STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155022	A. BUILDING _____ B. WING _____	**08/18/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to serve food in a sanitary manner related to staff touching resident's food with their bare hands for 2 of 4 staff members serving food. (CNA 2 and CNA 3) Findings include: 1. During a dining service observation, on 8/18/20 at 12:08 p.m., CNA 2 (certified nursing assistant) picked up a resident's hamburger bun with her bare hands. She then placed a white condiment onto the bun, replaced the hamburger bun on top of the hamburger, smooshed the bun down onto the hamburger with the palm of her hand. While holding the bun with her bare hand she cut the hamburger in half. 2. During an observation , on 8/18/20 at 12:11 p.m., CNA 3 was in the dining room. The CNA served a resident their lunch tray. She then removed the resident's hamburger bun with her bare hands, placed a white condiment onto the bun, and replaced the bun on top of the hamburger. An interview with ED on 8/18/20 at 12:17 p.m., he indicated the staff members assisting in the dining room should not be using bare hands to handle the resident's food.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation and interview, the facility failed to follow infection control guidelines related to Covid-19 for appropriate mask usage and hand hygiene during 2 of 7 observations. (OT 1 and LPN 1) Findings include: 1. During an observation, on 8/18/20 at 10:40 a.m., OT (Occupational Therapist) 1 was working with Resident 2. The OT's mask and the resident's mask were pulled down below their nose leaving their nose uncovered. Resident 2 and the OT were tossing a balloon back and forth. The OT pulled her mask up by touching the outside of the mask with her bare hand and continued to toss the balloon with the resident without performing hand hygiene. 2. During an observation, on 8/18/20 at 10:43 a.m., LPN (Licensed Practical Nurse) 1 was at the nursing station near the front door. The LPN was wearing her face mask so that her nose was uncovered. An interview with the ED (Executive Director), on 8/18/20 at 10:50 a.m., he indicated the facility did not require the residents to wear face masks outside of their rooms. It was the resident's right to decide if they wanted to wear a mask or not. On the Centers for Disease and Control (CDC) website, it stated HCP (Health Care Providers) should wear a facemask at all times while they are in the healthcare facility .or other spaces where they might encounter co-workers .Educate patients, visitors, and HCP about the importance of performing hand hygiene immediately before and after any contact with their facemask or cloth face covering. Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance . 3.1-18

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.