STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD, NEWBURGH, , 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00373112, IN00373946, IN00374352, IN00374430, IN00374448, IN00374450, IN00374462, IN00374662, IN00375364, IN00375951, IN00376937, and IN00377177. Complaint IN00373112-Substantiated. State deficiencies related to the allegations are cited at R407. Complaint IN00373946-Substantiated. State deficiencies related to the allegations are cited at R349. Complaint IN00374352-Unsubstantiated due to lack of evidence. Complaint IN00374430-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00374448-Unsubstantiated due to lack of	R 0000		

	evidence. Complaint IN00374450-Unsubstantiated due to lack of evidence. Complaint IN00374462-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00374662-Substantiated. State deficiencies related to the allegations are cited at R349 and R407. Complaint IN00375364-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00375951-Unsubstantiated due to lack of evidence. Complaint IN00376937-Unsubstantiated due to lack of evidence. Complaint IN00377177-Substantiated. No deficiencies related to the allegations are cited. Survey dates: April 18-20, 2022 Facility number: 014377 Residential Census: 91 These State Residential			

	Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 27, 2022.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review, and interview, the facility failed to accurately document in the resident's clinical record for 1 of 3 residents regarding documentation of isolation status (Resident N), and 2 of 3 residents regarding oxygen use (Resident M and Q). Findings include: 1. During the initial tour on 4/18/22 at 9:30 A.M., a sign indicating Resident Q was receiving oxygen was observed outside the room.	R 0349	Plan of Correction 05/08/2022 Facility ID: 014377 Survey Event ID: ID QG4Y11 **1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.** a. No residents experienced adverse effects from the alleged deficient practice. **2. Describe how the facility**	05/08/2022

	During a clinical record review on 4/18/22 at 2:11 P.M., oxygen use was not included on Resident Q's current physician orders dated April 2022. During an observation of Resident Q on 4/19/22 at 10:22 A.M., Resident Q was receiving oxygen via nasal cannula. Resident Q indicated at that time that Resident Q had been on oxygen for 2 years. During an interview with the Director of Nursing (DON) on 4/19/22 at 10:56 A.M., she indicated an order is needed for a resident to receive oxygen. DON was unable to find Resident Q's oxygen order in the current physician orders at that time. On 4/19/22 at 2:00 P.M., the DON provided a physician's order dated 10/28/21 which indicated "oxygen at 3 liters every shift to prevent/ relieve hypoxia [shortness of breath]." The physician's order was received from a previous facility on 4/19/22. On 4/19/22 at 2:18 P.M., the clinical record was again reviewed. A physician's order dated 4/19/22 indicated, "...oxygen at 3L [liters] via nasal cannula continuously." 2. During a clinical record review on 4/19/22 at 8:52 A.M., oxygen use was not included on		**reviewed** **all clients in the facility that could be affected by the same deficient** **practice, and state, what actions the facility took to correct the deficient** **practice for any client the facility identified as being affected.** A. All residents on oxygen has the potential to be effected. B. All residents in transmission-based precautions has the potential to be effected. **3. Describe the steps or systemic** **changes the facility has made or will make to ensure that the deficient** **practice does not recur, including any in-services, but this also should** **include any system changes you made.**	

	Resident M's current physician orders dated April 2022. On 4/19/22 at 2:00 P.M., the DON provided a physician's order dated 9/8/21 which indicated, "O2 [oxygen] at 2-3 liters via cannula continuous." During an observation on 4/20/22 at 10:00 A.M., Resident M was observed sitting in a wheelchair receiving oxygen via nasal cannula. Resident M indicated at that time that Resident M had been receiving oxygen for 2.5 years. 3. During a clinical record review on 4/18/22 at 2:18 P.M., a progress note indicated on 2/7/22 at 1:08 P.M., Resident N tested positive for COVID-19. During an interview with the DON on 4/20/22 at 10:45 A.M., she indicated Resident N was on transmission based precautions; however, Resident N's clinical record lacked documentation of transmission based precautions. On 4/20/22 at 2:28 P.M., the DON provided the current facility policy, "Documentation-Licensed Nursing" dated 1/6/2022. The policy included, "It is the responsibility of the licensed nursing staff to complete documentation in the resident's medical record. Documentation shall include but not limited to the following:		A. An audit has been conducted on all residents currently on oxygen to ensure current orders are reflected on the mar. ELP pharmacy to conduct Extended Living Pharmacy conducted in servicing with their staff to ensure oxygen are on the Mar. B. Inservice licensed nursing staff on proper medical record documentation for transmission based precautions. **4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur (ie what quality assurance program will be put into place)** The Director of Nursing or designee will audit the eMAR five (5) times per week for eight (8) weeks, then three (3) times a week for four (4) weeks, then two (2) times a week for four (4) weeks and then weekly for eight (8) weeks, then as needed to ensure that proper medication administration and	

	admission, discharge, medications, assessments, changes in clinical condition, incidents, notifications of responsible party and physician, as well as care provided and pertinent resident information." This state residential finding relates to Complaints IN00373946 and IN00374662. Based on observation, record review, and interview, the facility failed to accurately document in the resident's clinical record for 1 of 3 residents regarding documentation of isolation status (Resident N), and 2 of 3 residents regarding oxygen use (Resident M and Q). Findings include: 1. During the initial tour on 4/18/22 at 9:30 A.M., a sign indicating Resident Q was receiving oxygen was observed outside the room. During a clinical record review on 4/18/22 at 2:11 P.M., oxygen use was not included on Resident Q's current physician orders dated April 2022. During an observation of Resident Q on 4/19/22 at 10:22 A.M., Resident Q was receiving oxygen via nasal cannula. Resident Q indicated at that time that Resident Q had been on oxygen for 2 years.		documentation is being executed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on May 8, 2022.	

During an interview with the Director of Nursing (DON) on 4/19/22 at 10:56 A.M., she indicated an order is needed for a resident to receive oxygen. DON was unable to find Resident Q's oxygen order in the current physician orders at that time.

On 4/19/22 at 2:00 P.M., the DON provided a physician's order dated 10/28/21 which indicated "oxygen at 3 liters every shift to prevent/ relieve hypoxia [shortness of breath]." The physician's order was received from a previous facility on 4/19/22.

On 4/19/22 at 2:18 P.M., the clinical record was again reviewed. A physician's order dated 4/19/22 indicated, "...oxygen at 3L [liters] via nasal cannula continuously."

2. During a clinical record review on 4/19/22 at 8:52 A.M., oxygen use was not included on Resident M's current physician orders dated April 2022.

On 4/19/22 at 2:00 P.M., the DON provided a physician's order dated 9/8/21 which indicated, "O2 [oxygen] at 2-3 liters via cannula continuous."

During an observation on 4/20/22 at 10:00 A.M., Resident M was observed sitting in a wheelchair receiving oxygen via nasal cannula. Resident M

indicated at that time that Resident M had been receiving oxygen for 2.5 years.

3. During a clinical record review on 4/18/22 at 2:18 P.M., a progress note indicated on 2/7/22 at 1:08 P.M., Resident N tested positive for COVID-19.

During an interview with the DON on 4/20/22 at 10:45 A.M., she indicated Resident N was on transmission based precautions; however, Resident N's clinical record lacked documentation of transmission based precautions.

On 4/20/22 at 2:28 P.M., the DON provided the current facility policy, "Documentation-Licensed Nursing" dated 1/6/2022. The policy included, "It is the responsibility of the licensed nursing staff to complete documentation in the resident's medical record. Documentation shall include but not limited to the following: admission, discharge, medications, assessments, changes in clinical condition, incidents, notifications of responsible party and physician, as well as care provided and pertinent resident information."

This state residential finding relates to Complaints IN00373946 and IN00374662.

R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to follow infection control guidelines by failing to correctly clean glucometers with germicidal wipes, for 9 of 9 diabetic residents who received insulin injections from staff (Residents N, Q, U, V, W, BB, CC, DD, and FF). Findings include: On 4/18/22 at 11:10 A.M., LPN 1 was observed to use a glucometer to check Resident U's blood sugar, and then administer the resident an insulin injection. LPN 1 used an alcohol wipe to clean the	R 0407	Plan of Correction 05/08/2022 Facility ID: 014377 Survey Event ID: ID QG4Y11 **1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.** a. No residents experienced adverse effects from the alleged deficient practice. **2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient**	05/08/2022

	glucometer. She indicated at that time that each diabetic resident had their own glucometer, and that each glucometer was cleaned with alcohol wipes. LPN 1 indicated that alcohol wipes were the only wipe that was provided, but she knew staff were supposed to use a germicidal wipe. On 4/20/22 at 12:45 P.M., the Director of Nursing (DON) provided a list of residents who required insulin that was administered by facility staff. The list included 9 residents: Residents N, Q, U, V, W, BB, CC, DD, and FF. On 4/20/22 at 12:45 P.M., the DON provided the current facility policy, "How to clean glucometer," undated. The policy included: "Unfold PDI Super Sani-Cloth Germicidal Wipes and thoroughly wet surface. Allow treated surface to remain wet for two minutes and then let air dry...To be performed after each use of a glucometer after each resident." The DON included inservice documentation, dated 4/20/22, attached to the policy. This state residential Finding relates to Complaints IN00373112 and IN00374662. Based on observation, interview, and record review, the facility failed to follow infection		**practice for any client the facility identified as being affected.** a. All residents requiring the use of glucometers, by the facility, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all medical staff on procedures of appropriately disinfecting glucometers. Employees found to be out of compliance with disinfecting glucometers will receive additional education and possible corrective action. **3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.**	

	control guidelines by failing to correctly clean glucometers with germicidal wipes, for 9 of 9 diabetic residents who received insulin injections from staff (Residents N, Q, U, V, W, BB, CC, DD, and FF). Findings include: On 4/18/22 at 11:10 A.M., LPN 1 was observed to use a glucometer to check Resident U's blood sugar, and then administer the resident an insulin injection. LPN 1 used an alcohol wipe to clean the glucometer. She indicated at that time that each diabetic resident had their own glucometer, and that each glucometer was cleaned with alcohol wipes. LPN 1 indicated that alcohol wipes were the only wipe that was provided, but she knew staff were supposed to use a germicidal wipe. On 4/20/22 at 12:45 P.M., the Director of Nursing (DON) provided a list of residents who required insulin that was administered by facility staff. The list included 9 residents: Residents N, Q, U, V, W, BB, CC, DD, and FF. On 4/20/22 at 12:45 P.M., the DON provided the current facility policy, "How to clean glucometer," undated. The policy included: "Unfold PDI Super Sani-Cloth Germicidal		a. All clinical staff will be re-educated and in-serviced on disinfecting glucometers no later than May 8, 2022 with 1:10 bleach/water disinfectant, wipe dry. Apply an EPA-Registered disinfectant per product directions. Apply an EPA-Registered disinfectant per product directions. Allow glucometer to dry thoroughly between uses. Any clinical staff member out of compliance with facility's policies and protocols relating to disinfecting glucometers will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to disinfecting glucometers during employee job-specific orientation moving forward. **4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur (ie what quality assurance program will be put into place)**	

	Wipes and thoroughly wet surface. Allow treated surface to remain wet for two minutes and then let air dry...To be performed after each use of a glucometer after each resident." The DON included inservice documentation, dated 4/20/22, attached to the policy. This state residential Finding relates to Complaints IN00373112 and IN00374662.		a. The Director of Nursing or designee will audit the cleaning of glucometers two (2) times per week for eight (8) weeks, then one (1) time a week for four (4) weeks, then two (2) times a month for one (1) month and then as needed to ensure that proper disinfecting technique is being executed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on May 8, 2022	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE