

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 06/04/2014
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 28, 29, 30, June 2, 3, and 4, 2014</p> <p>Facility number: 000117 Provider number: 155210 AIM number: 100266460</p> <p>Survey team Barbara Gray, RN-TC Leslie Parrett, RN (May 28, 29, 30, June 3 and 4, 2014) Diane Sidell, RN Angel Tomlinson, RN (May 28, 29, and 30, 2014)</p> <p>Census bed type: SNF/NF: 37 Non-Certified Comprehensive (NCC): 20 Total: 57</p> <p>Census payor type: Medicare: 2 Medicaid: 35 Other: 20 Total: 57</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F000000	<p>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 4, 2014 and request a paper compliance review if applicable.</p>	

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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F000241 SS=D	<p>16.2-3.1.</p> <p>Quality review completed on June 10, 2014 by Cheryl Fielden, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview the facility failed to maintain residents dignity and respect for the residents eating in the Alzheimer's dining rooms for 2 of 2 observations of residents eating in the Alzheimer's unit and 1 resident escorted out of the dining for an appointment before she received assistance eating her meal and on her return the food was not properly warmed</p>	F000241	F 241 Dignity and Respect of Individuality 1 – Resident # 38 did not have any negative outcome from the alleged deficient practice. The resident has been served her meals with respect and dignity. Resident # 38 did receive a 10:00 am nourishment, a supplement at 11:30am, and sent a snack of yogurt, ice cream and juice with her to the appointment. All nursing staff caring for resident # 38 have been re-educated on	07/04/2014			

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	<p>(Resident # 38).</p> <p>5/28/14 at 12:10 p.m., observation of the lunch meal on the Alzheimer's Unit indicated 21 residents were being served their meal on trays with no salt and pepper available or offered by staff, the tables had no table cloths or center pieces on them. CNA # 1 and Activities Director # 2 were observed serving residents the lunch meal of peanut butter and jelly sandwiches/ grilled cheese sandwiches, vegetable soup, cheese curls and cinnamon rolls, 3 residents appeared to be sleeping, they were served their trays and the food was uncovered. CNA # 1 at 12:29 p.m., sat down to assist the residents that were not eating. Resident # 38 was one of the residents that appeared to be sleeping, transporter # 3 entered the dining room and indicated Resident # 38 had an appointment at 1:00 p.m., and escorted Resident # 38 out of the dining room. Resident # 38 had not received any food or assistance, CNA # 1 indicated she could warm food up when Resident # 38 returned. At 12:36 p.m., LPN # 4 indicated Resident # 38 had not had anything to eat and she provided a snack of magic cup, yogurt and juice to take with the Resident. Resident # 38 returned at 1:51 p.m., observed Resident # 38 sitting in the dining room with her food</p>		<p>assisting resident to eat, proper warming of food, and educated on resident receiving an early tray if an appointment is scheduled around the meal time. 2 - All residents have the potential to be affected by the alleged practice. Nursing, Dietary and Activity staff will be inserviced on dignity and respect, set up of meals, providing of salt and pepper if desired, providing table decoration, proper heating of food, assisting residents with meals if indicated, posting menu, and ensuring a meal is provided prior to resident leaving for an appointment. Residents' food will be removed from their trays and placed directly on the tables unless the resident's preference is to have their food left on the tray. The facility placed thermometers in each nourishment room in the event the resident's food must be warmed so that the proper temperature can be achieved. Residents who have an appointment will be offered an early tray. 3 – All staff will be inserviced on dignity and respect , set up of meals and assisting residents during mealtime as needed, proper re-heating of food to achieve proper temperature, providing salt and pepper, requesting an early meal tray if indicated, posting menus, and providing table decorations including table cloths. 4 – A "Meal Observation" audit tool</p>	

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	<p>on a tray in front of her, the food had a thick film like substance over it, like it had not been stirred. At 2:15 p.m., there were no staff assisting Resident # 38 to eat, LPN # 4 indicated sometimes Resident # 38 would feed herself but she would go to check on her. At 2:20 p.m., surveyor requested to have temperature of food taken, LPN # 4 indicated she knew staff had warmed her food. CNA # 1 at 2:21 p.m., took Resident # 38's food to warm up in microwave, the CNA # 1 indicated she did not know who put the food in front of Resident # 38 and the staff have to feed the Resident. Dietary Manager # 5 and Cook # 6 arrived on the unit at 2:22 p.m. The food temperature was 112 degrees after microwaving it for 1 minute, the Dietary Manger # 5 had the food re-warmed and the pureed grilled cheese sandwich, vegetable soup and cinnamon roll was 181 degrees when re-served to Resident # 38.</p> <p>Review of Resident # 38's record on 5/28/14 at 2:40 p.m., indicated Physician's recapulation orders dated 6/1/14 through 6/30/14 the Resident's diagnoses included but were not limited to osteoporosis, degenerative disc disease, anemia, depression, senile dementia, anxiety and senile degeneration of the brain. Resident # 38 diet ordered as pureed.</p>		(Attachment A) will be utilized by the DON or designee weekly for 4 weeks, then monthly for 3 months, then quarterly. The results of the audit will be reviewed by the Quality Assurance Committee and any recommendations made will be followed.	

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	<p>Record review of Minimum Data Set for Resident # 38-needs total assistance of 1 staff member to eat.</p> <p>Observation of on 5/28/14 at 12:40 p.m., indicated 22 residents in the main dining room eating lunch, table cloths and flower center pieces on all the tables. The menu was posted on the wall outside of the main dining room at an appropriate height for all residents to read. No observation of salt and pepper being offered to the residents.</p> <p>On 5/29/14 at 12:00 p.m., observation of 20 residents in the Alzheimer's dinning room with no menu posted. CNA # 8 was asked what the residents were having for lunch and she left to look for the menu with no menu found. CNA # 8 indicated it's usually kept in a wall holder at the nurses station. Observation of the wall holder indicated it was not visible to the residents or visitors. All of the residents were served on trays, no salt or pepper available on trays or offered by staff. No table cloths or center pieces observed on the tables.</p> <p>At 12:15 p.m., observation of 4 staff members serving residents lunch, staff members sat with the residents who needed assistance after serving their trays.</p>			

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	<p>On 5/29/14 at 12:20 p.m., an interview with CNA # 12 on the Alzheimer's unit indicated the salt and pepper packets are in a drawer in the cabinet that is against the wall in the dining room.</p> <p>An interview with CNA # 7 on 5/29/14 at 12:26 p.m., indicated usually 3 staff serve lunch to the Alzheimer's residents.</p> <p>On 5/29/14 at 12:34 p.m., observation of main dinning room lunch meal with 26 residents present, no salt or pepper on tables, tables have table clothes and flower center pieces. No residents were served on trays, salt, pepper packets were in a plastic divided holder that was on top of a cabinet against a wall in the dining room. Observed 1 ambulatory resident going to the cabinet to get salt and pepper packets for 2 other residents at his table.</p> <p>On 5/30/14 at 12:00 p.m., an interview with the Dietary Manager # 5 indicated she was not notified that Resident # 38 had an appointment on 5/28/14 at 1:00 p.m., sometimes the nurse will notify dietary if a resident has an appointment. We are suppose to serve the residents their meal before they go on an appointment.</p> <p>3.1-3(t)</p>						

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to administer insulin as ordered by the physician, for 1 of of 2 residents observed for insulin administration. (Resident #53)</p> <p>Findings include:</p> <p>Resident #53's record was reviewed on 5/29/14 at 3:49 p.m. Diagnoses included but were not limited to coronary artery disease, peripheral vascular disease, and diabetes mellitus.</p>	F000282	<p>F 282 Services by Qualified Persons 1 – There were no negative outcomes from this practice related to Resident # 53. LPN # 9 was re-educated on the proper administration of the insulin injection and MD order. The MD was notified of the medication error and medication error report sheet has been completed. 2 – All residents receiving injections have the potential to be affected by this practice. Nurses will be observed for proper administration of insulin during med pass by using the "Medication Administration Procedure" audit tool (Attachment B). No other nurses or residents have been identified. Should there be any other evidence that</p>	07/04/2014

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	<p>A physician's order documented on Resident #53's May 2014 Recapitulation orders, initiated 7/13/13, indicated he would receive 4 units of Novolog insulin subcutaneous 3 times a day after meals.</p> <p>On 5/29/14 at 3:40 p.m., Resident #53 was observed receiving 4 units of Novolog insulin subcutaneous in his left arm by LPN #9.</p> <p>On 5/29/14 at 3:56 p.m., LPN #9 reviewed Resident #53's physician's orders and indicated he should have received the 4 units of Novolog insulin given at 3:40 p.m., after supper.</p> <p>A review of the "Resident Meal Times" provided by the MDS Coordinator on 5/28/14 at 10:40 a.m., indicated the evening supper meal began at 5:15 p.m.</p> <p>A "Physician Order" policy and procedure provided by the Director of Nursing on 6/4/14 at 12:07 p.m., indicated the following: "Purpose: To obtain and carry out orders for care and treatment of resident(s) as may be necessary... Ensure medications/treatments are provided to resident upon receipt of supplies in accordance with the order."</p> <p>3.1-35(g)(2)</p>		<p>staff fail to comply with the facility policy on insulin injections, they will be immediately re-educated and progressively disciplined.</p> <p>3. All licensed nurses will be inserviced on the proper medication pass procedure with emphasis on insulin injections. This will also be conducted on new hires as part of the orientation process for licensed personnel. 4 – The DON or her designee will observe licensed nurses over the next four weeks for proper administration of insulin using the "Medication Administration Procedure" audit tool (Attachment B). Audits will continue to be conducted after the four weeks, monthly for 3 months, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Committee and any recommendations made will be followed.</p>	

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p>			

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	<p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to wear gloves while providing a blood sugar check and administering insulin, for 1 of 4 blood sugar check observations and 1 of 3 insulin administration observations. (Resident #53 and #28)</p> <p>Findings include:</p> <p>1. Resident #53's record was reviewed on 5/29/14 at 3:49 p.m. Diagnoses included but were not limited to coronary artery disease, peripheral vascular disease, and diabetes mellitus.</p> <p>A physician's order documented on Resident #53's May 2014 Recapitulation orders, initiated 7/13/13, indicated he would receive 4 units of Novolog insulin subcutaneous 3 times a day after meals.</p> <p>On 5/29/14 at 3:40 p.m., Resident #53 was observed receiving 4 units of Novolog insulin subcutaneous in his left arm by LPN #9 who was not wearing gloves.</p> <p>On 5/29/14 at 3:56 p.m., LPN #9</p>	F000441	<p>F 441 Infection Control 1 - There were no negative outcomes from this practice. LPN # 9 was counseled and re-educated on the use of gloves during injections. LPN # 10 was counselled and re-educated on the use of gloves during blood sugar checks. 2 – All residents have the potential to be affected by this practice. All nurses will satisfactorily complete the “Glucometer Check and Infection Skills Check Off” audit tool (Attachment C) by July 4, 2014 then annually and as needed. No other nurses or residents have been identified. Should there be any evidence that staff fail to comply with the facility policy and infection control programs they will be immediately re-educated and progressive discipline will be initiated. 3 – All licensed nurses will be inserviced on proper techniques for checking blood sugars and administering injections with an emphasis placed on glove use. QMAs will be inserviced on proper techniques for checking blood sugars with an emphasis placed on glove use. This will also be conducted on new hires as part of the orientation process. 4 – The DON or designee will observe licensed nurses and QMAs over</p>	07/04/2014

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	<p>indicated she wore gloves when she provided residents with blood sugar checks but usually did not wear gloves when administering insulin. She indicated she believed the facility policy was to wear gloves when administering insulin.</p> <p>2. Resident #28's record was reviewed on 5/29/14 at 3:51 p.m. Diagnoses included but were not limited to renal failure, peripheral neuropathy, and diabetes mellitus.</p> <p>A physician's order documented on Resident #28's May 2014 Recapitulation orders, initiated 3/14/14, indicated she would receive a blood sugar check 2 times a day.</p> <p>On 5/29/14 at 3:44 p.m., LPN #10 was observed providing Resident #28 with a blood sugar check and was not wearing gloves.</p> <p>On 5/29/14 at 3:53 p.m., LPN #10 indicated she did not usually wear gloves when checking a residents blood sugar. She indicated she had before. She stated "it's according to who it is." LPN #10 indicated she believed the facility policy was to wear gloves when checking a resident's blood sugar level.</p>		<p>the next 4 wks then monthly for 3 months then quarterly for glove use during injections and blood sugar checks using the "Glucometer Check and Infection Skills Check Off" audit tool (Attachment C). The results of the audit will be reviewed by the Quality Assurance Committee. Any recommendations will be followed.</p>				

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	<p>The "Universal Precautions" policy and procedure provided by RN # 11 on 6/4/14 at 10:11 a.m., indicated the following: "Purpose: Universal precautions are intended to prevent parenteral, mucous membrane, and nonintact skin exposure of health workers to bloodborne pathogens. Policy: Facility staff will provide care with an approach to infection control in which all blood and body fluids are treated as if know to be infectious. Procedure: 1. Universal precautions shall be observed for the following: a. Blood and any other body fluid containing visible blood. 2. CDC considers the risk of transmission of HIV and HBV from feces, urine, nasal secretions, sputum, tears, and vomits to be extremely low or non-existent unless they contain visible blood. However, staff will observe U.P., when handling these body fluids to minimize the risk of transmission of resistant organisms. 3. Protective barriers such as gloves, mask, and protective eyewear will be utilized to reduce the risk of exposure of staff to potentially infective materials, as outlined in #1 and #2. 6. Protective barriers will be used to prevent exposure to blood or body fluids containing visible blood...."</p> <p>The "Injections, Insulin" policy and procedure provided by RN #11 on 6/4/14</p>			

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	<p>at 10:11 a.m., indicated the following: "Purpose: Insulin is injected to aid oxidation and utilization of the blood sugar by the tissues, and to control blood sugar levels in Residents with Diabetes Mellitus. Equipment: Gloves. Administering Insulin: Apply gloves...."</p> <p>The "Blood Glucose System" policy and procedure provided by RN #11 on 6/4/14 at 10:11 a.m., indicated the following: Wash and dry your hands thoroughly. Put on gloves...."</p> <p>3.1-18(j)</p>			