of her face with her left hand and continued prepping the steam table without washing her hands.</p> <p>During an interview with the CDM, on 7/23/15 at 9:53 a.m., she indicated handwashing should be done for at least 20 seconds when entering or re-entering the kitchen, after touching one's face or hair, or anytime hands are contaminated. Review of a policy, titled "Handwashing", and obtained from the</p>			

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R 0000 Bldg. 00	<p>CDM on 7/22/15 at 2:44 p.m., indicated the following: "...1. When to Wash Hands: ...After touching bare human body parts...After engaging in other activities that contaminate the hands...." 3.1-21(i)(2)(3)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 167 Sample: 11</p> <p>Heritage Pointe was found to be in compliance with 410 IAC 16.2-5 in regard to State Residential Licensure Survey.</p>	R 0000	<p>Heritage Pointe is submitting our facility's Plan of Correction to the deficiencies of the Recertification and State Licensure Survey completed by your department July 19-24, 2015. Our staff would like to compliment the survey team and the site supervisor, Deb Barth, R.N., who performed the ISDH survey this year, for their professionalism and cooperation during the survey process.</p> <p>This letter and Plan of Correction serve as our allegation of compliance that by August 14, 2015 Heritage Pointe will have corrected the cited deficiencies and have all the systemic changes implemented to comply with state and federal regulations. In view of the fact that only two deficiencies were cited, one being an "F" with no substandard quality of care findings on the scope and severity scale, we would like for you to consider accepting the enclosed written paper compliance as evidence of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2015
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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	
			correction to confirm our substantial compliance in lieu of an on-site visit. We heartily thank you and your department for your service. Please contact us with any questions at 260-375-2201 or dsouder@ummh.org .		