STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 21, 22, 23, 24, and 27, 2023 Facility number: 000117 Provider number: 155210 AIM number: 100266460 Census Bed Type: SNF/NF: 53 Total: 53 Census Payor Type: Medicare: 4 Medicaid: 23 Other: 26 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 30, 2023.	F 0000	Please note the Plan of Correction for our annual survey ending March 27, 2023. Submission of this plan does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept the Plan of Correction as our credible allegation of compliance. We respectfully request paper compliance.	
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, observation, and record	F 0684	It has been and will continue to be	04/21/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charlson DePrez	Regional Manager	04/13/2023

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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	review, the facility failed to appropriately assess and administer treatments for 1 of 2 residents reviewed for wounds. (Resident 37) Findings include: During an interview on 03/22/23 at 9:54 A.M., Resident 37 indicated he had some skin conditions. He had a diabetic ulcer on his foot when he came to the facility. He has had venous ulcers on his legs and his ankle. Most of the wounds were healed at this time. He went to the local wound clinic weekly. On 03/27/23 at 8:50 A.M., the resident's wounds were observed with LPN (Licensed Practical Nurse) 3. The resident indicated he had weeping wounds on both of his lower legs in the past, but they were much improved. There were some flaky areas on the residents legs but no open wounds. The dressing on the left ankle was removed. The dressing was clean, there was no odor. The wound was approximately 0.5 cm (centimeters) x (by) 0.5 cm x 0.2 cm in depth. The wound bed was pink, there were no signs of infection. The wounds on the resident's left lateral foot and heel were healed. The resident's clinical record was reviewed on 03/24/23 at 1:41 P.M. An Admission MDS (Minimum Data Set) assessment, dated 11/17/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, arthritis, dementia, and seizure disorder. The resident had a diabetic foot ulcer on admission. During an interview on 03/24/23 at 2:00 P.M., RN 2 indicated the resident was admitted to the facility with wounds on his skin, including the diabetic		the policy of this facility that residents' wounds are appropriately assessed and treated. • **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**. *Resident 37's wounds were reassessed and are currently healed, no adverse effects noted.* • **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**. *All residents have the potential to be affected by this alleged deficient practice, but no other residents were affected by this alleged deficiency after review.* • **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** *All nurses were inserviced on wound treatment and proper documentation. Wound assessments will be completed weekly and PRN, and the information will be entered into residents' clinical records upon completion of the assessment. All treatments will be administered per physician's orders.* • **How the corrective action will be monitored to**	

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	foot wound. The facility completed an initial assessment of all of the resident's skin impairments and treatment orders were in place. The resident had always gone to the wound clinic weekly, sometimes more frequently. The facility did not document weekly assessments of the wounds, they referred to the wound clinic notes for the assessments. There should be a weekly wound assessment for each week from the wound clinic in the resident's clinical record. A Wound Clinic Progress Note, dated 12/15/22, indicated the resident had a venous ulcer on his left lower extremity that measured 6 cm x 6 cm x 0.1 cm. There was a moderate amount of drainage, and the ulcer bed had exposed subcutaneous tissue. The ordered treatment would be administered every other day for two weeks. The comments section indicated the physician would be on vacation for the next two weeks. The resident would see a different physician for one visit while he was away, and he would see the resident again in three weeks. The resident demonstrated understanding. The resident's December 2022 ETAR (Electronic Treatment Administration Record) included a physician's order, with a start date of 12/17/22, to cleanse the leg wound with normal saline, apply a hydrofiber antimicrobial wound dressing, an absorbent pad, wrap with a gauze roll, and secure with tape every other day for wound treatment. The ETAR lacked documentation the treatment was administered on 12/17, 12/19, 12/21, 12/23, 12/25, 12/27, and 12/29/22. The clinical record lacked wound assessments for the weeks of December 18, 2022 and December 25, 2022.		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**. *All residents who go to wound clinic will be monitored weekly for 26 weeks by DON/designee to ensure weekly wound assessments are completed and proper documentation was entered into EMAR and treatment orders followed. Any missing assessments or treatments will be immediately corrected and with education and progressing discipline administered. Results of the audit will be presented at the QAPI meetings and if 90% or greater compliance is obtained, the committee will make a decision on continuing or discontinuing the audits.*	

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During an interview on 03/24/23 at 3:48 P.M., WCN (wound care nurse) 7 indicated the resident was seen at the wound clinic on 12/15/22, and the wounds were assessed at that time. The next time the resident was seen in the clinic was on 01/05/23. The nurse indicated they tell the facilities they need to document their own weekly wound assessments incase there were times the resident wasn't seen at the wound clinic.

A Wound Clinic Progress Note, dated 01/05/23, indicated the resident's venous ulcer of the lower leg measured 13 cm x 9 cm x 0.1 cm.

During an interview on 03/28/23 at 11:05 A.M., WCN 8 indicated the wound clinic documentation from the visit on 01/05/23 indicated a new area on the resident's left leg merged with the area that was previously measured at 6 cm x 6 cm on 12/15/22. The new area was first identified on 01/05/23, but the original wound was still there. The 13 cm x 9 cm x 0.1 cm measurement included both areas. The wounds were finally healed at this time.

The current, undated facility policy, titled "SKIN CONDITION AND PRESSURE ULCER ASSESSMENT POLICY", was provided by the Administrator on 03/27/23 at 2:23 P.M. The policy indicated, "...Pressure or other ulcers present will be documented onto the Wound Summary form and updated weekly, using the Skin Condition Report as a guide to document same...Previous skin measurements will be reviewed to ensure all locations to the assessed are identified and to analyze the healing process..."

3.1-37(a)

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to assess a resident admitted with a pressure ulcer for 1 of 1 resident reviewed for pressure ulcers. (Resident 53) Findings include: During and observation and interview on 03/22/23 at 11:28 A.M., Resident 53 was sitting in his wheelchair in his room. The resident's family member indicated he had an open area on his buttocks that he had when he was admitted to the facility from the hospital. The clinical record for Resident 53 was reviewed on 03/22/23 at 3:08 P.M. The resident's diagnoses included, but were not limited to, senile degeneration of the brain, weakness, pressure ulcer of unspecified severity, pressure ulcer of right buttock, Stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle was not exposed. Slough may	F 0686	It has been and will continue to be the policy of this facility that the residents will be assessed upon admission and readmission for pressure ulcers. • **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** *An admission assessment which included a skin assessment and Braden Scale was completed on Resident 53 on 3/23/23. Resident 53 was not adversely affected by this alleged deficient practice.* • **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.**	04/21/2023

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	be present but does not obscure the depth of tissue loss. May include undermining or tunneling), pressure ulcer of the left buttock and hypertension. A Hospital Discharge Summary, dated 03/17/23, indicated the resident had Stage 3 pressure ulcers to the right and left buttocks, and a Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) pressure ulcer to the sacral region. No measurements were listed. A Facility Admission Assessment, dated 03/17/23, was incomplete and lacked documentation of the pressure ulcers described in the hospital discharge summary. A Progress Note, dated 03/17/23 at 2:33 P.M., indicated the hospital had called and given a report on the resident. The resident had areas to the bilateral buttocks that were Stage 2 and Stage 3 pressure ulcers. A current physician's order, with a start date of 03/18/23, indicated the staff were to apply Calmoseptine ointment to the buttocks, twice a day, to protect the skin. The treatment was completed per the order. A current physician's order, with a start date of 03/19/23, indicated the staff were to apply a Mepilex (absorbent foam dressing) pad to the coccyx, every 72 hours, for an open area. The treatment was completed per the order. The clinical record lacked an assessment of the resident's pressure ulcers to the buttocks.		*All new admissions and readmissions have the potential to be affected by this alleged deficient practice. An audit was conducted for all admissions from the past 30 days to ensure the admission assessment which includes the skin assessment and the Braden Scale were completed upon admission. No other residents were affected.* • **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** *On 3/23/23, nurses that were on shift for 3/17/23 were re-educated on the importance of completing admission assessments before leaving their shift. All nurses have been inserviced on the admission assessment policy to ensure completeness of paperwork upon new resident admissions.* • **How the corrective action 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 audit/monitor all new admissions and readmissions weekly for 26 weeks to ensure completeness of skin assessments. Any missing assessments will be immediately corrected and with education and progressing discipline administered. Results of the audit*	

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	During an interview on 03/23/23 at 1:52 P.M., RN 5 indicated Resident 58 had been in the facility for about 2 weeks. He had a coccyx wound that he was admitted with, and the staff administered the treatments every 3 days. The wound wasn't deep and looked more like shearing or a skin tear. The admitting nurse would assess the wound and document it in the admission assessment/skin assessment. It would need to be documented that it was present on admission. RN 2 was the wound nurse, and she completed wound rounds once a week. During an interview on 03/23/23 at 2:45 P.M., RN 2 indicated the resident was new and she didn't know much about him. There were no measurements or assessments of the resident's wounds. The wounds should have been assessed and measured on the admission assessment. During an interview on 03/23/23 at 3:31 P.M., the DON (Director of Nursing) indicated the admission assessment was incomplete and should have been completed. The current, undated, facility policy titled, "Skin Condition and Pressure Ulcer Assessment" was provided by the Administrator on 03/24/23 at 2:26 P.M. The policy indicated, "...To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown and pressure or other ulcers and assuring interventions are implemented. To provide a system and tools to evaluate the response to medical, nursing, and dietary treatment and intervention...A Skin Condition assessment and Pressure Ulcer Risk assessment will be performed at the time of admission, quarterly and as necessary. Residents identified by the Braden Scale as being at risk of a skin breakdown will		*will be presented at the QAPI meetings and if 90% or greater compliance is obtained, the committee will make a decision on continuing or discontinuing the audits.*	

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	have a weekly skin assessment by a licensed nurse..." 3.1-40(a)(2)			
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.			

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	§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post nurse staffing daily for the survey period of 03/21/23 through 03/27/23. Findings include: During an observation on 03/21/23 at 12:52 P.M., the nurse staffing was posted at Nurse's Station 4 and was dated for 03/20/23. During an observation on 03/22/23 at 1:05 P.M., the nurse staffing was posted at Nurse's Station 4 and was dated for 03/21/23. During an observation on 03/27/23 at 1:12 P.M., the nurse staffing was posted at Nurse's Station 4 and was dated for 03/25/23. During an interview on 03/27/23 at 3:00 P.M., the MDS (Minimum Data Set) assessment Coordinator indicated the night shift nurse filled out the nurse staffing form and placed it in the picture frame at the nurse's station prior to 7:00 A.M. each morning. During an interview on 03/27/23 at 3:56 P.M., the Administrator indicated the facility had no specific policy for staff posting, they followed the federal regulations.	F 0732	It has been and will continue to be the policy of this facility that nurse staffing data is posted daily. • **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** *The facility staff posting was corrected to reflect accurate census and staffing. No resident suffered any negative outcomes as a result of this alleged deficient practice.* • **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**. *No other residents were adversely affected by this alleged deficiency.* • **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** *The night shift nurse was reeducated on accuracy and completion of staff posting requirements on 4/13/2023. Any newly hired night shift nurse will receive education on the completion of the daily staff and*	04/21/2023

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			census posting requirements. • **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**. *Staff sheets will be reviewed by the DON or designee three times a week for four weeks, then twice weekly for nine weeks, then weekly for thirteen weeks. Any omission of the daily staffing sheet will be immediately corrected and with education and progressing discipline administered. Results of the audit will be presented at the QAPI meetings and if 90% or greater compliance is obtained, the committee will make a decision on continuing or discontinuing the audits.*	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.			

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	Based on interview and record review, the facility failed to address psychological evaluation recommendations for 1 of 5 residents reviewed for unnecessary medications. (Resident 16) Findings include: Resident 16's clinical record was reviewed on 03/27/23 at 2:48 P.M. An Annual MDS (Minimum Data Set) assessment, dated 09/23/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, alcohol dependence with alcohol induced persisting dementia, anxiety, depression, and PTSD (Post Traumatic Stress Disorder). A Psychological Evaluation Report, dated 11/08/22, indicated the resident was evaluated due to a significant change/re-escalation in behavior, re-writing his family member letters with bizarre/paranoid allegations. The psychologist's recommendations included, but were not limited to: - Recent initiation of behavior therapy, given medications alone were not resolving his active/ongoing depression/anxiety. - MD may consider adding routine Buspar (a medication for anxiety) for the resident's highly active anxiety/distress. - Rule out if it would be possible for the resident's family member to offer some reassuring contact at times, even if by letter. The clinical record lacked documentation the psychologist's recommendations were addressed by the resident's physician.	F 0740	It has been and will continue to be the policy of this facility that residents psychological evaluation recommendations will be addressed for unnecessary medications. • **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** *The psychologist's recommendation for Resident 16 was addressed by the primary physician, pharmacist, and behavior management team on 4/11/2023. The MD reviewed recommendations during behavior meeting and recommended resident's buspar to be reevaluated by psychologist upon his next visit. Resident 16 suffered no ill effects from this alleged deficient practice.* • **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** *All other residents have the potential to be affected by the alleged deficient practice, but no other residents were adversely affected. All records were reviewed by behavior management team with no issues noted.* • **What measures will be put into place and what systemic changes will be made**	04/21/2023

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	During an interview on 03/27/23 at 10:59 A.M., the Social Services Director indicated she was familiar with the resident. He didn't really exhibit behaviors. He could be very isolated at times and had a history of delusional behaviors. His family member did not come to see him, she communicated with him via letters. The resident had gone through cycles with his letter writing. There would be times he didn't send any letters and then times he would send out several letters at once. She was not sure if the resident's family member responded to the resident's letters directly. She communicated with the facility if the resident indicated he needed something or if there was a concern identified from his letters. The resident was reviewed in the monthly behavior meetings and anytime there was a concern identified. The resident had consistently received anti-anxiety medication, including at the time of the psychologist's recommendation. There were no current issues. During an interview on 03/27/23 at 2:25 P.M., the MDS Coordinator indicated the facility could not provide documentation that indicated whether the psychologist's recommendation was addressed one way or another. During an interview on 03/27/23 at 2:35 P.M., the Administrator indicated once a recommendation was made, it was sent on the MD and the MD would address it. The MD should indicate if they agreed with the recommendation or not. During an interview on 03/27/23 at 3:54 P.M., the Administrator indicated they could not provide a facility policy related to psychologist recommendations. 3.1-37(a)		**to ensure that the deficient practice does not recur**. *Previously psychologist's recommendations were handwritten and left with nurse at the facility. They are now being typed and faxed for more efficient communication.* • **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** *Recommendation will be reviewed in morning meetings once received by psychologist. The Social Services Director or designee will monitor/audit any recommendations weekly for 26 weeks to ensure they are addressed timely by physician. Results of the audit will be presented at the QAPI meetings and if 90% or greater compliance in recommendations being answered within two weeks is obtained, the committee will make a decision on continuing or discontinuing the audits.*	

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	155210	A. BUILDING 00 B. WING	03/27/2023

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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 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 record review and interview, the facility failed to ensure medications were available and administered as ordered by the physician for 3 of 6 residents reviewed for medications. (Residents	F 0755	It has been and will continue to be the policy of this facility that the residents receive and are administered their medications as	04/21/2023

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	20, 38, and 16) Findings include: 1. The clinical record for Resident 20 was reviewed on 03/23/23 at 10:12 A.M. An Admission MDS (minimum data set) assessment, dated 02/10/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, non-Alzheimer's dementia, and diabetes. A physician's order, dated 02/05/23 through 02/23/23, indicated the resident was to receive Trulicity (an insulin medication), 3 mg (milligrams), once a day, on Sundays. A current physician's order, with a start date of 02/26/23, indicated the resident was to receive Trulicity, 3 mg, once a day, on Sundays. The February and March 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had not received the medication on the following dates: - 02/05/23, indicated other/see progress notes, - 02/12/23, indicated other/see progress notes, - 02/19/23, indicated absent from home without medication, - 02/26/23, indicated other/see progress notes, - 03/05/23, indicated absent from home with medication, and - 03/12/23, indicated other/see progress notes. The February and March 2023 Progress Notes, indicated the following: - On 02/05/23 at 8:27 P.M., indicated the Trulicity		ordered. • **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** *Residents 20, 38, and 16 did not have any adverse effects as a result of this alleged deficiency.* • **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** *All residents have the potential to be affected by this alleged deficient practice, but no other residents experienced adverse effects.* · **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** *An inservice was conducted for all nurses, QMAs and nursing management to review steps to be taken when a medication is marked as no supply.* *All medications that have been noted as no supply for 48 hours will be brought to the attention of the DON or designee. DON or designee will contact pharmacy to determine the reason for missing medication and when it will be expected.* *In addition, the DON/designee will ensure the physician has been*	

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	medication was not available, and the family was made aware and were to supply the medication when it was available. - On 02/12/23 at 9:25 P.M., indicated the Trulicity medication was not available. - On 02/26/23 at 10:14 P.M., indicated the Trulicity medication was not available. - On 03/05/23 at 10:38 A.M., indicated the resident had gone home overnight with his family member and the medications were sent with him. - On 03/12/23 at 10:24 P.M., indicated the Trulicity medication was not available. A physician's order, dated 02/14/23, indicated the facility may obtain Trulicity from the local hospital pharmacy if available. If greater than 14 days since last given, then the medication should be restarted at 0.75 mg weekly. The resident's clinical record lacked documentation that the Trulicity medication was restarted at the 0.75 mg dose. The resident was given 3 mg on 03/19/23. During an interview on 03/24/23 at 10:26 A.M., RN 2 indicated the local hospital had no record of dispensing Trulicity for the resident for February or March and a local pharmacy had not dispensed it since October. During an interview on 03/24/23 at 1:06 P.M., RN 2 indicated the facility pharmacy had no record of filling the resident's Trulicity medication in February, but it was filled March 1st. If the facility ordered medication, it should have been delivered to the facility within 24 hours. The medication must stay in the refrigerator and was to be administered once a week. 2. The clinical record for Resident 38 was reviewed		*contacted regarding the lack of the ordered medication(s) to determine if another suitable medication could be ordered for the resident or if an outside pharmacy could be utilized if needed.* • **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** *DON or designee will audit three times a week for four weeks, then two times a week for nine weeks, then weekly for thirteen weeks to ensure the medication delivery system is working and physician has been contacted regarding the lack of ordered medication(s) to determine if another suitable medication could be ordered for the resident or if an outside pharmacy could be utilized if needed. Results of the audit will be presented at the QAPI meetings and if 90% or greater compliance is obtained, the committee will make a decision on continuing or discontinuing the audits.*	

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	on 03/22/23 at 1:31 P.M. A Quarterly MDS assessment, dated 02/07/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's disease, anemia, hypertension, renal insufficiency, obstructive uropathy, diabetes, and anxiety. A current physician's order, with a start date of 09/14/22, indicated the staff were to administer buspirone (an anxiety medication), 7.5 mg, twice a day. The January, February, and March 2023 EMAR/ETAR was reviewed and lacked documentation the medication was administered on the following dates and times: - 01/07/23 at 6:00 A.M., - 01/09/23 through 01/11/23, at 6:00 A.M., - 01/18/23 at 6:00 A.M., - 01/19/23 at 6:00 A.M., - 01/21/23 at 6:00 A.M., - 01/23/23 at 6:00 A.M., - 01/26/23 at 6:00 A.M., - 01/27/23 at 6:00 A.M., - 02/04/23 at 6:00 A.M., - 02/14/23 at 6:00 A.M. and 4:00 P.M., - 03/03/23 at 4:00 P.M., - 03/04/23 at 6:00 A.M., - 03/06/23 at 4:00 P.M., - 03/07/23 at 6:00 A.M. and 4:00 P.M., and - 03/08/23 at 6:00 A.M. and 4:00 P.M. The January, February, and March 2023 Progress Notes indicated the following: - On 02/14/23 at 6:11 A.M., indicated the medication was on order. - On 02/14/23 at 5:19 P.M., indicated there was no			

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	supply and the pharmacy was notified. - On 03/03/23 at 4:49 P.M., indicated there was no supply. - On 03/04/23 at 9:37 A.M., indicated the medication was on order. - On 03/06/23 at 4:17 P.M., indicated there was no supply. - On 03/07/23 at 9:02 A.M., indicated the medication was on order and the facility was waiting to receive. - On 03/07/23 at 5:08 P.M., indicated the medication was on order. - On 03/08/23 at 6:49 P.M., indicated the medication was on order. During an interview on 03/24/23 at 9:39 A.M., RN 6 indicated if a medication was not available, he would check the EDK (Emergency Drug Kit) first. If the medication was not available in the EDK he would see if he could get it sent STAT (immediately) from the pharmacy. The STAT medications would arrive within a few hours. If a medication was ordered early in the day, it would usually arrive that evening. If a medication was unavailable to be given, he would notify the pharmacy and the physician. 3. Resident 16's clinical record was reviewed on 03/27/23 at 2:48 P.M. A Quarterly MDS assessment, dated 12/20/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, alcohol dependence with alcohol induced persisting dementia, anxiety, depression, hyperlipidemia, GERD (Gastroesophageal reflux disease), and hypothyroidism. A current open ended physician's order, with a start date of 06/09/22, indicated the resident was to receive lorazepam, 0.5 mg three times a day (6:00 A.M., 2:00 P.M., and 8:00 P.M.) for anxiety.			

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	The March 2023 EMAR was reviewed and indicated the resident had not received the medication on the following dates and times: - 03/05/23 at 6:00 A.M., - 03/06/23 at 6:00 A.M., - 03/07/23 at 8:00 P.M., - 03/08/23 at 6:00 A.M., - 03/10/23 at 6:00 A.M., - 03/20/23 at 6:00 A.M., - 03/21/23 at 6:00 A.M., - 03/24/23 at 6:00 A.M., and - 03/25/23 at 2:00 P.M. A current open ended order, with a start date of 01/12/23, indicated the resident was to receive metoclopramide, 5 mg before meals related to nausea. The March 2023 EMAR was reviewed and indicated the resident had not received the medication on the following dates and times: - 03/05/23 at 6:00 A.M., - 03/06/23 at 6:00 A.M., and - 03/10/23 at 6:00 A.M. A current open ended order, with a start date of 08/12/22, indicated the resident was to receive levothyroxine, 75 mcg (micrograms) one time daily for hypothyroidism. The March 2023 EMAR was reviewed and indicated the resident had not received the medication on the following dates and times: - 03/05/23 at 6:00 A.M., - 03/06/23 at 6:00 A.M., and - 03/10/23 at 6:00 A.M.			

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A current open ended order, with a start date of 12/14/22, indicated the resident was to receive omeprazole delayed release, 40 mg daily for GERD.

The March 2023 EMAR was reviewed and indicated the resident had not received the medication on the following dates and times:

- 03/05/23 at 6:00 A.M.,
- 03/06/23 at 6:00 A.M., and
- 03/10/23 at 6:00 A.M.

During an interview on 03/24/23 at 1:44 P.M., RN 2 indicated if a medication was refused or if the resident was out of the building, that should be indicated on the EMAR. There could be an indication on the EMAR to review a progress note if there was an issue. There shouldn't be blank spaces on the EMAR for medication administration.

The clinical record lacked documentation that the medications were unavailable or that the resident refused the medications.

The current facility policy titled, "Unavailable Medications", dated 12/17, was provided by the Administrator on 03/24/23 at 3:33 P.M. The policy indicated, " ...The facility must make every effort to ensure that medications are available to meet the needs of each resident ...Nursing staff shall: Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available ..."

The current, undated, facility policy titled, "Oral Medication Administration" was provided by the Administrator on 03/24/23 at 2:45 P.M. The policy

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	155210	A. BUILDING 00 B. WING	03/27/2023

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	indicated, " ...The administration of oral medications shall be dispensed in a safe manner ...Document on the MAR as appropriate ..." 3.1-25(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to administer medications related to hold parameters for 3 of 6 residents reviewed for unnecessary medications. (Residents 20, 38, and 1) Findings include:	F 0757	It has been and will continue to be the policy of this facility that all residents only receive medications within the parameters ordered by the physician. • **What corrective action will be accomplished for those residents found to have been**	04/21/2023

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	155210	A. BUILDING 00 B. WING	03/27/2023

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	1. The clinical record for Resident 20 was reviewed on 03/23/23 at 10:12 A.M. An Admission MDS (Minimum Data Set) assessment, dated 02/10/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, non-Alzheimer's dementia, and diabetes. A physician's order, dated 02/04/23 through 02/23/23, indicated the resident was to take Metoprolol (a blood pressure medication) 50 mg (milligrams), twice a day for hypertension. The medication was to be held (not given) if the systolic blood pressure was less than 110 or pulse (heart rate) less than 60. A physician's order, dated 02/23/23 through 03/23/23, indicated the resident was to take Metoprolol 50 mg, twice a day for hypertension. The medication was to be held if the systolic blood pressure was less than 110 or pulse less than 60. The February and March 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Medication Administration Record) indicated the Metoprolol medication was given when the resident's systolic blood pressure was less than 110 or the pulse was less than 60: - 02/14/23 at 8:00 A.M., the blood pressure was 105/68, - 02/16/23 at 5:00 P.M., the pulse was 58, - 02/20/23 at 5:00 P.M., the pulse was 50, - 02/21/23 at 8:00 A.M., the pulse was 54, - 02/26/23 at 5:00 P.M., the pulse was 54, - 03/01/23 at 8:00 A.M., the blood pressure was 108/73, - 03/05/23 at 8:00 A.M., the blood pressure was 99/64 and the heart rate was 56,		**affected by the deficient practice.** *No residents were adversely affected by this alleged deficient practice.* *Orders for residents 20, 38, and 1 were reviewed with a focus on medications ordered with parameters.* • **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** *All residents have the potential to be affected by this alleged deficient practice; but no adverse effects were noted.* *Vital signs were reviewed for the past 30 days for residents with med-hold parameters. Any discrepancies noted in medications administered outside the parameters were noted and the MD was notified.* · **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** *All nurses and QMAs were inserviced of the importance of holding medications according to parameters per doctor's orders.* *Education provided by sister facility to nurse management on placing parameters within emr system.* • **How the corrective**	

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	- 03/13/23 at 5:00 P.M., the pulse was 55, - 03/15/23 at 5:00 P.M., the blood pressure was 98/85, - 03/20/23 at 8:00 A.M., the pulse was 54, and - 03/21/23 at 5:00 P.M., the blood pressure was 94/51. The clinical record lacked indication the medication was held on the above dates and times. 2. The clinical record for Resident 38 was reviewed on 03/22/23 at 1:31 P.M. A Quarterly MDS assessment, dated 02/07/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's disease, anemia, hypertension, renal insufficiency, obstructive uropathy, diabetes, and anxiety. A Progress Note, dated 02/15/23 at 7:49 A.M., indicated a new physician's order was received to discontinue lisinopril and start losartan-hydrochlorothiazide 100/25 mg, once a day, and hold for a systolic blood pressure less than 140. The current physician's order, with a start date of 02/15/23, indicated the resident was to receive Losartan-Potassium, 100-25 mg, once a day, for hypertension. The order lacked indication the medication was to be held if the systolic blood pressure was less than 140. The February and March 2023 EMAR/ETAR indicated the resident received the medication every day from 02/15/23 through 03/24/23, except on 03/08/23 when the medication was held.		**action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** *DON/designee will monitor/audit two residents with blood pressure or pulse parameters three times a week for four weeks, then biweekly for nine weeks, then weekly for thirteen weeks to ensure medications administered within parameters. Any meds given outside parameters will be immediately addressed and with education and progressing discipline administered. Any issues or concerns will be monitored through QAPI process on an ongoing basis for a minimum of twenty-six weeks to track trends. If any trends are identified, then audits are to be completed on QAPI recommendations. If no trends are identified, then reviews will be completed on a PRN basis.*	

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	155210	A. BUILDING 00 B. WING	03/27/2023

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The Vitals Report for February and March 2023 indicated the resident systolic blood pressure was less than 140 on the following dates:

- 02/23/23 the blood pressure was 131/85,
- 02/24/23 the blood pressure was 134/72,
- 02/26/23 the blood pressure was 132/78,
- 03/01/23 the blood pressure the was 138/72,
- 03/02/23 the blood pressure was 138/72,
- 03/03/23 the blood pressure was 138/85,
- 03/04/23 the blood pressure was 134/88,
- 03/05/23 the blood pressure was 128/68,
- 03/06/23 the blood pressure was 130/70,
- 03/07/23 the blood pressure was 134/86,
- 03/09/23 the blood pressure was 110/66,
- 03/10/23 the blood pressure was 138/74,
- 03/11/23 the blood pressure was 134/75,
- 03/12/23 the blood pressure was 132/76,
- 03/15/23 the blood pressure was 137/88,
- 03/16/23 the blood pressure was 139/74,
- 03/17/23 the blood pressure was 137/89,
- 03/18/23 the blood pressure was 138/73,
- 03/20/23 the blood pressure was 135/77,
- 03/21/23 the blood pressure was 134/76,
- 03/22/23 the blood pressure was 136/74,
- 03/23/23 the blood pressure was 113/81, and
- 03/24/23 the blood pressure was 124/82.

The current, undated, facility policy titled, "Oral Medication Administration" was provided by the Administrator on 03/24/23 at 2:45 P.M. The policy indicated, " ...The administration of oral medications shall be dispensed in a safe manner ...Document on the MAR as appropriate ..."

The current, undated, facility policy titled, "Physician Orders" was provided by the Administrator in 03/24/23 at 3:33 P.M. The policy indicated, "...To obtain orders for care and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	treatment of resident(s) as may be necessary...Document the new order on appropriate MAR or TAR as appropriate..." 3. The clinical record for Resident 1 was reviewed on 03/24/23 at 1:48 P.M. A Significant Change MDS assessment, dated 12/30/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, diabetes, neurogenic bladder, cerebral Palsy, anxiety and depression. A physician's order, with a start date of 01/01/2023, indicated the resident was to take Metoprolol 50 mg, twice a day for hypertension. The medication was to be held if the systolic blood pressure was less than 110 or pulse less than 60. The January, February and March 2023 EMAR/ETAR indicated the Metoprolol medication was given when the resident's systolic blood pressure was less than 110 or the pulse was less than 60: - 01/01/23 at 8:00 A.M., the pulse was 52, - 01/01/23 at 5:00 P.M., the pulse was 56, - 01/02/23 at 8:00 A.M., the pulse was 56, - 01/06/23 at 8:00 A.M., the pulse was 59, - 01/14/23 at 5:00 P.M., the pulse was 56, - 01/22/23 at 8:00 A.M., the pulse was 59, - 02/15/23 at 5:00 P.M., the blood pressure was 105/60, - 02/17/23 at 5:00 P.M., the pulse 54, - 02/20/23 at 5:00 P.M., the pulse was 58, - 03/05/23 at 8:00 A.M., the pulse was 55, - 03/08/23 at 5:00 P.M., the pulse was 59, - 03/11/23 at 5:00 P.M., the pulse was 50, and - 03/14/23 at 8:00 A.M., the pulse was 57. The clinical record lacked indication the			

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	medication was held on the above dates and times. During an interview on 03/24/23 at 1:35 P.M., RN 2 indicated if parameters are written on the medication order they should be followed. The current, undated, facility policy titled, "Oral Medication Administration" was provided by the Administrator on 03/24/23 at 2:45 P.M. The policy indicated, " ...The administration of oral medications shall be dispensed in a safe manner ...Document on the MAR as appropriate ..." The current, undated, facility policy titled, "Physician Orders" was provided by the Administrator in 03/24/23 at 3:33 P.M. The policy indicated, "...To obtain orders for care and treatment of resident(s) as may be necessary...Document the new order on appropriate MAR or TAR as appropriate..." 3.1-48(a)(6)			
F 0812 SS=D 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			

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	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	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 and interview, the facility failed to store foods appropriately related to thawing meat and labeling foods for 1 of 3 kitchen observations and labeling residents' food from outside sources for 1 of 2 snack refrigerators (Unit 1) observed. Findings include: 1. The initial kitchen tour was conducted on 03/21/23 at 10:10 A.M., and the following was observed: - A two compartment deep sink had two rolls of meat laying in the bottom of the left side. The meat was not in a pan. One roll was approximately two feet long and sealed at both ends. One roll was a partial roll, approximately eight inches long, of ground beef that was open on one end and covered loosely with plastic wrap. - The walk-in freezer had a large sheet cake pan of frozen cheddar biscuits. The bottom layer of approximately 64 biscuits was covered with parchment paper, 12 biscuits were laying on top of the parchment paper uncovered. The tray was not dated or labeled. The DM (Dietary Manager) removed the tray from the freezer, threw the top layer of biscuits away and labeled the parchment paper.	F 0812	It has been and will continue to be the policy of this facility that all food provided by the facility is properly thawed and labeled. • **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** *No residents were adversely affected by this alleged deficient practice.* • **How other residents having 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 this alleged deficient practice, but no residents were found to be adversely affected. All items found in snack refrigerator that were in violation of proper storing and labeling were immediately removed and disposed of. Tray in kitchen refrigerator was dated and labeled and anything placed in it for thawing in kitchen refrigerator now includes a label and when and*	04/21/2023

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	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	During an interview, on 03/21/23, the DM indicated she did not normally place meat in the sink. She had taken the meat out of the refrigerator to cook it. When she took it out of the pan on the rack in the refrigerator it was dripping blood, so she placed it in the sink. 2. The snack refrigerator on Unit 1 was observed on 03/21/23 at 12:09 P.M., with QMA (Qualified Medication Aide) 4 and contained the following: - A gray plastic bag with three plastic containers, one with vegetable soup, one with fruit Jell-o, and one with crackers and cheese. Each container was labeled with Resident 15's name but no date, - A large plastic tub of salad with cheese, bacon bits, and cucumbers that were liquefying, with no name or date, - An unlabeled unopened can of energy drink, - An unlabeled unopened yogurt cup, - An unlabeled unopened bottle of diet soda, - An unlabeled medium size plastic tub with 1/2 of a sandwich that had a bite out of it, and - In the freezer, a small white ice pack that the QMA indicated came with refrigerated medications when delivered by the pharmacy. The ice packs were not normally kept in the freezer. The ice pack was not labeled. During an interview on 03/21/23 at 2:08 P.M., QMA 4 indicated food items brought in by families should be labeled with the resident's name and a date.		*for what meal it will be served. No more meat was brought from refrigerator and placed in sink. Any meat brought from refrigerator is used immediately.* · **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** *Kitchen staff were immediately re-educated and inserviced on proper storage, thawing and labeling of food. All staff have been re-educated and are being inserviced on storage of foods in snack refrigerator with resident name and start and end dates.* • **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** *Snack refrigerators will be monitored to ensure all items are labeled with resident name, start and end dates. Items that have reached maturity date will be removed and discarded in trash. This will be monitored three times a week for four weeks, then two times a week for nine weeks, then weekly for thirteen weeks.* *Kitchen thawing procedures will be monitored to ensure thawed items are taken from the refrigerator and immediately used. All items in kitchen refrigerator will be covered, dated, and labeled.*	

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	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	The current undated Proper Thawing of Foods Policy was provided by the Administrator on 03/22/23 at 9:25 A.M. The policy indicated, "...Food shall be thawed in a way that minimizes growth of microorganisms and is in compliance with sanitation regulations...Place food on a tray/pan with label and date. Also include what day and meal it is for..." The current undated Personal Food Items policy was provided by the DON (Director of Nursing) on 03/22/23 at 9:13 A.M. The policy indicated, "...It is the policy of this facility to properly label, store, and discard food items provided from any outside source for a resident...Items should be labeled with...Resident Name/Room Number...Date for discard..." 3.1-21(i)(3)		*Administrator or designee will monitor/audit three times a week for four weeks, then two times a week for nine weeks, then weekly for thirteen weeks.* *Any issues noted will be immediately fixed and education and progressing discipline administered. Results of the audit will be presented at the QAPI meeting for further review and action taken as appropriate and if 90% or greater compliance is obtained, the committee will make a decision on continuing or discontinuing the audits.*	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and			

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	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	(iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to offer a resident the pneumococcal	F 0883	It has been and will continue to be the policy of this facility that	04/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	vaccine for 1 of 5 residents reviewed for immunizations. (Resident 45) Findings include: The clinical record for Resident 45 was reviewed on 03/23/23 at 11:10 A.M. The Admission MDS (minimum data set) assessment, dated 2/6/23, indicated the resident's vaccine status for pneumococcal vaccine on the MDS was left blank. An Influenza/Pneumonia Vaccination Consent Form indicated the resident wanted to receive the Pneumonia Vaccine. The form was signed by the resident's POA (Power of Attorney) on 02/17/23. The resident's record lacked indication he had received the pneumonia vaccine since admission to the facility. The resident's immunization record was provided on 03/24/23 at 1:30 P.M. The record indicated the resident had last received a pneumonia vaccine on 11/13/08. During an interview on 03/23/23 at 2:57 P.M., RN 2 indicated if a resident or POA signed a vaccine consent form, the Social Service Director would obtain the vaccine records. During an interview on 03/24/23 at 1:05 P.M., RN 2 indicated if the resident was eligible for the vaccine, such as pneumonia, the facility ordered it from their pharmacy and it would arrive within a few days. The resident would then get the vaccine in the facility. If the resident was over 65 they were eligible for the pneumonia vaccine. During an interview on 03/24/23 at 10:32 A.M., the Social Service Director indicated she had sent an email this morning about getting the resident's		residents are offer and receive the pneumococcal vaccine if desired. • **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** *Resident 45 was assessed and offered the Pneumonia vaccine. Prevnar 20 was administered on 4/4/2023.* • **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** *All residents have the potential to be affected by the alleged deficient practice. There were no adverse events and no cases of pneumonia diagnosed for any resident who had not received their pneumonia vaccine. There was an audit conducted on 4/2/23 to assess any residents who were eligible for the Pneumovac. All residents are up to date on their Pneumovac if consent has been given.* • **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**. *Social Services has been educated on bringing vaccine concerns to morning meetings for review.* *The admissions coordinator will*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	records for his vaccine status. She would usually notify them right away about getting the record. T During an interview on 03/24/23 at 1:51 P.M., RN 2 indicated the resident should have been offered and given the vaccine if it had been signed for and requested on admission to the facility. The current facility policy titled, "Influenza/Pneumococcal Vaccination Program", with a revised date of 04/07/14, was provided by the Administrator on 03/21/23 at 11:30 A.M. The policy indicated, "...Pneumococcal pneumonia is the most frequent cause of secondary bacterial pneumonia following influenza infection. Unless contraindicated pneumococcal vaccine is strongly recommended for all person over 65 years of age and should receive a second dose of vaccine if more than 5 years have passed since their initial vaccination AND their age was less than 65 years at the time of the initial vaccination..." 3.1-18(b)		*notify the ADON of the preference (consent or declination) of the COVID vaccination or booster at the time of admission. New admissions will be reviewed at the morning meeting for to assure the resident consent or declination of the COVID vaccine or booster is communicated.* *Any new admission will be assessed for the need for the pneumovac and if the resident or POA gives consent for the pneumovac, it will be administered within 7 days of admission to facility.* • **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** *New admissions will be monitored by the DON or designee for the need for pneumovac weekly for 26 weeks to ensure receiving vaccination if desired. Results of the audit will be presented at the QAPI meetings and if 90% or greater compliance is obtained, the committee will make a decision on continuing or discontinuing the audits.*	
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical			

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	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on interview and record review, the facility failed to offer a resident the COVID-19 vaccine or booster for 1 of 5 residents reviewed for immunizations. (Resident 45) Findings include: The clinical record for Resident 45 was reviewed on 03/23/23 at 11:10 A.M. The resident's Admission MDS (minimum data set) assessment was dated 2/6/23. A COVID-19 Vaccine or Booster Consent form indicated the resident wanted to receive the COVID-19 vaccine booster. The form was signed by the resident's POA (Power of Attorney) on 02/17/23. The resident's record lacked indication he had received the COVID-19 vaccine booster since admission to the facility. The resident's immunization record was provided on 03/24/23 at 1:30 P.M. The record indicated the resident had received the COVID-19 vaccine on 02/22/21, 03/22/21, and 11/24/21. During an interview on 03/23/23 at 2:28 P.M., RN 2	F 0887	It has been and will continue to be the policy of this facility that the residents are offered and receive the Covid-19 vaccine if so desired. • **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** *Resident 45 was assessed and the COVID vaccine was administered on 4/4/23 per resident wishes.* • **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** *All residents have the potential to be affected by this alleged deficient practice, but no other residents were found to be adversely affected. An audit was conducted on 4/3/23 to ensure all residents are up to date on their*	04/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	indicated the facility offered for residents and staff to get the COVID-19 vaccine and the easiest way to give them was to have a clinic because they could administer more at one time. If a resident was admitted and wanted the vaccine, the facility would arrange for them to get it somewhere else like a local pharmacy, the health department, or hospital. During an interview on 03/23/23 at 2:57 P.M., RN 2 indicated if a resident or POA signed a vaccine consent form, the Social Service Director would obtain the vaccine records. During an interview on 03/24/23 at 10:32 A.M., the Social Service Director indicated she had sent an email this morning about getting the resident's records for his vaccine status. She would usually notify them right away about getting the record. During an interview on 03/24/23 at 1:51 P.M., RN 2 indicated the resident should have been offered and given the vaccine if it was signed for on admission to the facility. The current facility policy titled, "SARS V-2 COVID-19 VACCINE", and dated 05/25/21, was provided but the Administrator on 03/21/23 at 11:30 A.M. The policy indicated, "...In an effort to protect residents, employees and the community, it is the policy of the facility that all residents and employees will be offered the COVID-19 vaccine...All residents should be offered opportunities to receive COVID-19 immunization..." 3.1-18(b)		*COVID vaccine if consent was given. No additional concerns were noted. COVID vaccinations were administered to those residents who were eligible on 4/4/2023.* • **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** *Any new admission will be assessed for the need for the pneumovac and if the resident or POA gives consent for the pneumovac, it will be administered within 7 days of admission to facility.* *The admissions coordinator will notify ADON of the preference (consent or declination) of the COVID vaccination or booster at the time of admission. New admissions will be reviewed at the morning meeting to ensure the resident consent or declination of the COVID vaccine or booster is communicated.* *Social Services has been educated on bringing vaccine concents to morning meetings for review.* • **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** *New admissions will be monitored by the DON or designee for the*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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			need for Covid-19 weekly for 26 weeks to ensure receiving vaccination if desired. Results of the audit will be presented at the QAPI meetings and if 90% or greater compliance is obtained, the committee will make a decision on continuing or discontinuing the audits.	