This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00283242.

Complaint IN00283242 - Substantiated. No deficiencies related to the allegations are cited.

Survey dates: February 1, 4, 5, 6, 7, 8, 11 and 12, 2019.

Facility number: 000038
Provider number: 155095
AIM number: 100274830

Census Bed Type:
- SNF/NF: 141
- SNF: 22
- Total: 163

Census Payor Type:
- Medicare: 10
- Medicaid: 114
- Other: 39
- Total: 163

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed February 15, 2019.

483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Tmsfr
§483.15(d) Notice of bed-hold policy and return-
§483.15(d)(1) Notice before transfer. Before a

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.
nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-

(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;

(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;

(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and

(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

Based on interview and record review, the facility failed to ensure a Bed Hold policy was provided on transfer for 4 of 5 residents reviewed with transfers. (Resident 116, Resident 142, Resident 92, Resident 24)

Findings include:

1. A review of Resident 116's record on 2/7/2019 at 4:14 p.m., indicated they had a BIMS (Basic Interview for Mental Status) score of 5 out of 15, meaning the resident had severe cognitive impairment. Diagnoses included, but were not limited to: heart disease, dementia, osteoporosis,
An Emergency Resident Transfer Form, dated 1/1/2019 at 12:01 p.m., indicated Resident 116 was transferred to a local acute care hospital for evaluation and treatment for right hip pain. The section, Resident Representative Notification, indicated yes (box checked) that the Bed Hold Policy was provided to the resident and the resident representative. The documentation had not indicated a name of the representative that was provided the Bed Hold Policy.

During an interview on 2/8/2019 at 10:47 p.m., Nurse 11 indicated the facility has ready made packets of paperwork to be completed for a transfer, and that the facility just sends the paperwork with the resident.

2. A review of Resident 142's record on 2/8/2019 at 4:56 p.m., indicated the resident had a BIMS score of 5 out of 15, meaning they had severe cognitive impairment. Diagnoses included, but were not limited to: Alzheimer's disease, blood clots, seizures, high blood pressure, and anxiety.

An Emergency Resident Transfer Form, dated 8/9/2018 at 5:03 p.m., indicated Resident 142 was transferred to a local area acute care hospital for abnormal x-ray results. The Notice of Discharge/Transfer and Bedhold form box was checked yes, but did not indicate to whom it had been provided.

A Progress Note, dated 8/9/2018 at 9:16 p.m., indicated the paperwork, including the Bed Hold policy had been put in the transfer packet.

A Progress Note, dated 8/31/2018 at 9:30 a.m., indicated Resident 142 had been transferred by

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What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:

- Resident 116:
  A bed hold policy was sent to the resident's representative with an explanation regarding reason for paperwork.

- Resident 142:
  A bed hold policy was sent to the resident's representative with an explanation regarding reason for paperwork.

- Resident 92:
  A bed hold policy was given to the resident's representative with an explanation regarding reason for paperwork.

- Resident 24:
  A bed hold policy was sent to the resident's representative with an explanation regarding reason for paperwork.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

- Residents residing in the facility being transferred to the hospital or taking a therapeutic leave have the potential to be affected.

- No other residents were found to have been affected by the alleged deficient practice.

- It is this facility's practice to provide and explain the Bed Hold Policy.
Statement of Deficiencies and Plan of Correction

Name of Provider or Supplier: Heritage Park

Identification Number: 155095

Street Address, City, State, Zip Code: 2001 Hobson Rd, Fort Wayne, IN 46805

Date Survey Completed: 02/12/2019

Summary Statement of Deficiency:

An Emergency Resident Transfer Form, dated 11/29/2018 at 4:32 p.m., indicated Resident 142 was transferred to a local acute care hospital for an abnormal venous doppler (test for blood clots). The Notice of Discharge/Transfer and Bedhold form box was checked yes, but did not indicate to whom it had been provided.

During an interview on 2/8/2019 at 10:47 p.m., Nurse 11 indicated the facility has ready made packets of paperwork to be completed for a transfer. Nurse 11 provided a copy for review. Nurse 11 further indicated documentation of the transfer was to be completed in the EHR (Electronic Health Record), under the Observation section. Furthermore, the transfer paper packets were to be copied and filed in the resident's paper chart and/or medical records, and the original copies were to be sent with the resident.

During an interview on 2/8/2019 at 2 p.m., the DNS (Director of Nursing Services) indicated copies of the Transfer papers were not kept for the clinical record.

3. On 2/8/19 at 3:00 p.m., the record of Resident 92 was reviewed. Diagnoses included, but were not limited to, the following: type 2 diabetes with diabetic chronic kidney disease and congestive heart failure.

A significant change MDS, dated 10/13/18, indicated the resident was alert and interviewable.

A progress note, dated 11/14/18 at 4:48 p.m.,
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**IDENTIFICATION NUMBER**

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<tr>
<th>X1) PROVIDER/SUPPLIER/CLIA AGENCY NAME</th>
<th>X2) MULTIPLE CONSTRUCTION A. BUILDING</th>
<th>X3) DATE SURVEY COMPLETED</th>
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<tr>
<td>PROVIDER/SUPPLIER/CLIA</td>
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<td><strong>NAME OF PROVIDER OR SUPPLIER</strong></td>
<td><strong>STREET ADDRESS, CITY, STATE, ZIP COD</strong></td>
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<td>HERITAGE PARK</td>
<td>2001 HOBSON RD FORT WAYNE, IN 46805</td>
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**STATEMENT OF DEFICIENCY**

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**SUMMARY STATEMENT OF DEFICIENCY**

- indicated the resident had been sent to the emergency room, report had been called and the bed hold policy had been sent.

- On 2/12/19 at 1:57 p.m., the DNS was interviewed. She indicated the documentation in the progress note, dated 11/14/18 at 4:48 p.m., of the bed hold policy having been sent, indicated the bed hold policy had been sent to the hospital with the packet, but not to the resident or their representative. The DNS also indicated the family did not want a copy of the bedhold when they were notified of this transfer on 11/14/18.

- An Observation Detail List Report/Emergency Resident Transfer Form, dated 11/14/18 at 3:43 p.m. included the following: send to (name of hospital); date and time of transfer: 11/14/18 at 4 p.m.; reason for transfer: possible abd (abdominal) infection. The form indicated the resident representative had been notified of the resident’s condition, the reason for the transfer and the location of transfer. The form indicated the name of the representative who had been notified. The form indicated the Bed Hold policy and right to appeal had been explained to the resident or resident representative and the representative did not request to receive the Bed Hold Policy and Right to Appeal Transfer documents in writing.

- The Bed Hold Policy, which was included in the Observation Detail List Report included, but was not limited to, the information the residents will be provided the Bed Hold Policy at the time of the hospital transfer and the resident's representative will be informed of the bed hold policy at the time of notification of the transfer. The policy also indicated the resident representative would be provided a copy of the bed hold policy upon request and the facility staff will document the notification to the resident and the resident phone call explaining the Bed Hold Policy and relaying the Bed Hold will be mailed to them.

- The Medical Records Department has been educated on the Bed Hold Policy. Education includes but is not limited to timely mailing out of the Bed Hold Policy as well as required documentation expectations in the resident’s medical record reflecting who/when the Bed Hold Policy was sent via USPS.

- Education provided by facility Clinical Education Co-ordinator on March 4, 2019.

**What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:**

- It is this facility’s practice to provide and explain the Bed Hold Policy to new admissions and the resident representative at the time of admission. The resident representative is provided a copy of the Bed Hold policy at this time.

- The Bed Hold Policy is provided to the resident at the time of transfer or leaving facility for therapeutic leave. If the resident’s responsible party is at the facility at the time the resident is leaving the premises a copy of the Bed Hold Policy is provided to them. If the resident’s responsible party is not at the facility they are notified via phone call from facility staff of the resident leaving the facility.
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- Representative of the bed hold policy on the Emergency Resident Transfer form. A note dated 11/14/18 at 4:48 p.m. on this form indicated the resident had been sent to the emergency room, report called, bed hold policy sent and the family had been notified.

4. On 2/8/19 at 11:30 a.m., the record of Resident 24 was reviewed. Diagnoses included, but were not limited to, the following: aphasia, dysphagia, chronic obstructive pulmonary disease, cerebral infarction and generalized anxiety disorder.

An admission MDS (minimum data set) assessment, dated 1/15/19, indicated the resident had severe cognitive impairment.

An Event Report form dated 2/4/19 at 2:26 p.m., included, but was not limited to, the following: mental status was lethargic and based on assessment, the bedside clinician concludes: increased lethargy, decreased blood pressure.

A progress note, dated 2/4/19 at 2:54 p.m., included, but was not limited to, the following: Resident had a change in condition this shift, increased lethargy, decreased blood pressure. Nurse Practitioner notified. Family notified.

A progress note, dated 2/4/19 at 4:40 p.m., included the following: New order to send to (name of hospital) per son (name of son).

A progress note, dated 2/5/19 at 6:21 a.m., included the following: this writer called (name of hospital) for update and resident was being admitted for UTI (urinary tract infection).

An Observation Detail List Report/Emergency Resident Transfer Form, dated 2/4/19 at 4:36 p.m., explaining the Bed Hold Policy and informing them the facility will be mailing a copy to their address on file via USPS.

- The Medical Records Department is notified of the transfer utilizing the daily Matrix Admission/Discharge Report. Medical Records is responsible to send the Bed Hold Policy to the resident representative if the responsible party is not in the facility to receive a copy at time of transfer.

- Education has been provided to the Licensed Staff in the facility. Education includes but is not limited to the explanation of the Bed Hold Policy and requirement to provide a copy to the resident and their responsible party. If the resident’s responsible party is not in the facility- they are notified via phone call explaining the Bed Hold Policy and relaying the Bed Hold will be mailed to them.

- The Medical Records Department has been educated on the Bed Hold Policy. Education includes but is not limited to timely mailing out of the Bed Hold Policy as well as required documentation expectations in the resident’s medical record reflecting who/when the Bed Hold Policy was sent via USPS.

- Education provided by facility Clinical Education Co-ordinator on March 4, 2019.
indicated the following: Send to (name of hospital) ER (emergency room) for eval (evaluation) and treat; reason for transfer was decreased LOC (level of consciousness) and decreased blood pressure. The Resident Representative Notification portion of the form included the following: the resident representative had been notified of the resident's condition, reason for transfer and the location of transfer. The name of the resident representative notified (name of family member notified) was documented. Also documented on the form was the Transfer Form and Bed Hold Policy had been provided to the resident and the resident representative (if applicable). The Bed Hold Policy was included in the Observation Detail List Report and included, but was not limited to, the following: the residents will be provided the Bed Hold Policy at the time of the hospital transfer; the Resident's Representative will be informed of the bed hold policy at the time of notification of the transfer; the Resident Representative will be provided a copy of the bed hold policy and the facility staff will document the notification to the resident and the resident representative of the bed hold policy on the Emergency Resident Transfer form.

On 2/04/19 at 4:55 p.m., Resident 24 was observed to leave the facility transported by (name of ambulance service).

On 2/8/19 at 3:49 p.m., the DNS and LPN 2 were interviewed. They indicated the following: when a resident was transferred to the hospital, they send a copy of the bed hold policy as part of the hard copies sent to the hospital. LPN 2 indicated when the facility called the resident representative to inform them of the resident's transfer to the hospital, the facility lets the resident representative notification portion of the form included the following: the resident representative had been notified of the resident's condition, reason for transfer and the location of transfer. The name of the resident representative notified (name of family member notified) was documented. Also documented on the form was the Transfer Form and Bed Hold Policy had been provided to the resident and the resident representative (if applicable). The Bed Hold Policy was included in the Observation Detail List Report and included, but was not limited to, the following: the residents will be provided the Bed Hold Policy at the time of the hospital transfer; the Resident's Representative will be informed of the bed hold policy at the time of notification of the transfer; the Resident Representative will be provided a copy of the bed hold policy and the facility staff will document the notification to the resident and the resident representative of the bed hold policy on the Emergency Resident Transfer form.

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How will the corrective action(s) be monitored to ensure the deficient practice will not recur:

- A QAPI Monitoring Tool titled "Bed Hold Policy Notification" will be utilized every week x 4, monthly x 6 and quarterly thereafter.
- Data will be submitted to the QAPI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed
- Non-compliance with facility procedure may result in disciplinary action up to and including termination.
representative know they have a hard copy of the bed hold information and ask the resident representative if they want a copy. LPN 2 indicated if the resident representative request a copy of the bed hold, the facility will provide them a copy. LPN 2 indicated she had told Resident 24's resident representative he could have a copy of the bed hold if he wanted one but he did not want a copy. LPN 2 indicated she did not mail the resident representative a copy of the bed hold policy. LPN 2 indicated when she checked the box "yes" for the comment pertaining to the Transfer form and Bed Hold Policy having been provided to the resident and the resident representative (if applicable), this was where she documented she had asked the resident representative if he wanted a copy of the bed hold policy. LPN 2 indicated she had not actually provided a copy of the bed hold policy to the resident representative, she had asked him if he wanted a copy.

On 2/12/19 at 1:57 p.m., the DNS (Director of Nursing Service) provided a copy of the Observation Detail List Report/Emergency Resident Transfer Form dated 2/4/19. The DNS was interviewed regarding the portion of the form which referenced the Transfer Form and Bed Hold Policy having been provided to the resident and the resident representative. This portion of the form had been check "yes." The DNS indicated the documentation indicated the Transfer Form and Bed Hold Policy had been sent with the resident to the hospital. The DNS indicated the transferring nurse had indicated when she notified the family member of the resident's transfer to the hospital, the family member indicated he did not want a copy of the Bed Hold Policy.

On 2/11/19 at 3:44 p.m., a current copy of the
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| 155095 | A. BUILDING | 00 | Facility policy and procedure for Bed Hold was received from the DNS (Director of Nursing Service). The policy and procedure was dated revised 1/2019 and included, but was not limited to, the following: the purpose of policy was to provide guidance to facility staff for holding a bed during a resident transfer. The bed hold policy will be distributed at the time of admission, in the admission packet. The residents will be provided the bed hold policy at the time of the hospital transfer or therapeutic leave. The Resident's Representative will be informed of the bed hold policy at the time of notification of the transfer. The Resident's Representative will be provided a copy of the bed hold policy. The facility staff will document the notification to the resident and resident representative of the bed hold policy on the Emergency Transfer Form. | 3.1-12(a)(25)(26) | F 0644 | SS=E | Bldg. 00 | Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual}
disability, or a related condition for level II resident review upon a significant change in status assessment.

Based on interview, and record review, the facility failed to ensure residents were referred for a PASRR (Preadmission Screening and Resident Review) Level II evaluation for 3 of 4 residents reviewed for Level II evaluation. (Resident 51, Resident 75, Resident 113)

Findings include:

1. A review of Resident 51's record on 2/6/2019 at 12:33 p.m., indicated the resident had a BIMS (Brief Interview of Mental Status) score of 3 out of 15, meaning the resident had severe cognitive impairment. Diagnoses included, but were not limited to: stroke, dementia, depression, and delusional disorder.

   A Physician's Order, dated 5/11/2017, indicated Resident 51 may receive psych services.

   A review of the MDS Annual assessment, dated 8/29/2018, indicated the following: Section A1500 the resident was checked as not currently considered by the State Level II PASRR process to not have a serious mental illness, Section A1510 was not checked for a Level II Pre Admission Screening & Resident Review (PASRR) Conditions, and Section I had an active diagnosis of depression and psychotic disorder.

   A Care Plan for behaviors and the diagnosis of delusional disorder, was initiated and was dated 2/19/2018.

   The facility did not submit for a Level II screening after mental illness diagnoses were added.

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It is the practice of this facility to ensure residents are referred for a PASRR Level II evaluation when newly diagnosed with a serious mental disorder, intellectual disability or a related condition.

This provider respectfully requests a face-to-face Informal Dispute Resolution opportunity to discuss this citation. This provider disagrees with the scope and severity of this citation.

However; based on the alleged deficient practice the following has been implemented:

**What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:**

- Resident #51:
  Resident was referred during Annual Survey. Park Center notified facility this was an inappropriate referral.

- Resident #75:
  Resident was referred during Annual Survey. Park Center notified facility this was an inappropriate referral.

- Resident #113:
  Resident was referred during Annual Survey. Park Center notified facility this was an inappropriate referral.

- Resident #3:
A review of Resident 75's record on 2/5/2019 at 4:33 p.m., indicated a BIMS of 99, meaning the resident has severe cognitive impairment and was unable to complete the assessment. Diagnoses included, but were not limited to: lung disease, heart disease, dementia with behaviors, mood disorder, anxiety, and unspecified psychosis.


A review of the MDS (Minimum Data Set) quarterly assessment, dated 1/8/2019, indicated, but was not limited to a diagnosis of psychotic disorder.

A review of the MDS quarterly assessment, dated 7/25/2018, indicated, but was not limited to diagnoses of anxiety, depression, and psychotic disorder.

A review of the MDS annual assessment, dated 5/9/2018, indicated, but was not limited to diagnoses of anxiety, depression, and psychotic disorder. Also, the Section's A1500 and A1510 were checked no.

A review of the Face Sheet indicated a diagnoses list and the following diagnoses were added: unspecified psychosis, dated 3/19/2013, pseudobulbar affect (involuntary laughing and crying due to a nervous system disorder), dated 9/11/2013, unspecified mood disorder, dated 5/10/2018, and persistent mood disorder, 5/11/2018.

A Care Plan for behaviors and the diagnosis of non-organic psychosis, was initiated and was dated 12/4/2015.

2. This resident’s Level II was most recently updated March 2018. This was determined to be an inappropriate referral by Park Center.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

- Resident's newly diagnosed with a serious mental disorder, intellectual disability or a related condition and not referred for a Level II evaluation have the potential to be affected by the alleged deficient practice.
- No other residents were found to have been affected by the alleged deficient practice.
- Residents residing in the facility have been audited. Those with a new serious mental disorder, intellectual disability or a related condition diagnosed after implementation of ASCEND in July 2016 have had a request submitted to Park Center for a Level II Referral.
- Residents are reviewed per the MDS Schedule for a significant change and new diagnosis. If a resident has been newly diagnosed with a serious mental disorder, intellectual disability or a related condition; a request for Level II Referral is submitted to Park Center.
- The facility Social Services Department has been re-educated.
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<td>The facility did not submit for a Level II screening after mental illness diagnoses were added.</td>
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<td>on the expectations of submitting requests for new Level II Referral thru Park Center. Education includes but is not limited to participation in the ASCEND Webinar March 6, 2019. Education provided by the Home Office ASC Social Service Consultant March 6, 2019. The Social Service Department has been provided the new ASCEND Policy and Procedure manual dated 2017 for reference. <strong>What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:</strong>&lt;br&gt;- Residents are reviewed per the MDS Schedule for a significant change and new diagnosis. If a resident has been newly diagnosed with a serious mental disorder, intellectual disability or a related condition; a request for Level II Referral is submitted to Park Center. &lt;br&gt;- The facility Social Services Department has been re-educated on the expectations of submitting requests for new Level II Referrals thru Park Center. Education includes but is not limited to participation in the ASCEND Webinar March 6, 2019. Education provided by the Home Office ASC Social Service Consultant March 6, 2019.</td>
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<td>3. A review of Resident 113's record on 2/5/2019 at 2:26 p.m., indicated a BIMS (Brief Interview of Mental Status) score of 3 out of 13, meaning the resident had severe cognitive impairment. Diagnoses included, but were not limited to: Parkinson's disease, dementia with behaviors, and delusional disorder.</td>
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<td>The facility did not submit for a Level II screening after mental illness diagnoses were added.</td>
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<td>A Physician's Order indicated Resident 113 may receive psych services, dated 10/26/2019.</td>
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<td>The facility did not submit for a Level II screening after mental illness diagnoses were added.</td>
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<td>A Physician's Order indicated Resident 113 received quetiapine (an antipsychotic medication) 50 mg (milligrams) every day at bedtime for a delusional disorder, dated 4/16/2019.</td>
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<td>The facility did not submit for a Level II screening after mental illness diagnoses were added.</td>
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<td>The MDS annual assessment, dated 8/22/2018, indicated a no was checked on Section's A1500 and A1510. Also, Section I indicated an active diagnosis of Psychotic disorder.</td>
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<td>The facility did not submit for a Level II screening after mental illness diagnoses were added.</td>
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<td>A Care Plan, revised on 12/26/2018, indicated Resident 113 utilizes psychotropic medications due to hallucinations which cause aggressive behaviors towards others.</td>
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<td>The facility did not submit for a Level II screening after mental illness diagnoses were added.</td>
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<td>During an interview on 2/8/2019 at 3:50 p.m., the SSD (Social Service Director) 4, indicated Resident 51, Resident 75, and Resident 113 should have had a Level II completed when there was a change, and she would look for them.</td>
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<td>The facility did not submit for a Level II screening after mental illness diagnoses were added.</td>
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<td>During an interview on 2/8/2019 at 4:02 p.m., the SSD 4 indicated the Level II's had not been completed for the resident's listed above.</td>
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<td>The facility did not submit for a Level II screening after mental illness diagnoses were added.</td>
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<td>The Indiana, dated 2016, PASRR Level I &amp; LOC</td>
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<td>The facility did not submit for a Level II screening after mental illness diagnoses were added.</td>
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**Heritage Park**

**Heritage Park**

**Statement of Deficiencies and Plan of Correction**

**Identification Number:** 155095

**Date Survey Completed:** 02/12/2019

**Name of Provider or Supplier:** Heritage Park

**Street Address, City, State, Zip Code:** 2001 Hobson Rd

**Fort Wayne, IN 46805**

**Summary Statement of Deficiency:**

- **Prefix:** F 0658
- **Tag:** SS=D Bldg. 00

Provider Policy & Procedures indicated the following: "...Mental status change referrals must be submitted within 14 days of the significant change event. Examples of a mental status change event include: A new mental health diagnosis that is not listed on previous/initial LI or LII. A newly prescribed psychotropic medication for mental illness. For PASRR purposes, a psychotropic medication for a medical condition (ie regulating sleep, appetite, etc) does not trigger a new Level I or need for a Level II. A significant increase in or newly exhibited mental health symptoms (depression, anxiety, hallucinations, refusal to eat, etc)..."

A current facility policy, PASRR Policy, dated 11/2017, provided by the DNS (Director of Nursing Services) on 2/11/2019 at 10:11 a.m., indicated the following: "...PASRR assessments are updated with significant changes in mental or physical status. 3. Any resident with an Intellectual, Mental Disability or related condition will be referred to the designated mental health or intellectual disability authority with a significant change in mental or physical status..."

**Regulatory or LSC Identifying Information**

- **Prefix:** F 0658
- **Tag:** F658

**Provider’s Plan of Correction:**

- The Social Services Director is responsible for oversight.

**How will the corrective action(s) be monitored to ensure the deficient practice will not recur:**

- A QAPI Monitoring Tool titled “Level II Submission” will be utilized every week x 4, monthly x 6 and quarterly thereafter.
- Data will be submitted to the QAPI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed.
- Non-compliance with facility procedure may result in disciplinary action up to and including termination.

**Services Provided Meet Professional Standards**

§483.21(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quality.

Based on observation, interview and record review, the facility failed to ensure manufacturer's instructions were followed for devices used for 1 of 1 resident's observed during medication pass. (Resident 50)

**F 0658**

**F 0658**

**03/12/2019**

**Facility ID:** 000038

**Event ID:** KYT711

**If continuation sheet:** Page 13 of 25

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**Event ID:** KYT711

**Facility ID:** 000038

**If continuation sheet:** Page 13 of 25
Findings include:

On 2/5/19 at 4:21 p.m. RN 1 was observed to prepare to obtain a glucometer check from Resident 50. RN 1 was observed to go to Resident 50's room, inserted the glucose strip into the glucometer and indicated it was not working properly. RN indicated he would get a brand new glucometer to use. At 4:38 p.m., RN 1 was then observed to obtain a new glucometer from the supply room. RN 1 was observed to remove the new glucometer from the box and cleanse it with a bleach wipe. The new glucometer was not observed to have been calibrated. At 4:43 p.m., RN was observed to performed the glucometer check on resident 50. The result of the glucometer check was 166 mg/dl (milligrams/deciliter). RN 1 indicated the resident had a blood sugar check ordered at this time to check her blood sugar. RN 1 indicated the amount of insulin the resident received at this time, was a standing order and not a sliding scale insulin order.

On 2/5/19 at 4:47 p.m., RN 1 was observed to dial the Humalog insulin pen to 2 units as he indicated he needed to prime the insulin pen. RN 1 was then observed to dial the pen to a dose of 20 units of humalog insulin. RN 1 was observed to place the insulin pen against the resident's skin and activated the insulin pen. RN 1 was observed to remove the insulin pen from the resident's skin within 4 seconds.

On 2/5/19 at 4:55 p.m., RN 1 was interviewed. He indicated he did not hold the insulin pen against the resident's skin for a specific amount of time. RN 1 indicated he did not count to ensure the pen is held against the skin a specific amount of time. He indicated he holds the insulin pen against the skin just long enough to make sure the insulin is implemented:

What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:

- Resident 50: The glucometer was calibrated and found to be within an acceptable range for accuracy. The resident's blood sugar was checked an hour after the Humalog Quick Pen insulin administration with an appropriate reduction in mg/dl noted reflecting the resident received the therapeutic dose of insulin.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

- Residents residing in the facility with a diagnosis of Diabetes requiring insulin administration via Insulin Pen or requiring glucometer blood sugar monitoring have the potential to be affected.
- No other residents were found to have been affected by the alleged deficient practice.
- Licensed Nurses have been re-educated on Glucose Meter calibration as well as Insulin Pen insulin administration. Education included but is not limited to when a glucose meter is to be calibrated, steps required to administer insulin via an insulin pen and the acceptable timeframe.
On 2/5/19 at 4:48 p.m., RN 1 was interviewed regarding the use of the control solution test prior to the first use of the new glucometer. He indicated he was not sure if he should use the control solution test prior to the first time use of a new glucometer. He indicated the 3rd shift staff used the control solution test on the glucometers.

On 2/5/19 at 4:59 p.m., the DNS (Director of Nursing Service) was made aware RN 1 was not observed to have used the control solution test on the new glucometer prior to use on Resident 50 on 2/5/19 at 4:43 p.m.

On 2/6/19 at 8:10 a.m. the physician orders for Resident 50 were reviewed and indicated the following: Diabetic orders (10/11/18): accucheck (blood sugar check) as needed for signs and symptoms of hypo/hyperglycemia. 10/24/18: Diabetic orders: accu check before meals and at bedtime. Special Instructions: notify physician if accu check is below 60 or greater than 400; 11/19/18: Humalog (name of insulin pen) subcutaneous three times a day.

On 2/6/19 at 8:10 a.m. the DNS was interviewed. She indicated the facility did not have a policy and procedure for insulin pens.

On 2/6/19 at 10:03 a.m., the DNS provided a copy of the manufacturer's instructions User's guide for the (name of glucometer), dated 1/2016. The Control Solution Testing information indicated the purpose of the control solution testing was to validate the (name of glucometer) was working properly with the test strips. The information also indicated the control solution test should be performed when the glucometer was used for the to hold the insulin pen against the resident's skin to ensure the appropriate dose is administered. Licensed Nurses performed return demonstrations for calibrating blood glucose meters as well as return demonstrations for administering insulin via an insulin pen.

Education provided February 27, 2019 by the Clinical Education Co-ordinator.

Licensed Staff are observed weekly to ensure compliance with glucometer calibration and Insulin Pen insulin administration. Observation is conducted by the Clinical Education Co-ordinator/Designee

What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:

- Licensed Nurses have been re-educated on Glucose Meter calibration as well as Insulin Pen insulin administration. Education included but is not limited to when a glucose meter is to be calibrated, steps required to administer insulin via an insulin pen and the acceptable timeframe to hold the insulin pen against the resident's skin to ensure the appropriate dose is administered.

- Licensed Nurses performed return demonstrations for calibrating meters as well as return demonstrations for
On 2/12/19 at 12:40 p.m., the DNS was interviewed. She indicated when the facility does not have a policy and procedure for the insulin pen administration, the facility follows the Skills Validation form for insulin pens.

On 2/12/19 at 12:40 p.m., a Skills Validation form was provided as 12:40 p.m. on 2/12/19 for Insulin Pen Administration. The Skills Validation form included, but was not limited to, the following:
- Wait 5-10 seconds while keeping insulin pen needle in place, to ensure all insulin is given.

3.1-35(g)(1)

How will the corrective action(s) be monitored to ensure the deficient practice will not recur:
- QAPI Monitoring Tools titled “Blood Glucose Calibration” and “Insulin Pen Administration” will be utilized every week x 4, monthly x 6 and quarterly thereafter.
- Data will be submitted to the QAPI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed.
- Non-compliance with facility procedure may result in disciplinary action up to and including termination.
comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv) When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be
Based on observation, interview and record review, the facility failed to follow infection control procedures for 2 of 3 residents who were on transmission based precautions. (Resident 31 and Resident 74)

Findings include:

1. The record review for Resident 31 began on 2-7-2019 at 3:56 p.m. Diagnoses included but were not limited to, diabetes with neuropathy, spastic hemiplegia affecting right dominant side, hypertension, atrial fibrillation, congestive heart failure, history of falls, and terminal stage Alzheimer's disease. Resident 74 had diagnoses including but were not limited to diabetes with neuropathy, arterial insufficiency, spastic hemiplegia affecting left hand, right foot, and left leg.

It is the practice of this facility to ensure the facility follows infection control procedures for residents on transmission-based precautions. However; based on the alleged deficient practice the following has been implemented:

What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice:

- Resident #31:
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### IDENTIFICATION NUMBER
155095

### BUILDING WING
A. 00  
B. 

### DATE SURVEY COMPLETED
02/12/2019

### NAME OF PROVIDER OR SUPPLIER
HERITAGE PARK

### ADDRESS
2001 HOBSON RD
FORT WAYNE, IN 46805

### ID PREFIX TAG

### SUMMARY STATEMENT OF DEFICIENCY

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This resident is no longer in isolation
- Resident #74: This resident is no longer in isolation

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:
- Residents residing in the facility with a communicable disease or infectious agent requiring isolation have the potential to be affected.
- No other residents were found to have been affected by the alleged deficient practice.
- Staff have been re-educated on the facility Infection Control Program regarding the expectations for preventing the spread of infections. Education included but is not limited to signage used on doors to identify active isolation precautions, application and removal of personal protective equipment, disposal/removal of items from the room, disinfecting objects and proper handwashing. Education provided by the Clinical Education Co-ordinator by Feb 28, 2019.

What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:
- Staff have been re-educated on the facility Infection Control Program regarding the

### Failure, Cerebral Infarction, Cerebrovascular Disease, Pain in Left Leg, Pain in Right Foot, and Pseudomonas (Aeruginosa) (Bacteria) as the Cause of Diseases Classified Elsewhere RLE (Right Lower Extremity) Wound.

The most recent quarterly MDS (Minimum Data Set) assessment for Resident 31 dated 1-8-2019, indicated a BIMS (Brief Interview for Mental Status) was 12/15 (moderate cognitive impairment). The resident required and extensive assist of 2 for bed mobility, transfers, and toileting. Walking room/corridor did not occur. The resident required an extensive assist of 1 for locomotion on/off unit, dressing, and personal hygiene, and a limited assist of 1 for eating. Resident 31 required the total dependence of 2 persons for bathing. The resident had impairment on one side of upper and lower extremity and used a wheel chair. The assessment indicated Resident 31 did not have a pressure ulcer, but an open lesion other than ulcers, rashes, and cuts was marked. Application of nonsurgical dressing and ointment/medications other than to feet was also marked.

The most current physician orders for temperature every shift and contact isolation related to Pseudomonas aeruginosa for Resident 31 were dated 1-28-2019.

A review of the last 14 days of the 2019 TAR (Treatment Administration History) for Resident 31 indicated nursing initialed each shift for the order temp (temperature) q (every) shift and contact isolation r/t (related to) Pseudomonas aeruginosa from evening shift 1-28-2019 through day shift 2-3-2019.

A copy of the lab culture for the right lower extremity is no longer in isolation.
- Resident #74: This resident is no longer in isolation
EXTREMITY WOUND:

An extremity wound for Resident 31 was dated Final 1-26-2019. The report indicated 2+ light growth of Pseudomonas aeruginosa, 2+ light growth of Escherichia coli, 4+ abundant growth Corynebacterium species and 3+ moderate growth of Proteus mirabilis (all bacteria).

A care plan for the need for isolation related to Pseudomonas aeruginosa in the RLE wound was initiated on 1-24-2019 and discontinued on 2-5-2019 indicated to follow facility's Infection Control policies/procedures when cleaning/disinfecting room, handling soiled and/or contaminated linen, disinfecting equipment, isolation precautions were marked contact and to utilize guidelines for Transmission-Based Precautions.

During an observation of Resident 31's room on 2-1-2019 at 11:07 a.m., a sign on the Resident 3's room door indicated to see the nurse, a picture of a gown and gloves and use handwashing or sanitizer. CNA 6 (Certified Nurse Assistant) was observed in the room and was observed to bring a trash bag out of the room and placed it in the trash cart. The CNA was not observed to have donned or removed any of the personal protective equipment or washed his hands or used hand sanitizer after disposing of the trash. An interview at this time with CNA 6, indicated he was new and not aware of anything about the sign on Resident 31's door.

An interview with CNA 7 on 2-1-2019 at 11:08 a.m., indicated she was the CNA caring for Resident 31. CNA 7 indicated the resident was not in isolation anymore and the gown or gloves did not have to be worn.
An interview with Nurse 8 on 2-1-2019 at 11:09 a.m., indicated Resident 31 had Pseudomonas aeruginosa in her outer right lower leg wound and remained on contact isolation.

An observation of the Resident 31's room indicated personal protective equipment of gowns and gloves were hanging in a bin on the back of the door.

2. The record review for Resident 74 began on 2-11-2019 at 3:07 p.m. Diagnoses included but were not limited to, complete traumatic amputation of left midfoot, acute osteomyelitis of left ankle and foot, nontraumatic intracranial hemorrhage, hemiplegia affecting unspecified side, diabetes with diabetic polyneuropathy, peripheral vascular disease, and acquired absence of right great toe.

A review of the most recent current physician orders for Resident 74 indicated on 1-14-2019 an order for contact isolation secondary to MRSA (Methicillin Resistant Staphylococcus aureus, a difficult to treat bacterial infection) to wound L (left) foot was implemented. An end date to this order was 2-20-2019.

A review of the last 29 days of the TAR documentation for Resident 74 indicated on 1-14-2019 second shift nursing initials were marked for the order contact isolation secondary to MRSA wound L (left) foot. Nursing initials on the TAR were entered each shift on the TAR through 2-11-2019 day shift, when the form was printed and provided by the ADNS on 2-11-2019 at 3:07 p.m.

A review of the care plan for isolation related to
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**HERITAGE PARK**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2001 HOBSON RD

FORT WAYNE, IN 46805

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

155095

**MULTIPLE CONSTRUCTION**

A. BUILDING 00

B. WING

**DATE SURVEY COMPLETED**

02/12/2019

**NAME OF PROVIDER OR SUPPLIER**

HERITAGE PARK

**SUMMARY STATEMENT OF DEFICIENCY**

(MRSA for Resident 74 indicated the problem start date was 1-14-2019. The approaches indicated to follow facility's Infection Control policies/procedures when cleaning/disinfecting room, handling soiled and/or contaminated linen, disinfecting equipment, isolation precautions were marked contact and to utilize guidelines for Transmission-Based Precautions)

During an observation of the 900 hall on 2-6-2019 at 9:42 a.m., Resident 74's door had a sign which had a picture of a gown, gloves, handwashing and sanitizer and to see the nurse. An interview at this time with Nurse 9, indicated Resident 74 had a history of MRSA in the left foot and had an opened wound on that foot.

An observation of Resident 74's room on 2-6-2019 at 9:47 a.m., indicated Nurse 9 entered the room and was not observed to don a gown or gloves. Nurse 9 assisted Resident 74 with his breakfast set up. Nurse 9 was observed to obtain his breakfast plate from the refrigerator, covered it with a tissue and carried the plate to the kitchen area in the 900 hall. Nurse 9 was not observed to wash her hands or use hand sanitizer prior to carrying the plate to the kitchen. Nurse 9 was observed to carry the plate with a dome cover back to the room and entered Resident 74's room without donning the gown or gloves. She was then observed to don gloves and assisted the resident with his food prep. Nurse 9 was observed to remove the gloves and wash her hands. An interview at this time with Nurse 9 indicated, she would wear the gown and gloves for any extreme patient care and gave examples such as a linen change or treatment to the left foot or right shin. Nurse 9 indicated most of the time she used just the gloves, because the foot was wrapped with dry clean dressing and the
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

**MULTIPLE CONSTRUCTION**

A. BUILDING  00

B. WING

**DATE SURVEY COMPLETED**

02/12/2019

**NAME OF PROVIDER OR SUPPLIER**

HERITAGE PARK

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2001 HOBSON RD

FORT WAYNE, IN 46805

**SUMMARY STATEMENT OF DEFICIENCY**

**PREFIX**

ID

**TAG**

PREFIX

**REGULATORY OR LSC IDENTIFYING INFORMATION**

**PROVIDER'S PLAN OF CORRECTION**

**COMPLETION DATE**

MRSA was contained.

An interview with the ADNS (Assistant Director of Nursing Services), who was also the Infection Control Nurse, on 2-11-2019 at 1:11 p.m., indicated there were 3 residents in the building on contact isolation during the survey period with one more resident added this date for contact precautions. She indicated for residents on contact precautions, staff entering the room would follow those precautions and wear the gloves and a gown.

An interview with the ADNS and the CEC (Clinical Education Coordinator), who was the previous Infection Control Nurse, on 2-11-2019 at 2:19 p.m., indicated for staff entering a room with a contact precaution order and sign on the door, staff would don the appropriate personal protective equipment. Both the ADNS and the CED indicated entering the room to assist the resident or touching objects in the room, would require the use of the gown and gloves for contact precautions. Further interview with both the ADNS and the CEC, indicated entering a contact isolation room to collect trash or to set up a meal tray for a resident would require the staff to don a gown and gloves. The ADNS and the CEC indicated staff cannot choose which personal protective equipment to use or not to use, when a resident was in contact isolation. Both the ADNS and CEC indicated the gown and gloves should be donned and worn when entering a contact isolation room, even if the staff would only be touching surfaces in the room.

A current policy, "Isolation/Transmission-Based Precautions" last reviewed date of March 2018 was provided by the ADNS and the CEC on 2-11-2019 at 2:20 p.m. The policy indicated "...the
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facility shall utilize the appropriate infection prevention and control precaution guidelines based on the type and duration of isolation, depending on the infectious agent or organism involved...CONTACT PRECAUTION...refers to measures intended to prevent transmission of infectious agents by direct or indirect contact either with the resident or with the resident's environment...Post a "Please, See Nurse" sign on the resident door...Use of Personal Protective Equipment - Gown and Gloves: applies to anyone entering the room who may touch the resident or objects in the room should wear PPE...perform hand hygiene prior to entering the room and before leaving the room...put on gown upon entry to room...gown protects clothing from potential contamination from direct contact with resident, environmental surfaces or equipment...remove gown, ensure that clothing or skin do not contact potentially contaminated areas...Gloves...maintain standard precautions...wear gloves whenever touching resident's skin or surfaces close to the resident...remove gloves...perform hand hygiene..."

3.1-18(a)  
3.1-18(B)  
3.1-18(B)(1)

This visit was for a State Residential Licensure Survey.

Survey dates: February 11 and 12, 2019

Facility number: 000038

Residential Census: 36
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<th>X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</th>
<th>X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</th>
<th>X3) DATE SURVEY COMPLETED</th>
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<td>STRENGTH ADDRESS, CITY, STATE, ZIP CODE</td>
<td>DATE SURVEY COMPLETED</td>
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<td>HERITAGE PARK FORT WAYNE, IN 46805</td>
<td>02/12/2019</td>
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<td>ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</td>
<td>(X5) COMPLETION DATE</td>
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<td>Heritage Park Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</td>
<td>Quality review completed February 13, 2019.</td>
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State Form Event ID: KYT711 Facility ID: 000038 If continuation sheet Page 25 of 25