STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE REHABILITATION & HEALTH CARE CENTEI	281 S COUNTY ROAD 200 EAST CONNERSVILLE, IN 47331

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 19, 20, 21, and 22, 2022 Facility number: 000225 Provider number: 155332 AIM number: 100267670 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 12 Medicaid: 61 Other: 17 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 28, 2022	F 0000	/p> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 10/15/2022.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record	F 0689	**F 689 Free of Accident**	10/15/2022

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

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	review the facility failed to implement fall interventions for residents who were at high risk for falls for 2 of 5 residents reviewed for accidents (Resident 22 and Resident 33). Findings include: 1.) During an observation and interview 9/21/22 at 10:00 a.m., CNA 5 and CNA 6 lifted Resident 22 underneath her arms and transferred her from the bed to the wheelchair without utilizing a gait belt. Resident 22 was minimally able to assist with the transfer. When queried why a gait belt was not used, CNA 5 indicated there was usually a gait belt in each of the resident's room, but Resident 22 did not have one in her room. Review of the record of Resident 22 on 9/21/22 at 1:00 p.m., indicated the resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, chronic kidney disease, major depressive disorder, unsteadiness on feet, lack of coordination and muscle weakness. The Admission Minimum Data (MDS) for Resident 22, dated 4/13/22, indicated the resident required extensive assistance of two staff for transfers. The plan of care for Resident 22, dated 7/13/22, indicated the resident required assistance with ADL's including bed mobility, transfers, eating and toileting related to inability to care for self, Parkinson's, inability to walk, dementia, psychosis. The interventions included, but were not limited to, assist with transfers x's 2 people. The fall risk assessment for Resident 22, dated		**Hazards/Supervision/Devices** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Gait belt replaced in Resident 22 room and staff immediately educated on use of gait belt. · Care plan updated on Resident 33 to reflect current preferences. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · All residents fall plans of care to be reviewed and updated by 10/15/2022. · All licensed staff to be in-serviced on fall program and how to identify resident specific interventions and needs by 10/15/2022. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · All residents fall plans of care to be reviewed and updated by 10/15/2022. · All licensed staff to be in-serviced on fall program and how to identify resident specific	

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	7/13/22, indicated the resident was at high risk for falls. 2. The clinical record for Resident 33 was reviewed on 9/19/2022 at 1:52 p.m. The medical diagnoses included, but were not limited to, muscle weakness and age-related osteoporosis. A Significant Change in Condition Assessment completed on 7/24/2022 indicated Resident 33 needed assistance of two staff members for transferring tasks, was only able to stabilize during transfers with staff assistance, and had no falls during the review period. A fall risk assessment completed on 7/21/2022 indicated Resident 33 was a high risk for falls. A fall care plan, reviewed on 8/3/2022, indicated for Resident 33 to be assisted to bed or recliner following meals. An observation on 9/19/2022 at 1:32 p.m. indicated Resident 33 sitting in her wheelchair to the side of her bed. An observation on 9/21/2022 at 1:05 p.m. indicated Resident 33 sitting in her wheelchair to the side of her bed. An observation on 9/21/22 at 10:20 a.m. indicated Resident 33 sitting in her wheelchair to the side of her bed. An interview with the Director of Nursing on 9/22/2022 at 11:12 a.m. indicated that the care plan indicated to assist Resident 33 back to bed or in the recliner needed to be updated. She indicated that Resident 33's preference was to be in her wheelchair, but right after admission it was the family's preference to have the resident lay down or back to the recliner after meals.		interventions and needs by 10/15/2022. · Residents fall plan of care to be reviewed and updated quarterly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** · DNS/designee to complete audit on resident interventions on minimum of 10 residents per week x 4 weeks, then 20 residents per month x 5 months. · DNS/designee to complete Fall intervention QA tool weekly x 4 weeks, then monthly x 5 months. The results will be reviewed by the CQI committee overseen by the ED with a compliance threshold of 95%. **By what date the systemic changes will be completed:** Completion Date: 10/15/2022	

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	A policy entitled, "Fall Management Policy", was provided by the Director of Nursing on 9/22/2022 at 10:05 a.m. The policy indicated, " ...A care plan will be developed at the time of admission with specific care plan intervention to address each resident's fall risk factors. Care plan including interventions and fall risks will be reviewed at least quarterly ..." A policy entitled, "TRANSFER TO WHEELCHAIR", was provided by the Director of Nursing on 9/22/2022 at 10:05 a.m. The policy indicated, " ...Place gait belt around resident's waist ..." 3.1-45(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure one dietary staff member's hair was appropriately covered, failed to ensure a range hood was clean, and failed to ensure an area of floor was clean. This had the potential to affect all 90 residents who resided in the facility. Findings include: A dietary observation, on 9/22/22 at 10:32 a.m., indicated, on the floor beside the wall, on the right of the walk in freezer door, a 6 inch by 3 inch area had a buildup of dark brown debris with white particles on top of it. The inside of the range hood, above the range and steam table, had rust colored areas on the galvanized steel. A sticker on the outside corner of the range hood indicated the range hood was last cleaned on 4/6/22. Culinary Aide 7, who was preparing beverages, had long hair in braids and did not have her hair covered. Cook 9 indicated she wasn't sure of the policy for wearing hair covering for synthetic hair. On 9/22/22 at 12:43 p.m., the Dietary Manager indicated he didn't know if the hood vent was rusty, and there was no debris falling from it. He said the area beside the freezer door was caused by a build up of moisture from the freezer being so cold because it was along the wall by the freezer and it would be deep cleaned. Culinary Aide 7 was working and did not have her hair covered. When queried about hair covering, Culinary Aide 7 said they told her to wear a hair net and she tried to wear it but it slides off. The	F 0812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents were identified as being affected by the alleged deficient practice. · The culinary staff was immediately given an additional hair net to cover her braids. · The range hood and area of the floor were scrubbed down to ensure cleanliness 2. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All culinary employees were educated on the use of hair covering by the ED or designee on or before 10/15/22. · The area on the range hood and the area on the floor were thoroughly cleaned. · All culinary employees were	10/15/2022

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	Dietary Manager said he would find out from the Dietitian what the policy was for synthetic hair covering. On 9/22/22 at 1:18 p.m., the Maintenance Supervisor said when the range hood vent was cleaned in April, it had been steam cleaned and it is due to be cleaned in October. He said he rubbed the rust colored areas of the vent and nothing came off of it. A policy for "Dietary Personal Hygiene" was provided by the Administrator on 9/22/22 at 1:57 p.m. The policy included, but was not limited to: "Policy: Employees will maintain good personal hygiene to prevent food contamination...3. Personal Cleanliness. a. Wear a clean hat and/or other hair restraint...." 3.1-21(i)(2) 3.1-21(i)(3)		educated on cleaning standards in food service area by ED or designee on or before 10/15/22. 3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** · All culinary employees were educated on the use of hair covering by the ED or designee on or before 10/15/22. · The culinary manager or designee will monitor staff regularly to ensure staff's hair is covered appropriately. Appropriate hair covering will be present and available upon entry to the kitchen at all times and checked daily to ensure adequate supply is present. · The Culinary manager will audit the cleanliness of the range hood and floor area on a regular basis. Environmental services will be scheduled to clean floor areas regularly. Hood vent scheduled to be deep cleaned on or before 10/15/22 by vendor. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Culinary manager will	

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			complete the Use of Hair Nets QA tool weekly times 4 weeks, then monthly x 5 months. The results will be reviewed by the CQI committee overseen by the ED with a compliance threshold of 95%. · Culinary manager will complete the Kitchen Sanitation/Environmental Review short form weekly times 4 weeks, then monthly x 5 months. The results will be reviewed by the CQI committee overseen by the ED with a compliance threshold of 95%. POC correction date 10/15/22	
F 0814 SS=D Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure the area around the dumpsters was free of debris for one of one observation. This had the potential to affect all 90 residents who resided in the facility. Findings include: On 9/22/22 at 12:55 p.m., the fenced in dumpster area was observed with the Dietary Manager. He unlocked the gate and four covered dumpsters were observed. Around the dumpsters was debris that included, spoons, styrofoam cups, paper towel rolls, masks, gloves, cup lids, clear plastic bags, clear plastic cups, papers, an empty odor	F 0814	F814 Dispose Garbage and Refuse Properly 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents were identified as being affected by the alleged deficient practice. · The area around the dumpster was immediately cleaned and made free of debris. 2. **How will you identify**	10/15/2022

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	eliminator bottle, a wooden pallet, used depends, and broken glass. The Dietary Manager indicated housekeeping was responsible to keep the area clean. On 9/22/22 at 1:14 p.m., the Administrator said their trash service just picked up the trash today; when they come and do the trash, some of it falls out and they don't pick it up. 3.1-21(i)(5)		**other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Environmental services will complete minimal of daily checks for debris around dumpster. · Appropriate staff will be educated on or before 10/15/22 regarding the importance of ensuring the ground is free of debris after discarding trash and when the vendor empties trash. 3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** · Environmental services will complete minimal of twice a day checks to ensure dumpster area is free of debris. · Appropriate staff will be educated on or before 10/15/22 regarding the importance of ensuring the ground is free of debris after discarding trash and when the vendor empties trash. · 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place? · Environmental Services will complete the Environmental Checklist QA tool weekly x 4 weeks then monthly x 5 months. The results will be reviewed by the CQI committee overseen by the ED with a compliance threshold of 95%. POC correction date 10/15/22	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread			

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	of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review the facility failed to complete proper hand washing and change of gloves during incontinent care for 1 of 3 observation of incontinent care (Resident 22). Finding include: During an observation and interview 9/21/22 at 10:00 a.m., CNA 5 and CNA 6 provided incontinent care for Resident 22. Resident 22 was incontinent of her bowels and bladder. CNA 5 was observed touching both curtains and top of cabinet with soiled gloves searching for a incontinent brief. CNA 5 picked up the soiled linen and soiled trash and left the resident's room touching the door knob with soiled gloves. When queried about not removing soiled gloves and performing handwashing prior to touching surfaces, CNA 5 indicated she normally would have all her supplies gathered prior to providing care so she would not leave the resident's bedside and avoid potentially contaminating surfaces with soiled gloves. Review of the record of Resident 22 on 9/21/22 at 1:00 p.m., indicated the resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, chronic kidney disease, major depressive disorder, unsteadiness on feet, lack of coordination and muscle weakness.	F 0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Residents identified during survey were not noted to have any ill effects from the alleged deficient practices. · All licensed staff working at time of incident were educated on hand washing and glove use. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, observation, and QA tools. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · A Root Cause Analysis will	10/15/2022

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	The Admission Minimum Data (MDS) for Resident 22, dated 4/13/22, indicated the resident is frequently incontinent of bowels and bladder. The incontinent care policy provided by the Director Of Nursing (DON) on 9/22/22 at 11:05 a.m., indicated after providing incontinent care to remove gloves and wash hands. "Do not leave the resident room". 3.1-18(a)		be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause. · The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, observation, and QA tools. · All staff will be in-serviced by DNS/designee by 10/15/2022 on infection control practices to include proper hand hygiene and changing of gloves along with Skills validations on all licensed staff. · The facility LTC Infection Control Self-Assessment will be reviewed with the consultant IP to determine accuracy. · Daily observational rounds will be conducted varied shifts for 4 weeks until compliance is maintained by the IP/designee using audit tool. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** · The IP/DNS/Designee will monitor each solution/systemic change identified in the RCA daily or more often as necessary for 6	

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			weeks and until compliance is maintained. · Daily observational rounds will be conducted varied shifts for 4 weeks until compliance is maintained by the IP/designee using audit tool. · The IP/designee will be responsible for the completion of the Infection Control-hand hygiene short form QA Tool weekly x 4, monthly x 5 months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. · CEC/designee to complete Hand Hygiene QA tool weekly x 4 weeks, biweekly for 1 month, monthly x 4 months, quarterly for 2 consecutive quarters. Results of these audits to be reviewed by QAPI committee overseen by ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. · The facility will review, update and make changes to the DPOC as needed with input and oversight from the Consultant Infection Preventionist for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			By what date the systemic changes will be completed: Completion Date: 10/15/2022	