STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: August 8, 2024 Facility number: 014377 Residential Census: 121 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 21, 2024.	R 0000	The creation of this plan of correction constitutes this provider's written compliance for the alleged deficiencies cited. The submission of this plan of correction is not an admission of nor agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Heritage Woods of Newburgh respectfully requests consideration for a desk review (paper compliance) of this plan of correction.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on record review and interview, the facility failed to ensure QMAs (Qualified Medication Aide) had a current and valid license to work in the facility for 1 of 14 QMAs reviewed for licensure. (QMA 7) Finding includes: On 8/8/24 at 2:36 P.M. employee records were reviewed. QMA 7's license expired on 7/20/24. She was hired on 11/14/23. On 8/8/24 at 3:15 P.M., the Director of Nursing (DON) indicated she was aware that QMA 7's license was expired and that QMA 7 was not supposed to be working with an expired license. She further indicated she was the one responsible for ensuring licenses remained current and valid.	R 0123	**1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** 1.No residents experienced adverse effects from the alleged deficient practice. **1.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** 1.All residents that reside in the facility had the potential to be affected by the alleged deficient	09/05/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samuel Creel	Executive Director	09/05/2024

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	At that time, the DON provided dates QMA 7 worked with an expired license. QMA 7 worked as a QMA on 7/28/24, 8/1/24, 8/2/24, 8/4/24, 8/5/24, and 8/6/24. On 8/8/24 at 3:41 P.M., the DON provided a current Personnel Records - Update policy, effective 1/2022, that indicated "All Employees are expected to notify the community of any changes in personal information to include...licensure...".		practice. DON or designee will provide an in-service to all Licensed Professionals regarding current licensure and expiration dates. BOM or designee will monitor for upcoming license expiration and renewal dates. Employees found to be out of compliance with proper processes and procedures will receive additional education and possible corrective action. **1.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** 1.DON or designee will provide an in-service to all Licensed Professionals regarding current licensure and expiration dates. BOM or designee will monitor for upcoming license expiration and renewal dates. Any clinical staff member out of compliance with facility's policies and protocols relating to expired licensure will receive progressive corrective action. **1.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:** 1.The Director of Nursing, BOM	

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			or designee will audit all licenses monthly on an ongoing basis. Results to be reviewed at monthly QAPI meetings and make further recommendations based off audit results. **1.By what date will the systematic changes be completed** 1.Education and in-service will be provided to all licensed staff by 9/5/2024.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on observation, interview, and record review, the facility failed to ensure residents that were self-administering medications were assessed for capability to self-administer medications for 5 of 10 residents reviewed for self administration of medication. (Resident 4, Resident 9, Resident 11, Resident 12, Resident 6) Findings include: 1. On 8/8/24 at 8:30 A.M., a tube of Betamethasone Cream was observed on Resident 4's bathroom sink. On 8/8/24 at 2:05 P.M., Resident 4's clinical record was reviewed. Physician orders included, but were not limited to: Betamethasone Val 0.1%CRM (Cream) (Steroid) 45 GM (Grams). Apply to affected areas twice daily dated 1/31/24. The clinical record lacked an assessment for	R 0216	**1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** 1.No residents experienced adverse effects from the alleged deficient practice. **1.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** 1.All residents that self-administer medications had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all Nurses on properly	09/05/2024

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	self-administration of medications and a physicians order to self administer medications.. 2. On 8/8/24 at 9:00 A.M., a tube of Aspercreme Cream was observed on Resident 9's bathroom sink. On 8/8/24 at 3:31 P.M., Resident 9's clinical record was reviewed. Physician orders included, but were not limited to: Aspercreme 10% (Pain Relief) 141 GM Apply topically to right lower lateral chest wall 3 times daily dated 6/19/24 The clinical record lacked an assessment for self administration of medications and a physician order to self administer medications. 3. On 8/8/24 at 10:09 A.M., a bottle of stool softener and a bottle of ibuprofen was observed sitting on a table next to Resident 11's chair. On 8/8/24 at 2:50 P.M., Resident 11's clinic record was reviewed. The clinical record lacked orders for the stool softener and ibuprofen. The clinical record lacked an assessment for self administration of medications and a physicians order to self administer medications. 4. On 8/8/24 at 10:15 A.M., a bottle of Fluticasone Spray was observed on Resident's 12 bedside nightstand. On 28/8/24 at 3:31 P.M., Resident 12's clinical record was reviewed. Physician orders included, but were not limited to, Fluticasone propionate 50 MCG (Micrograms) (Steroid Spray). Instill 1 spray into each nostril twice daily in the AM and at bedtime dated		assessing and care planning residents that have been found to have capacity to give their meds independently. Employees found to be out of compliance with proper processes and procedures will receive additional education and possible corrective action. **1.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** 1.Nursing personnel will be in-serviced on self-medication assessment and care planning related to residents that self-administer their own medications no later than **09/05/2024**. Any clinical staff member out of compliance with facility's policies and protocols relating to self-medication administration will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to assessing and care planning those residents found to have capacity to self-administer medications, during employee job-specific orientation moving forward. **1.How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	7/24/24. The clinical record lacked an assessment for self administration of medications and a physicians order to self administer medications. 5. On 8/8/24 at 10:10 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but was not limited to, chronic kidney disease, hypertension, diabetes mellitus, and borderline personality disorder. Physician orders included, but were not limited to: Alendronate 70 milligrams (mg) - Take one tablet by mouth every week with 8 ounces (oz) water, dated 7/7/22 Buspirone 30 mg - Take one tablet by mouth twice a day, dated 7/7/22 Carvedilol 6.25 mg - Take one tablet by mouth twice daily, dated 5/3/21 Vitamin B12 1000 micrograms (mcg) - Take one tablet by mouth once daily, dated 5/3/21 Duloxetine 60 mg - Take one capsule by mouth every evening, dated 5/3/21 Folic acid 1 mg - Take one tablet by mouth once daily, dated 5/3/21 Gemfibrozil 600 mg - Take one tablet by mouth twice daily before meals, dated 7/7/22 Hydrocodone acetaminophen 5-325 mg - Take one tablet by mouth four times daily as needed, dated 2/6/24 Tresiba U-200 Flex - Inject 75 units subcutaneously at bedtime, dated 9/27/21 Humalog 100 U/ml (units per milliliter) Kwik Pen - Inject 3 times daily per sliding scale: 100-150=0U; 151-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U; <70 or >400 call MD (medical doctor), dated 5/12/21 Humalog 100 U/ml Kwik Pen - Inject subcutaneously 18 units 3 times a day with meals, dated 7/7/22		**recur, i.e what quality assurance program will be put into place:** 1.The Director of Nursing or designee will audit care plans two times per month for two months, then one time a month for twelve months, and then as needed to ensure that self-administration assessments are obtained and recorded. Results to be reviewed at monthly QAPI meetings and make further recommendations based off audit results. **1.By what date will the systematic changes be completed** 1.Education and in-service will be provided to all clinical staff by 9/5/2024.	

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	Victoza 3-pen 18 mg/3 ml - Inject 0.3 ml subcutaneously once daily, dated 8/3/22 Losartan 25 mg - Take one tablet by mouth once daily, dated 7/31/23 Meloxicam 7.5 mg - Take one tablet by mouth once daily, dated 1/4/24 Modafinil 200 mg - Take one tablet by mouth once daily, dated 1/4/24 Prednisolone 1% eye drop - Instill one drop into the right eye four times a day, dated 1/17/24 Quetiapine 400 mg - Take one tablet by mouth at bedtime, dated 5/10/21 Rosuvastatin 10 mg - Take one tablet by mouth at bedtime, dated 5/3/21 Tizanidine 4 mg - Take one tablet by mouth three times daily as needed for muscle spasm, dated 9/15/22 Vitamin B6 50 mg - Take two tablets by mouth daily, dated 7/18/23 The clinical record lacked an assessment for self administration of medications and physicians order to self administer medications. On 8/8/24 at 11:00 A.M., the Director of Nursing (DON) indicated Resident 6 administered her own medication but did not have an assessment for self administration of medication because she refused to take it. On 8/8/24 at 3:20 P.M., Resident 6 indicated she self administered her own medication and staff had never offered to give her an evaluation on whether she was capable to do so. On 8/8/24 at 1:30 P.M., the DON indicated if a resident has an administer notification for the staff to give medication there should be no medications left at the bedside. On 8/8/24 at 11:30 A.M., the Administrator			

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	provided a current "Medication Management, Administration, and Storage (Indiana and Ohio Only)" policy, revised 1/2024, that indicated "The Director of Nursing, or licensed nurse designee, will assess the resident's ability to self-administer daily medications utilizing the Self-Medication Assessment. The assessment will determine what level of assistance, if any, is needed by the resident. Medication set-up and storage protocol will be implemented based on the assessment outcome. The medication assessment will be reviewed biannually as part of the review process, and episodically with any significant change in condition or as level of service indicate".			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were signed by residents for 4 of 8 residents reviewed for service plans. (Resident 2, Resident 4, Resident 6, and Resident 7) Findings include: 1. On 8/8/24 at 1:33 P.M., Resident 7's clinical record was reviewed. Resident 7 was admitted to the facility on 3/28/24. The most current Resident service Plan, dated 3/28/24, was not signed by the resident. 2. On 8/8/24 at 10:10 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted to the facility on 5/5/21. The most current Resident service Plan, dated 4/26/24, was not signed by the resident. 3. On 8/8/24 at 2:05 P.M., Resident 4's clinical record was reviewed. The most current Resident Service Plan, dated 5/20/24, lacked a signature	R 0217	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** 1.No residents experienced adverse effects from the alleged deficient practice. **1.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** 1.All residents had the potential to be affected by the alleged deficient practice. DON and/or designee will ensure the resident service plans are reviewed and	09/05/2024

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	from the resident. 4. On 8/9/24 at 11:22 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 1/19/21. The most recent Resident Service Plan documented in the clinical record, initially dated 1/19/21 and most recently dated 5/31/24, lacked a signature from Resident 2. On 8/8/24 at 11:00 A.M., the Director of Nursing (DON) indicated nurses went over services plans with the residents and had them sign on an iPad after they were reviewed. If the resident was unavailable while the nurse was rounding, the nurse may have forgotten to go back to review the service plan with the resident and get them to sign it. She further indicated that signed service plans could not be found for some of the residents. On 8/8/24 at 3:41 P.M., the DON provided a current Service Plans policy, revised 6/2022, that indicated "the agreed upon service plan shall be signed and dated by the resident...".		signed by the resident, in a timely manner. Licensed clinical staff will be educated on obtaining signatures on resident service plans during the admission process or upon reassessment. **1.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** 1.DON and/or designee will ensure the resident service plans are reviewed and signed by the resident, in a timely manner. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward. **1.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;** 1.This process will be reviewed by ED/designee on a monthly basis for six months and as needed thereafter as part of the QAPI process.	

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			2.Results will be reviewed as part of the QAPI process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QAPI team and reviewed as needed until resolved. **1.By what date the systemic changes will be completed;** 1. Education and in-service will be provided to all clinical staff by 9/5/2024.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure that medications were administered according to standard practices of care. Insulin was given without the pen being primed (get out air bubbles) before administering the insulin to a resident for 1 of 1 residents observed during insulin administration. (Resident 10) Finding includes: On 8/8/24 at 10:27 A.M., QMA (Qualified Medication Aide) 11 was observed preparing an insulin pen for Resident 10. Resident 10 received a total of 7 units for a blood sugar of 151. They failed to prime the Humalog Insulin KwikPen with 2 units of insulin prior to administering insulin to Resident 10. On 8/8/24 at 11:30 A.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.	R 0247	**1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. No residents experienced adverse effects from the alleged deficient practice. **1.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents that receive insulin from nursing staff had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all nurses and QMAs on	09/05/2024

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	Current physician orders included, but were not limited to: Lisopro (Humalog) KwikPen 100 U/ML, - Inject per sliding scare three times daily: 150-200=2 U; 201-250=4 U; 251-300=6 U; 301-350=8 U; 351-400=10 U Humalog 100 U/ML KwikPen 5 units sq (subcutaneously) with meals hold if <150 During an interview on 8/8/24 at 10:30 A.M., QMA 11 indicated the pen should be primed with 2 units before insulin administration, but they forgot to. A current Humalog KwikPen manufacturer's guide, dated April 2020, provided by the DON on 8/8/24 at 2:00 P.M., indicated to "prime before each injection. Priming ensures the Pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little (insulin)".		procedure of priming prior to dosing and administering insulin. Employees found to be out of compliance with practice will receive additional education and possible corrective action. **1.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. All staff nurses and QMAs will be re-educated and in-serviced on the correct practice no later than **9/5/2024**. Any staff nurse or QMA found out of compliance with facility's policies and protocols relating to practice will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired QMAs and nurses on policies and protocols relating to priming insulin pens prior to dosing during employee job-specific orientation moving forward. **1.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:** a. The Director of Nursing or designee will audit for appropriate priming of insulin needles monthly for three months to ensure the	

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			proper process is being followed. Results to be reviewed at monthly QAPI meetings and make further recommendations based off audit results **1.By what date will the systematic changes be completed** 1.Education and in-service will be provided to all clinical staff by 9/5/2024.	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency Based on observation, interview and record review, the facility failed to ensure staff properly washed their hands before and after each direct resident contact indicated by accepted professional practice for 5 random observations. (Room 302, Room 308, Room 325, Resident 324, Room 326) Findings include: 1. On 8/8/24 at 8:30 A.M., QMA (Qualified Medicine Aide) 11 was observed leaving Room 325 without sanitizing her hands. 2. On 8/8/24 at 8:40 A.M., QMA 11 was observed not sanitizing her hands prior to entering and leaving Room 324. 3. On 8/8/24 at 8:50 A.M., QMA 11 was observed not sanitizing her hands prior to entering Room 326. 4. On 8/8/24 at 10:20 A.M., QMA 11 was observed	R 0414	**1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** 1.No residents experienced adverse effects from the alleged deficient practice. **1.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** 1.All residents requiring proper staff hand hygiene before providing care, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all medical staff on procedures of appropriate	09/05/2024

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	not sanitizing her hands after leaving Room 308 and before entering Room 302. During an interview on 8/8/24 at 1:30 P.M., the DON (Director of Nursing) indicated staff should sanitize their hands between resident rooms. On 8/8/24 at 2:00 P.M., the DON provided a current "Hand Hygiene" policy, revised 3/2024, that indicated "... it is the responsibility of all staff to follow proper handwashing and hygiene guidelines...in most situations, the preferred method of hand hygiene is alcohol based hand sanitizer...and is used for the following situations...before and after direct contact with residents and before preparing or handling medications...".		hand hygiene. Employees found to be out of compliance with hand hygiene will receive additional education and possible corrective action. **1.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** 1.All clinical staff will be re-educated and in-serviced on the hand hygiene policy no later than **9/5/2024**. Any clinical staff member out of compliance with facility's policies and protocols relating to hand hygiene will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to hand hygiene during employee job-specific orientation moving forward. **1.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:** 1.The Director of Nursing or designee will audit appropriate hand hygiene one time a week for four weeks, then two times a month for one month and then as needed to ensure that proper hand	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

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			hygiene is being executed. Results to be reviewed at monthly QAPI meetings and make further recommendations based off audit results **1.By what date will the systematic changes be completed** 1.Education and in-service will be provided to all clinical staff by 9/5/2024.	