STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155022	A. BUILDING 00 B. WING	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00388818, IN00390109 and IN00390677. Complaint IN00388818 - Substantiated. Federal/state deficiency related to the allegations is cited at F580. Complaint IN00390109 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00390677 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: September 21, 22 and 23, 2022 Facility number: 000009 Provider number: 155022 AIM number: 100274760 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 3 Medicaid: 46 Other: 11 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on September 28, 2022	F 0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because is required by the provisions of Federal and State Law. Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask for your consideration for paper compliance.	

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

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F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, interview and record review, the facility failed to ensure privacy and dignity were provided during resident care for 1 of 1 residents receiving diabetic care. (Resident F) Findings include: During a meal observation on 9-22-22 at 11:52 a.m., in the main dining room, LPN 3 was observed to obtain a blood sample for a blood sugar test from Resident F. She was then observed to return to her medication cart, look at some paperwork, draw up an unspecified amount of a clear liquid from a medication bottle into a syringe and return to Resident F and inject the clear liquid into the arm of Resident F. At the time of these events, there were 21 other residents and 5 other staff in the main dining room. In an interview at this time with LPN 3, she indicated she always tries to get blood sugars and insulins completed for each resident requiring such, prior to the resident being in dining room, but did not have that opportunity to do so that morning. She indicated she was not sure what the facility's policy regarding this is currently. The clinical record of Resident F was reviewed on 9-23-22 at 9:56 a.m. Her diagnoses included, but	F 0557	**F557 Respect, dignity/Right to have personal property** **What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** LPN was observed obtaining blood sample for a blood sugar test from resident F. The LPN then returned to resident after drawing up clear liquid from a medication vial. She then injected the liquid into the resident's arm. LPN was educated on need for dignity and need to give injections and blood samples in a private area. There was no actual harm to the resident. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All diabetic residents that require blood sugars and insulin have potential to be affected by the	10/14/2022

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	were not limited to diabetes and polyneuropathy. Her physician orders included, but were not limited to, Humalog insulin, 100 units per milliliter, to administer a sliding scale of this insulin subcutaneously (under the skin) twice daily for diabetes, based upon her blood sugar results. The sliding scale indicated to administer the following: 70 to 79, give 13 units; 80 to 150, give 14 units; 151 to 200, give 15 units; 201 to 250, give 16 units; 251 to 300, give 17 units; 301 to 350, give 18 units; 351 to 400 units, give 19 units; 401 to 450, give 20 units, 451 to 500, give 21 units; 501 to 600, give 22 units. An additional order indicated to notify the physician for any blood sugar results less than 70 or greater than 350. The accompanying medication administration record (MAR) indicated Resident F's blood sugar for the noon meal at 11:52 a.m. was 257 and she received 17 units of the Humalog insulin. In an interview with the Director of Nursing on 9-23-22 at 1:10 p.m., she indicated she was unable to locate a policy related to obtaining blood sugars or giving insulins in the dining room. She indicated her expectation is the staff would conduct those activities in the resident's room or other private area of the facility. 3.1-3(o) 3.1-3(p)(2)		alleged deficient practice. All nurses will be educated on need for privacy when obtaining blood samples and giving insulin injections. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur.** The DON or designee will educate nurses on or before 10/14/2022 regarding dignity and need for privacy when obtaining blood samples or giving insulin injections. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** DON or designee will do dining room audits 5 times weekly for 2 weeks, biweekly for 6 weeks, and weekly for 4 months to ensure privacy when obtaining blood samples and giving insulin injections. Any identified trends will be corrected upon discover, documented on facility QA tool and reported during QA committee meeting overseen by the HFA.	
F 0580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.)			

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Bldg. 00	§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).			

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	§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify the attending physician and/or nurse practitioner of a resident's change in condition promptly, contributing to a hospitalization of the resident for 1 of 3 residents reviewed for resident assessment. (Resident D) Findings include: The clinical record of Resident D was reviewed on 9-22-22 at 12:52 p.m. Her diagnoses included, but were not limited to chronic diastolic congestive heart failure, unspecified right bundle-branch block (cardiac electrical anomaly), hypertension, functional quadriplegia, iron-deficiency anemia, localized edema, lymphedema, mild cognitive impairment of uncertain or unknown etiology, peripheral vascular disease, protein-calorie malnutrition and recent Covid-19. A review of Resident D's progress notes indicated she had tested positive for Covid-19 on 7-26-22. Review of her nutritional notes indicated the facility had concerns for her nutritional status since admission on 5-27-22, due to limited oral intake, limited weight loss, edema of her lower extremities and her multiple co-morbidities. A review of a quarterly Minimum Data Set (MDS) assessment, dated 7-27-22, indicated she was severely cognitively impaired, was unable to walk,	F 0580	**F580 Notify of Changes (Injury/Decline/Room, etc.)** **What corrective action (s) will be accomplished for those residents found to be affected by the deficient practice?** Resident D who had multiple comorbidities as well as recent covid-19 had been in declining health since admission. During a review of the provider's note it indicated that resident appeared dehydrated, confused and drowsy. In the provider's note she reported having spoke to a nurse who stated that the resident had been like this for a few days but that nothing had been reported to the provider. In the facility documentation there was no evidence that the resident had had a decline or change in condition over the past few days and that the resident did in fact have a change on 8/8/2022 when the resident was seen by the provider. The provider gave orders at that time, however, the family wanted resident to be sent to the hospital.	10/14/2022

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	used a wheelchair for mobility and required extensive assistance of 1 person with eating and was dependent of the remainder of her activities of daily living, such as turning and repositioning, bathing, hygiene and toileting. It indicated she was incontinent of bowel and bladder. A review of a Nurse Practitioner's note, dated, 8-8-22, indicated the resident appeared dehydrated, confused and drowsy. "Nurse reports patient has been like this for a few days--nothing has been reported to provider." A review of the facility's nursing notes for the past 3 days indicated there were no nursing notations on 8-7-22; the 8-6-22 notes reflected the resident had recovered from her Covid-19 diagnosis and was moved back to her original room and had developed an open area to her mid-back area. There was an absence of nursing progress notes for 8-5-22 and 8-4-22. The facility's "Nursing-Skilled Covid," note dated 8-6-22 at 3:08 a.m., indicated Resident D was alert and oriented to person, place, time and situation; was afebrile, was dependent for any transfers from one location to another, bed mobility, dressing and toileting. It indicated she was incontinent of bladder and her lungs were clear without a cough and without any shortness of breath and was without pain. It did not indicate if the resident had any loss of appetite, taste or smell, had any fatigue, general body aches or edema. A "Nursing-Skilled Covid," note dated 8-5-22 at 12:20 a.m., indicated all of the same, with the exception of identification of edema, located to her left hand and arm and chronic gross lymphedema to the bilateral lower extremity and mild pitting edema. A "Nursing-Skilled Covid," note dated 8-5-22 at 11:46 p.m., indicated Resident D was alert		The resident was sent per family request and provider's order. **How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility have potential to be affected by the alleged deficient practice. 100% audit of nursing progress notes were conducted on 10/4/2022 from past 5 days. No findings were found at time of audit. **What measures will be put into place or what systemic changes will be made to ensure deficient practice does not occur?** The DON or designee will educate staff on or before 10/14/2022 regarding the need to notify a provider of change of condition of a resident. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON or designee will do progress note audits 5 times weekly for 2 weeks, biweekly for 6 weeks, and weekly for 4 months to ensure any change of condition is reported to the provider.	

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	and oriented to person, place, time and situation; was afebrile, was dependent for any transfers from one location to another, bed mobility, dressing and toileting. It indicated she was incontinent of bladder and her lungs were clear without a cough and without any shortness of breath and was without pain. It did not indicate if the resident had any loss of appetite, taste or smell, had any fatigue or edema. Additional notes, entitled, "Nursing-Daily Covid-19 Monitoring" note, dated 8-6-22 at 11:02 p.m. and 8-7-22 at 11:06 p.m., indicated Resident D remained afebrile, had clear lungs and did not require supplemental oxygen and was experiencing no signs or symptoms of Covid-19. These notes did not specify any changes in mental acuity, food or fluid intake or edema. In an interview with the Nurse Practitioner (NP 4) on 9-23-22 at 8:50 a.m., she indicated she came into the facility to conduct a visit with Resident D on Monday, 8-8-22. She indicated she had a new concern of dehydration that date when she saw the resident. She described Resident D as having a very dry tongue, oral cavity and lips, resulting in her stopping the resident's diuretic and ordering stat (immediate) blood work and urinalysis. She also indicated Resident D had a history of significant lower extremity edema, but it had worsened with the resident's lower legs now weeping. She indicated she would have expected the staff to call either her or the on-call staff over the weekend to update them on the resident's status. In an interview with LPN 3 on 9-23-22 at 1:40 p.m., she indicated she had taken care of Resident D on the day she was sent out to the hospital and in the days prior. LPN 3 recalled in the days prior to		Any identified trends will be corrected upon discover, documented on facility QA tool and reported during QA committee meeting overseen by the HFA.	

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	her going to the hospital on 8-8-22, Resident D had been very anxious and had significant edema of her lower extremities. She recalled it was not unusual for her to be anxious and calling out. "So, I tried to spend extra time with her, especially when she was in isolation for Covid-19. I would sit and talk with her and try to keep her company. Even when she was lying down, she would call out and would say she was afraid of falling or if she was sitting up in the chair, she would call out and tell you she wanted to sit down to keep from falling. But it seemed like her anxiety was worse than usual. She wasn't eating or drinking much at all, even less than normal for her. Her swelling of her lower legs and feet and toes was pretty bad, actually worse than it normally was." LPN 3 indicated she did not notify the Nurse Practitioner (NP) of these things in the days prior to the NP coming in to see Resident D on 8-8-22. LPN 3 did indicate she did notify Resident 3's family on 8-8-22, after the NP had written new orders, and the family member elected to have Resident D sent to the local hospital. On 9-23-22 at 1:55 p.m., the Director of Nursing provided a copy of a policy entitled, "Change in Resident's Condition or Status," with a policy date of 11-28-2016. This policy indicated, "It is the policy of the facility that if a change in condition or status of a Resident occurs, the attending physician, the resident and the resident's representative will be promptly notified. A change may include, but is not limited to, a medical/mental condition change and/or status change (level of care, billing or payments or resident rights). The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician if:... A significant change in the resident's physical/emotional/mental condition; A need to			

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	alter the resident's medical treatment significantly...Except in medical emergencies, notification will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status...The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status." This Federal tag relates to Complaint IN00388818. 3.1-5(a)(2)			