STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00406588. Complaint IN00406588 - No deficiencies related to the allegations are cited. Survey dates: April 20, 21, 24, 25, 26 and 27, 2023. Facility number: 000271 Provider number: 155402 AIM number: 100291260 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 7 Medicaid: 54 Other: 7 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on May 9, 2023.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure a MDS (Minimum Data Set) assessment was accurate for 1 of 1 resident reviewed for resident assessments. (Resident 42)	F 0641	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because	05/24/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joshua Davis	Executive Director	05/22/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Finding includes: The record for Resident 42 was reviewed on 4/24/23 at 3:29 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, acute kidney failure, and hemiplegia and hemiparesis following cerebral infarction. A quarterly MDS assessment, dated 3/28/23, indicated the resident received insulin 7 days out of the last 7 days. During a review of the physician orders, the resident's insulin had been discontinued 8/2022. During an interview, on 4/24/23 at 11:19 a.m., the MDS Coordinator indicated she marked the March 28, 2023, MDS assessment as the resident was receiving insulin. She indicated she was not aware Victoza (a non-insulin medication which lowers blood sugar) was not insulin. The resident was receiving Victoza and not insulin. The MDS should have only been coded for receiving injections and not insulin. A current policy, titled "Resident Assessment Instrument & Care plan Development," dated as revised on 8/16/22 and received from the Administrator on 4/26/23 at 4:45 p.m., indicated "...The facility will follow the procedures set forth in the Resident Assessment Instrument [RAI] User's Manual 3.0 when completing the MDS, Care Area Assessment, and Comprehensive Care Plan...A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument [RAI] specified by CMS...."		Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 641 Assessments** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The MDS Coordinator has submitted a corrected MDS indicating Resident 42 had injections provided, not insulin. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** The MDS Coordinator/designee completed an audit for all residents with orders for Victoza. **What measures will be put into**	

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	3.1-31(d)(3)		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** ED/designee to provide education to the MDS Coordinator on properly coding the MDS for injections including Victoza. Routine auditing of the MDS will be completed as stated below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The MDS Coordinator/designee will complete routine auditing of residents with orders for GLP-1 injections and will ensure that the MDS has been coded correctly. Auditing to occur: 4 residents with GLP-1 orders weekly x's 4 weeks if they exist, then 4 residents with GLP-1 orders if they exist monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing	

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			process. Compliance date: 5/24/23. The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident with congestive heart failure received daily weights and the physician was notified of a weight gain as ordered for 1 of 3 residents reviewed for quality of care. (Resident 33) Findings include: During an interview, on 4/20/23 at 2:00 p.m., Resident 33 indicated she had lost weight. The resident had an order for daily weights and was not always weighed daily. The record for Resident 33 was reviewed on 04/24/23 at 10:32 a.m. Diagnosis included, but were not limited to, heart failure, hypertension, vascular dementia, atrial fibrillation (irregular, rapid heartbeat), Alzheimer's disease, and cognitive communication deficit.	F 0684	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction.	05/25/2023

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	A physician's order, dated 5/11/22, indicated daily weights and to notify the physician if there was a plus or minus of 3 pounds a day or 5 pounds a week or if there was a 5% plus or minus change in 30 days. Notify the physician and Director of Nursing (DON) for all refusals as soon as possible. A physician's order, dated 6/26/22, indicated furosemide (a diuretic) tablet 20 mg (milligrams), to give 3 tablets by mouth twice a day related to heart failure and edema (swelling). A care plan, dated as revised on 11/16/22, indicated the resident was at risk for fluctuation in weights related to congestive heart failure. The interventions included, but were not limited to, daily weights. The Medication Administration Record (MAR) indicated a daily weight was not taken on 3/1/23, 3/23/23 and 3/29/23. The MAR indicated the physician should have been notified of the following weights: a. A weight gain of 4.4 pounds on 3/14/23. b. A weight gain of 4.7 pounds on 4/21/23. During an interview, on 4/25/23 at 9:13 a.m., the DON indicated if the resident was a daily weight and had congestive heart failure they needed to be weighed daily. The physician's order should be followed, and the physician notified of a weight gain. During an interview, on 4/25/23 at 2:39 p.m., the DON did not have weights for 3/1/23, 3/23/23 and 3/29/23 and the facility did not have a policy for congestive heart failure.		We respectfully request a desk review. **F 684 Quality of Care** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** DON/designee obtained residents daily weight on 4/24/23 DON/designee notified Resident 33's physician and responsible party of current weight and overall current weight changes. No new orders given. DON/designee notified the physician and responsible party of missed daily weights. No new orders given. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who have an order for a daily weight have the potential to be affected DON/designee will complete a medical record audit of residents with orders for daily weights and will ensure that the physician and responsible party have been notified of any significant daily weight changes as well as any missed daily weights x's last 30 days.	

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	A current policy, titled "Changes in Resident's Condition or Status," received from the Administrator on 4/25/3 at 3:08 p.m., indicated "...The facility will notify the resident, his/her attending physician, and representative (sponsor) of changes in the resident's condition and/or status. The following will outline the process. 1. Nursing services will be responsible for notifying the resident's attending physician when: b. There is significant change in the resident's physical, mental, or emotional status. c. The resident refuses treatment of medications and reason(s) why...4. All notifications must be made as soon as practical, but in no case will such notification exceed twenty-four (24) hours...." 3.1-37(a)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee to provide education to licensed and certified nursing staff on the requirement to ensure obtain daily weights as ordered and for the licensed nurse to notify the physician and responsible party of significant daily weight changes as ordered. Routine auditing of the medical record will be completed as stated below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee to complete routine auditing of daily weight values to ensure weights have been obtained/documented, and that the physician and responsible party are notified of any significant daily weight changes as per the physicians order. Auditing to occur: 5 x's wkly x's 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a total	

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			of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process. Compliance date: 5/25/23 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all			

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	controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview and record review, the facility failed to ensure the controlled substance record used was provided by the pharmacy and not altered by facility staff for 1 of 3 medication carts observed for medication storage. (Ross Hall) Findings include: During an observation of Ross Hall medication cart, on 4/26/23 at 11:15 a.m., the following was observed for Resident 11: 1. Resident 11's controlled substance record from the pharmacy for lorazepam 0.5 mg indicated there were 27 tablets remaining. 2. The card for the lorazepam 0.5 mg contained 25 tablets. 3. The controlled substance record from the pharmacy for hydrocodone-acetaminophen 5-325 milligrams indicated 26 tablets remained. 4. The card for the hydrocodone-acetaminophen had 26 tablets. 5. The controlled substance records for the medications had been switched by the staff and the counts for the medication were off by one tablet. A controlled substance record, dated 4/24/23, indicated hydrocodone-acetaminophen 5-325 milligram tablets. The hydrocodone-acetaminophen had a line drawn through it with an arrow pointing below and Lorazepam 0.5 milligrams was handwritten and	F 0755	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 755 Pharmacy Srvs/Procedures/Pharmacist/Records** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	05/24/2023

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	highlighted. A controlled substance record, dated 4/24/23, indicated lorazepam 0.5 mg tablets. The lorazepam had a line drawn through it with an arrow pointing below and Hydrocodone-acetaminophen 5-325 milligrams was handwritten and highlighted. During an interview, on 4/26/23 at 11:20 a.m., QMA 3 indicated the controlled substance records had been switched. During an interview, on 4/26/23 at 11:45 a.m., the Director of Nursing indicated the controlled substance records should not have been switched. A current policy, titled "Storage and Expiration Dating of Medications, Biologicals," received from the Administrator, on 4/27/23 at 4:45 p.m., indicated "...applying with its obligations pursuant to Applicable Law relating to proper storage, labeling, security and accountability of medications and biologicals...facility personnel should...inspect storage areas for proper storage compliance...." 3.1-25(e)(2) 3.1-25(e)(3)		Resident 11 did not experience a negative outcome from the medication names being marked through and written over on the narcotic sheets. Narcotic counts for Ross Hall was conducted for all residents including Resident 11 on 4/26/23 with no other findings identified. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No other residents were identified in this statement of deficiency and no residents experienced a negative outcome. DON/designee completed a facility wide audit of all count sheets to ensure no existing discrepancies. None were identified. A narcotic count also completed to ensure count is accurate and that they match the count sheet. None identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Nursing/designee will provide education to licensed nurses/QMAs on the requirement to not alter pharmacy generated narcotic count sheets and how to make changes to the medical	

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			record when an error has been made. The DON/designee will complete routine auditing of new orders for controlled substances to ensure count sheets are not inappropriately altered. Any findings will be addressed. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing of new orders for controlled substances to ensure count sheets are not inappropriately altered. Any findings will be addressed. Auditing to occur: 4 controlled substance count sheets wkly x's 4 wks, then 4 controlled substance count sheets monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	

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			Compliance date: 5/24/23 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction	
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. §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 expired food was discarded, the refrigerator did not contain employee lunches and the dishwasher was washing at the recommended temperature. The deficient practice had the potential to affect 67 of 68 residents who received food from the kitchen. Findings include:	F 0812	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the	05/24/2023

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	During an observation, on 4/20/23 at 11:36 a.m., the walk-in refrigerator had a container of creamed corn and a container of cottage cheese with expiration dates of 4/17/23. The 3-door refrigerator had a yellow sack which contained the Dietary Manager's lunch. During an observation, on 4/20/23 at 11:45 a.m., the Dietary Manager (DM) started the dishwasher. She indicated the wash cycle temperature needed to be at least 160 degrees. The temperature dial on the dishwasher was stationary at 140 degrees during the wash cycle. She was given a thermometer by the [name of company] technician to place into the machine to get a temperature when the machine ran through a cycle. She placed the thermometer in the dishwasher and ran two cycles. She opened the dishwasher and removed the thermometer. The thermometer had a temperature of 123 degrees. The machine was missing two bolts at the bottom left and when the dishwasher was running water was coming out of the holes. During an interview, on 4/20/23 at 11:36 a.m., the DM indicated the container of creamed corn, and the cottage cheese was expired and should have been discarded. During an interview, on 4/20/23 at 11:53 a.m., the DM indicated the temperature on the dishwasher should be at least 160 degrees and the temp was 123 degrees when she used the thermometer. They had a technician out twice and who told the facility nothing was wrong. The dishwasher was also missing two bolts on the lower side of the dishwasher and water was coming out of the holes when the dishwasher was in use.		health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 812 Food Procurement, Store/Prepare/Serve-Sanitary** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The creamed corn and cottage cheese that were expired were discarded upon identification. The staff member's lunch which was found in the walk – in fridge was removed from the kitchen at the time of identification. The vendor for the dishwasher, Ecolab, was called into the facility the same day of identification of low temperatures. They adjusted several settings and replaced several parts which corrected the low temperatures. **How other residents have the potential to be affected by the**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	During an interview, on 4/20/23 at 2:03 p.m., the Service Employee with [name of company] indicated the dishwasher was getting up to the recommended temperature when he arrived at the facility. The temperature was 160 degrees, and it was found nothing was wrong. An Installation and Operation Manual from [name of appliance company] indicated the water requirements for the wash temperature was a minimum of 150 degrees Fahrenheit and a recommended wash temperature of 160 degrees Fahrenheit. During an interview, on 4/20/23 at 2:04 p.m., the Administrator indicated when he checked the temperature with the DM it went up to 150 degrees and did not hold at the recommended temperature. During an interview, on 4/20/23 at 2:05 p.m., the Maintenance Director indicated he could not understand why the temperature did not stay at the correct temperature. He thought it could be because they were doing laundry at the same time as running the dishwasher. During an interview, on 4/21/23 at 9:15 a.m., the Administrator indicated the dishwasher had to go through 5 cycles to get the recommended temperature. During an interview, on 4/21/23 at 9:33 a.m., the DM indicated since the dishwasher did not get up to the recommended temperature this had a potential to have bacteria left on the plates, cups and silverware which could cause the residents to become sick. A current policy, titled "Sanitation," received from		**same deficient practice will be identified and what corrective actions will be taken?** All residents had the potential to be affected by the alleged deficiencies. An audit was conducted of the kitchen to ensure there were no other expired items. An audit was conducted to ensure there were no items stored incorrectly in the kitchen. Ecolab has been out to the facility multiple times to audit the dishwasher and ensure it is reaching temperature properly. No new issues were identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** ED/designee to provide education to the dietary staff on properly storage of food and removing expired items. Education was also provided on what items can and cannot be stored in the kitchen. Facility has requested the dishwasher be replaced by the contracted leasing company. Routine auditing of the kitchen will be completed as stated below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	155402	A. BUILDING 00 B. WING	04/27/2023

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	the Administrator on 4/24/3 at 9:57 a.m., indicated "...Residents in long-term care facilities are especially vulnerable to organisms and all persons associated with the handling of food be trained in this area...Food-borne illnesses can usually be prevented by proper storage, preparation, distribution, handing and serving of food...Any food not in its original container must be labeled with the date and contents and must be securely covered...The dish machine should be clean inside and out...There is no outdated food (over 72 hours old or per manufacturer's guidelines...." 3.1-21(i)(3)		**into place?** The Dietary Manager/designee will complete routine auditing to ensure expired food is discarded. The Dietary Manager/designee will also audit to ensure there are no employee meals stored in the kitchen The Dietary Manager/designee will audit to ensure the dishwasher is reaching proper temperature. Auditing to occur: 5x daily x's 4 weeks, then then weekly for 5 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process. Compliance date: 5/24/23. The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction	
F 0921 SS=E	483.90(i) Safe/Functional/Sanitary/Comfortable Environ			

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Bldg. 00	§483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure the resident hallways and a bathroom were clean and in good repair for 2 of 4 hallways and 1 of 10 bathrooms observed for the environment. (Earhart and Ross Hall) Findings include: During an observation of the Ross Hall, on 4/20/23 at 1:49 p.m., the following was observed: 1. The beige carpet on the lower half of the wall below the handrails had several bubbled areas all throughout the hallway and appeared like the carpet was coming off the wall. 2. The carpet on the floor in the hallway was faded and worn. During an observation of the Earhart hallway, on 4/21/23 at 11:08 a.m., the following was observed: 1. The carpet on the floor in the hallway between room 11 and room 12 had a hole larger than the size of a softball. 2. The carpet on the floor in the hallway between room 5 and room 6 had two very large dark stains. 3. The carpet on the wall between room 5 and room 6 was bubbled up and coming apart from the wall. 4. The ceiling light between room 5 and room 6 had one bulb out and there was dirt and debris in the light fixture cover. 5. The bathroom of room 8 had multiple dead bugs in the windowsill. During an observation and interview, on 4/26/23 at 11:54 a.m., the Administrator indicated he had	F 0921	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 921** **Safe/Functional/Sanitary/Comfortable Environ** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The residents on Ross and Earhart hall have the potential to be affected by this alleged	05/24/2023

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	quotes for the removal of the carpet on the walls. The quotes included laminate to replace the floor carpet. He indicated he was not sure when the bathroom of room 8 was last cleaned and noted the dead bugs in the windowsill. The carpet in the hallways on the floor and wall were supposed to have been replaced last year and it was not done yet. A current policy, titled "Plant Operations-General Policy," received from the Administrator on 4/26/23 at 4:45 p.m., indicated "...A safe, clean, and structurally sound environment shall be achieved in the facility through the development and implementation of the Plant Operations Program, the development and training of personnel, and the evaluation of goals in the department to assure correlation with the goals of the facility...The maintenance and operation of all facilities, buildings, grounds, structures, plant components, utilities...internal and external lighting, and grounds are the primary responsibilities essential to the Plant Operations Program...Where authorized, all maintenance responsibilities will include...Repairs...Alterations...Minor construction...Remodeling...Facility personnel will perform all duties when feasible...Outside contractors will be utilized when necessary...." A current policy, titled "Housekeeping-General Policy," reviewed on 7/28/2022 and received from the Administrator on 4/26/23 at 4:45 p.m., indicated "...It is the responsibility of the Executive Director through the Environmental Services Director to assure that Housekeeping Policies are implemented and followed...The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for		deficiency. A scope of order has been completed and the facility has gotten bids to replace both the wall and floor carpeting. The flooring has been approved for replacement and will be replaced as soon as the replacement flooring arrives. The ceiling light between room 5 and 6 has had the bulb replaced and has been cleaned. The bathroom windowsill in room 8 has been cleaned. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents had the potential to be affected by the alleged deficiencies. The carpet in the facility has been audited with no further concerns noted. The ceiling lights in the facility have been audited with no further concerns noted. The bathroom windowsills in the facility have been audited with no further concerns noted. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** ED/designee to provide education	

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	daily living safely...." 3.1-19(f)(5)		to the Maintenance Director and Environmental Services director on maintaining a safe and sanitary environment. Routine auditing of the facility will be completed as stated below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Maintenance Director/designee will complete routine auditing to ensure carpeted areas and lighting are well maintained. The Environmental Services Director/designee will audit to ensure the resident windowsills are maintained in a clean condition. Auditing to occur: Daily x's 4 weeks, then then weekly for 5 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas	

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			of noncompliance are identified during the auditing process. Compliance date: 5/24/23 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction	