

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 06/19/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00175046.</p> <p>Complaint IN00175046 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: June 15, 16, 17, 18, and 19, 2015</p> <p>Facility number: 000117 Provider number: 155210 AIM number: 100266460</p> <p>Census bed type: SNF/NF: 59 Total: 59</p> <p>Census payor type: Medicaid: 32 Medicare: 5 Other: 22 Total: 59</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Please accept this Plan of Correction as our credible allegation 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 July, 2015 and request a paper compliance review if applicable.	

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.

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 06/19/2015	
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 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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 distribute and/or serve food under sanitary conditions in that proper hand washing was not performed when hands became contaminated (unclean) while serving the meals for 7 of 56 residents, during 3 of 4 dining observations, for 2 of 2 dining rooms observed. (Residents #16, #22, #32, #36, #44, # 72, and #73)</p> <p>Findings include:</p> <p>1. An observation of the Main Dining Room was conducted on 06/17/2015 at 12:05 P.M. At 12:13 P.M. drinks were served by CNA (Certified Nursing Assistant) #5. CNA #5 served a cup of punch to Resident #16 and assisted the resident with the cup by touching the resident's right hand. CNA #5 then served a cup of lemonade to Resident #36. An inverted tray, that had been used</p>	F 0371	<p>F 371 1. There were no negative outcomes from this practice. CNA # 5 and OTA # 3 were re-educated on handwashing specifically related to serving and distributing food. 2. All residents have the potential to be affected by this practice. All staff handling meal trays will be observed for handwashing/hand sanitizer during meal time using the "Handwashing Procedure" audit tool (see attachment A). No other residents have been identified. Should there be any evidence that the staff fail to comply with the facility policy on handwashing/hand sanitizer they will be immediately re-educated. Progressive discipline will be initiated if additional actions are required. 3. All staff handling meal trays will be in-serviced on proper handwashing/hand sanitizer procedure. This will also be conducted on new hires as part of the orientation process. 4. The DON or designee will</p>	07/18/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
	<p>to cover the tops of a group of cups filled with water, tea, punch, and lemonade, fell to the floor, top side down. CNA #5 picked up the tray, touched the edge that had come into contact with the floor, and passed the tray through the kitchen door to the dishwasher. CNA #5 then placed two cups of iced tea and two cups of ice water on an unoccupied table. CNA #5 then served a cup of iced tea to Resident #22. No handwashing or sanitizing was performed throughout this observation.</p> <p>During an interview on 06/17/2015 at 12:19 P.M., CNA #5 indicated she did not know she needed to wash her hands after picking the tray up off of the floor.</p> <p>2. During an observation of the Dementia Unit Dining Room on 06/15/2015 at 12:11 P.M., OTA (Occupational Therapy Assistant) #3 assisted Resident #73 to straighten her shirt. OTA #3 then brought a resident from the hall into the dining room via wheelchair. After positioning the resident at the table, OTA #3 took a seat next to Resident #72 and assisted/encouraged the resident to eat. OTA #3 turned the plate with her bare hands and assisted the resident with applying pepper to the food. OTA #3 then got up and straightened Resident #73's shirt again before returning to sit with Resident #72. OTA #3 assisted Resident #72 with applying salt to her</p>		<p>observe all staff passing trays over the next 4 weeks for proper handwashing/hand sanitizer during meal time using the "Handwashing Procedure" audit tool. These audits will be conducted monthly for 3 months then quarterly thereafter. Anyone found to be noncompliant will be re-educated and progressively disciplined. The results of the audits will be reviewed by the Quality Assurance Committee and any recommendations made will be followed.</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 06/19/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
	<p>food and used the resident's fork to spear some mixed vegetables for her. During this observation OTA #3 did not wash her hands or use hand sanitizer.</p> <p>During an interview on 06/15/2015 at 12:38 P.M., LPN (Licensed Practical Nurse) #2 indicated that hands should be washed with soap and water before starting to serve trays and hand sanitizer should be used between trays. LPN #2 also indicated that if hands were soiled during dining then they should be washed with soap and water again.</p> <p>3. During an observation of the Dementia Unit Dining Room on 06/17/2015 at 12:07 P.M., OTA #3 transported Resident #44 by wheelchair to the table and locked his wheelchair. OTA #3 slid an empty chair towards the table, sat next to Resident #32 and began to assist her in cutting her food into smaller pieces using the resident's silverware. During this observation OTA #3 did not wash her hands or use hand sanitizer. After meal service, OTA #3 was not available for interview.</p> <p>During an interview on 06/17/2015 at 12:16 P.M., CNA (Certified Nursing Assistant) #4 indicated after touching a resident, hands must be washed before serving trays or assisting other residents</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 06/19/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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 0431 SS=E Bldg. 00	<p>to dine.</p> <p>During an interview on 06/17/15 at 12:20 P.M., the DM (Dietary Manager) indicated that staff must wash their hands with soap and water after touching a resident, before serving other residents in the dining room.</p> <p>The current hand washing policy titled, "Hand Hygiene", was provided by the Administrative Assistant on 06/17/2015 at 9:05 A.M. and reviewed on 06/18/2015 at 2:37 P.M. The policy indicated hand washing should be done "...after handling any contaminated items such as linens, soiled briefs, garbage, etc...when hands are obviously soiled...before and after caring for each Resident ..." The policy also indicated that alcohol hand sanitizer should be used "...only when visible soil is ABSENT [sic]...after contact with resident's INTACT [sic] skin, as in taking pulse, B/P...after contact with inanimate objects, including medical equipment ..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to follow current, acceptable practice for the disposal of expired medications for 4 residents in 2 of 6 Medication storage areas. (Residents #3, #14, #27 and #37)</p>	F 0431	<p>F 431</p> <p>1. There were no negative outcomes from this deficient practice. Resident #s 3, 14, and 27 Lantus was immediately removed from the medication cart and properly disposed of. Resident # 37's hemorrhoid</p>	07/18/2015

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 06/19/2015
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	
	<p>Findings include:</p> <p>1. On 06/18/2015 at 10:00 A.M., an observation of the Unit 4 long hallway medication cart was conducted with RN (Registered Nurse) #1. Three open vials, labeled "Lantus", were located in the top drawer of the medication cart. According to the manufacturer's guidelines, Lantus vials lose their stability and potency 28 days after being opened. One Lantus vial was opened on 05/06/2015 indicating an expiration date of 06/03/2015. The second Lantus vial was opened on 05/08/2015 indicating an expiration date of 06/05/2015. A third Lantus vial was opened on 05/20/2015 indicating an expiration date of 06/17/2015.</p> <p>During an interview on 06/18/2015 at 10:06 A.M., RN #1 indicated the expired vials of Lantus medication were for Resident #3, Resident #14 and Resident #27. She further indicated all three of the Lantus vials should have been properly disposed of and not in the medication cart.</p> <p>During an interview, on 06/18/2015 at 10:18 A.M., the DON (Director of Nursing) indicated all of the expired medications should have been properly disposed of and not in the medications carts. The DON indicated she had</p>		<p>ointment was also removed from the treatment cart and disposed of properly.</p> <p>2. All residents have the potential to be affected by this practice. All residents' medications and treatments and current MD orders will be monitored for expiration dates and physician orders. Should there be any evidence of expired medications or treatments without a current order will immediately be removed from the medication and treatment carts and disposed of properly. No other residents medications/treatments have been identified. Should there be any evidence that staff fail to comply with the facility policy on "Medication Storage in the Facility" they will immediately be re-educated and progressive discipline will be initiated if additional actions are required.</p> <p>3. All licensed nurses and QMAs will be in-serviced on proper medication storage with emphasis on expiration dates and discontinued medications being removed from the medicine/treatment carts. This will be conducted on new hires as part of the orientation process.</p> <p>4. The DON or designee and Pharmacist Consultant will monitor the medication/treatment carts over the next 4 weeks to ensure all expired and/or discontinued medication/treatments have been removed and properly disposed</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 06/19/2015	
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			
	<p>disposed of the expired Lantus vials and new vials of Lantus had been ordered. The DON further indicated the staff can acquire the necessary medications from the emergency drug kit until the vials are replaced.</p> <p>The Medication Administration Records (MAR) for Residents #3, #14 and #27 were reviewed on 06/18/2015 at 2:20 P.M., and indicated the following:</p> <p>Resident #3's Lantus vial expired on 06/05/2015. The resident received Lantus injections daily at bed time and had last received 5 units of Lantus on 06/17/2015.</p> <p>Resident #14's Lantus vial expired on 06/17/2015. The resident received Lantus injections every morning and had last received 22 units of Lantus on 06/18/2015.</p> <p>Resident #27's Lantus vial expired on 06/03/2015. The resident received Lantus injections daily at bed time and had last received 20 units of Lantus on 06/17/2015.</p> <p>2. On 06/18/2015 at 10:42 A.M., an observation of the Unit 4 treatment cart was conducted with LPN (Licensed Practical Nurse) #6. An ointment, labeled "Hemorrhoidal Ointment", had an</p>		<p>of using the "Proper Medication Storage" tool (attachment B). The Pharmacist will conduct random audits of the medication/treatment carts during visits to the facility. Audits will be conducted weekly for 4 weeks then monthly for 3 months then quarterly thereafter. The results of the audit will be reviewed by the Quality Assurance Committee and any recommendations made will be followed.</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 06/19/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
	<p>expiration date of 04/2015 (April, 2015) and was lying on the top of the treatment cart.</p> <p>During an interview on 06/18/2015 at 10:44 A.M., LPN #6 indicated the ointment was for Resident #37 and should have been properly disposed of and not in the treatment cart.</p> <p>The Medication Administration Record (MAR) for Resident #37 was reviewed on 06/18/2015 at 2:24 P.M. The MAR indicated the resident had no current orders for the use of the Hemorrhoidal Ointment.</p> <p>The current medication storage policy titled, "Medication Storage in the Facility", and dated 2006, was provided by the Administrator on 06/18/2015 at 3:00 P.M. The policy indicated, "Procedure: M...Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy if a current order exists..."</p> <p>3.1-25(o)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2015
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	