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	09/23/2021

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: September 21, 22, and 23, 2021. Facility number: 014377 Residential Census: 85 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 27, 2021.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure at least one staff member was on duty at all times who was certified in First Aid for 3 of 7 days reviewed. Finding includes: The staffing schedule was provided by the Director of Nursing (DON) on 9/23/21 at 7:45 a.m. The schedule was reviewed for the time period of 9/12/21 through 9/18/21. The First Aid certifications for staff were provided by the Administrator and reviewed on 9/23/21 at 9:05 a.m. - 1:15 p.m. The schedule indicated the facility lacked an employee with First Aid certification from 10:00 p.m. - 6:00 a.m. on 9/12/21, 9/16/21, and 9/17/21. On 9/23/21 at 9:30 a.m., the Administrator indicated the facility had recently had a class on CPR and First Aid and had another class scheduled for the employees. The facility lacked documentation of a policy for First Aid certification of employees.	R 0117	Deficiency ID : R- 117 Completion Date: 10/08/2021 Plan of Correction Text: 1. No residents were affected by the alleged deficient practice. 2. All residents had the potential to be affected by the alleged deficient practice. 3. In-Service training was completed by Administrator for hiring managers regarding our policy on CPR and First Aid certification for all staff members. CPR and First Aid course is scheduled for October 7 and October 13th. The policy related to CPR and First Aid certifications is attached here. 4. Administrator and/or designee will audit CPR/First Aid certificates (& compared to staff schedules) for all staff employed not later than October 8, 2021. Ongoing compliance will be ensured through monthly audits of new employee files for all employees hired on or after October 8, 2021 to ensure that all new employees are certified in both CPR & First Aid and/or any employees who are hired without CPR and First Aid Certification are assigned to attend a course to	10/08/2021

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			obtain the appropriate certification and are not scheduled to work on a shift without another individual with the required certification. 5. Systematic changes will be completed by October 8, 2021	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served in a sanitary manner during 2 of 2 kitchen observations, and 1 of 1 dining room observations. Food was not dated, floors were soiled, hand hygiene was not performed, temperatures were not documented, and flies were observed in the kitchen. (Resident 48, Kitchen, Cook 1, CNA 1) Findings include: On 9/21/21 at 8:35 a.m., during the initial tour of the kitchen, the following was observed : 1. Floors were soiled under equipment, tables, dirt buildup around the base of the walls. 2. A temperature log was hanging in a plastic sleeve on the side of the dishwasher with a date of March, 2021. 3. Temperature logs were hanging on the doors of the walk in freezer and walk in cooler with the last temperature recorded on 9/14/21. Temperature log	R 0273	Deficiency ID R-273 Compliance Date: 10/08/21 Plan of Correction Text 1. No residents were affected by the alleged deficient practice. 2. All residents had the potential to be affected by the alleged deficient practice. 3. In-Service completed by Dietary Manager with all kitchen staff. In service topics will include hair covering, masks, proper food storage including labeling and dating, hand hygiene, cleaning logs, dumpster lids. Policies related to kitchen cleaning, proper food storage, infection control practices in the kitchen, appropriate documentation of temperatures are attached. The faulty seal on the receiving door was replaced. The company we contract pest control services with was called out and completed a site visit to address the flies in the kitchen area.	10/08/2021

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	on the stand refrigerator last temperature dated 9/15/21. 4. A gallon freezer bag of leftover food, marked shrimp scampi with no date. 5. Flies were observed flying around the kitchen. On 9/22/21 at 9:05 a.m., the same was observed, the shrimp scampi was gone. 6. On 9/21/21 at 11:15 a.m., during an observation of the noon meal service. Cook 1 was observed to touch her mask multiple times while plating the food. No hand hygiene was done. 7. On 9/21/21 at 11:30 a.m., CNA 1 was observed going in and out of the kitchen with her hair hanging out of her hair cover while serving the lunch meal. On 9/21/21 at 9:05 a.m., the Dietary Manager indicated she had only been at the facility for 2 weeks, the kitchen has all new staff, and they were in training. On 9/21/21 at 9:08 a.m., Cook 1 indicated no one instructed her to document dishwasher temperatures. On 9/21/21 at 11:20 a.m., Resident 48 was sitting in the dining room eating lunch. She indicated she does not like that flies were in the dining room, she would bring her own fly swatter to the dining room for meals. On 9/22/21 at 9:10 a.m., Cook 1 indicated she changed gloves if she touched something not on the steam table, she washed her hands if she touched something not on the steam table, like the		4. Administrator and or/designee will audit/observe for infection control practices in dining room/kitchen to ensure ongoing compliance daily for 1 week, then 5 times a week for 2 weeks, and then 2 times per week for 3 months. The Dietary Manager, or designee, will audit proper food storage and labeling daily for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months. The Dietary Manager, or designee, will audit temperature log documentation daily for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months. The Dietary Manager, or designee, will audit cleaning schedule for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months. The results of both audits/reviews will be discussed at the monthly Quality Improvement Meeting monthly for 3 months and then quarterly thereafter once compliance is 100%. 5. Systematic changes will be completed by Oct 8, 2021	

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	trash, food, or sauce. Cook 1 further indicated she had noticed flies in the kitchen, had informed the Dietary Manager, and had been told they were not allowed to put up fly traps in the kitchen. On 9/22/21 at 2:15 p.m., the Dietary Manager indicated she was aware of the flies in the kitchen, they were coming in the service door when trash was being taken out. Pest control services was coming in the following day to put up blue lighting in the hallway leading to the service door for fly control. She further indicated all staff in the kitchen were new and in training, the old staff was saving everything and she had to go in and clean out the freezer and refrigerators, floors were swept and mopped daily, she was still working on a cleaning schedule for staff, as some things were not in place when she started. On 9/22/21 at 11:10 a.m., the Administrator indicated the pest control company was coming in to put up fly traps, the door to the outside needed a new seal and would be fixed. On 9/23/21 at 12:15 p.m., the Administrator indicated she had observed CNA 1 with her hair hanging out of her hair cover going in and out of the kitchen. She indicated the Dietary Manager and the DON would be meeting with the staff to go over some of the observations they have observed during dining since both areas served the meals. On 9/23/21 at 11:48 a.m., a document titled, "Hand Hygiene," was provided by the Administrator, with a revision date of 9/20. The document included, but was not limited to, all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections.			

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	All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, visitors. The facility lacked documentation of a policy for cleaning the kitchen floor, dating of foods, documenting temperature, or hair covering. 410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure medications were given for 1 of 7 residents reviewed for medication administration. (Resident 47, DON, LPN 1) Finding includes: On 9/22/21 at 9:58 a.m., Resident 47 indicated she had not received her medications the prior day for the noon and evening doses, had many health issues, and could not sleep and was up until 3:00 a.m. due to not receiving her medication. She had informed the aide, who stated she would notify a nurse. The nurse never came to give her medications. She indicated one nurse in particular seemed to leave out her diabetic medication, she was unsure of staff names. On 9/22/21 at 3:00 p.m. Resident 47 indicated she left the facility with her daughter on 9/21/21 to attend her granddaughter's volleyball game, returned to the facility around 8:30 to 9:00 p.m.			
R 0297 Bldg. 00		R 0297	Deficiency ID: R 297 Completion Date: 10/8/2021 Plan of Correction Text: 1. No residents were affected by the alleged deficient practice 2. All residents had the potential to be affected by the alleged deficient practice 3. In-service training completed by the Director of Nursing on Sept 30 and Oct 4th topic included appropriate documentation of medication administration. The policy related to Medication Oversight, Administration, Storage is attached here. 4. Administrator/Director of Nursing or designee will audit eMAR documentation to ensure appropriate documentation for attempts made when residents are LOA. Audit of eMAR will be daily	10/08/2021

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	She further indicated she rang her pendant, an aide came to her room and said she would tell the nurse she wanted her medications. The nurse never brought the medications. She also did not get her noon medications. On 9/22/21 at 10:37 a.m., Resident 47's record was reviewed. She had diagnoses that included, but were not limited to, Diabetes Mellitus, hypertension, and insomnia. The record indicated resident 47 was alert and oriented with mild neurocognitive disorder. September, 2021 physician orders included, but were not limited to: hydralazine (blood pressure medication), 25 mg (milligrams), 1 tab by mouth three times a day at 8:00 a.m., noon, 8:00 p.m., start date 7/26/21 Melatonin 10 mg (used for sleep aide), 1 tablet by mouth at bedtime, start date 8/26/21 nystatin 100000/GM CRM-D (antifungal cream), apply to skin on ABD (abdomen) 3 times a day, 8:00 a.m., 12:00 p.m., 4:00 p.m., start date 9/13/21 ropinirole (dopamine agonist), 1 mg by mouth three times a day 8:00 a.m., 12:00 p.m., 8: 00 p.m., start date 1/18/21 propranolol (beta blocker), 10 mg by mouth twice daily, 8:00 a.m., 8:00 p.m., start date 1/18/21 The September EMAR (electronic medication administration record), was reviewed and the following medications were not documented as given on 9/21/21: hydralazine 25 mg 12:00 p.m., not marked , 8:00		for 1 week, then 5 times a week for 4 weeks, and the 2 times per week for 3 months. The results will be discussed at the monthly quality improvement meeting monthly for 3 months and then quarterly thereafter once compliance is 100%. 5. Systematic changes will be completed by Oct 8th, 2021	

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	p.m. marked A=away melatonin 10 mg 8:00 p.m., marked A=away metformin 1,000 mg 8:00 p.m., marked A=away propranolol 10 mg 8:00 p.m. marked A=away ropinirole 1 mg 12:00 p.m. not marked , 8:00 p.m. marked A=away nystatin 100000/GM 12:00 p.m., not marked, 8:00 p.m., marked 0=other On 9/23/21 at 11:48 a.m., a resident sign out and in log was reviewed for 9/21/21. Resident 47 had a signed signature with the time of 4:00 for time leaving, 7:30 for anticipated return time, no time was signed for actual return time. On 9/22/21 at 11:39 a.m. the DON indicated Resident 47 was out of the facility with her daughter the evening of 9/21/21. The resident had informed her she got her medications at 2:00 a.m.. The DON indicated the medications were given, just not documented as given. On 9/23/21 at 12:00 p.m., the DON and LPN 1 were interviewed. The DON indicated the noon medications were not given on 9/21/21 due to she had been training LPN on her first day on the floor and had been called off the floor, things got behind. LPN 1 indicated it was her first day on the floor alone and the DON was training her and got called away. The DON further indicated she went over the medications LPN 1 gave to see if any were missed, they were behind, and it was possible some got missed, but would have been to late to give anyway. On 9/23/21 at 12:50 p.m., the Regional Consultant indicated it was not a policy , but staff knew to attempt 3 times to give a resident medications. No documentation was reviewed in the record, nor provided, that medications had been attempted 3			

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	times to be given to Resident 47. On 9/23/21 at 11: 48 a.m., the Administrator provided a document titled "Indiana Medication Oversight, Administration, Storage." The document was undated, and included, but was not limited to, if a resident is assessed as needing medication administration, it is the responsibility of the licensed nursing personnel or qualified medication aide to administer the medications to the resident. Administration: Medication administration shall be be provide as ordered by the resident's physician and shall be supervised or provided by a licensed nurse on the premises or on call as follows: medication shall be administered by licensed nursing personal or qualified medication aides...the individual administering the medication shall document the administration in the individual's medication and treatment records that indicate the following: time, name of the medication, dosage (if applicable), name or initials of the person administering the drug or treatment.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.	R 0407	Deficiency ID: R_ 407	10/08/2021

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	Based on observation, interview, and record review, the facility failed to properly prevent and/or contain COVID-19 and to ensure infection control practices were followed for 1 of 1 observations of COVID-19 testing. Required PPE (personal protective equipment) was not worn during testing and hand hygiene was not performed. (DON) Finding includes: On 9/21/21 at 1:23 p.m., the DON (Director of Nursing), was observed performing COVID-19 testing on an employee. The DON was observed to have on a surgical mask and a face shield. The DON was observed to don gloves, no hand hygiene was done prior to donning gloves. On 9/22/21 at 1:28 p.m., the DON indicated she wore everything, gown, gloves, KN95 mask, and face shield when she swabbed the residents for their testing, but for staff she wore a surgical mask and face shield. On 9/23/21 at 11:48 a.m., the Administrator provided a document titled " COVID-19 Testing & Response Strategy", revised 8/17/21. The document included, but was not limited to: Specimen collection preparation: A. The registered nurse, or staff nurse, designee, shall don appropriate personal protective equipment (PPE), for droplet and contact precautions. This includes a gown, gloves, face shield or goggles, and an N95 mask prior to initiate testing. On 9/23/21 at 11:48 a.m., a document titled, "Hand Hygiene" was provided by the Administrator, with a revision date of 9/20. The document included, but was not limited to, all personnel		Completion Date 10/08/2021 Plan of Correction Text 1. No residents were affected by the alleged deficient practice. 2. All residents had the potential to be affected by the alleged deficient practice. 3. In-Service completed by Administrator/DON with all staff members regarding infection control practices, especially donning doffing, PPE protocols, appropriate face mask practices, hand hygiene & COVID-19 testing guidelines. 4. Administrator and or/designee will complete audits of COVID-19 testing twice a week for 6 weeks, and then once monthly for 6 months. The results of these reviews will be discussed at the monthly quality Improvement meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Administrator and/or designee will conduct competency reviews with all staff following training to endure understanding of infection control practices.	

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	shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, visitors.			