STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. BUILDING _____ B. WING _____	**10/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE OF HUNTINGTON	**1180 WEST 500 NORTH HUNTINGTON, IN 46750**

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation and interview, the facility failed to ensure medications were securely stored for 1 of 1 observation of the L hallway. Findings include: During an observation, on 10/8/20 at 9:08 a.m., on the L Hallway, a medication cart was unlocked and unattended in the hallway, with the third drawer open and medication cards stacked upside down on top of the other medication cards stored inside the drawer. A set of keys were on top of cart, near the computer. A pair of safety glasses were on top of a jacket, which was on top of the cart. A fast food drink cup with a large opening at the lid with an exposed straw, in another open drawer. During an interview, at the time of the observation, RN 35 indicated the cart should not have been left open and unlocked, but no one had been around, so she had left it open. During an interview, on 10/8/20 at 11:27 a.m., the DON indicated RN 35 should not have left the cart unlocked and unattended. 3.1-25(m)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to initiate and maintain transmission based precautions, during a COVID-19 pandemic, for 3 of 3 residents reviewed for infection control (Resident 2, Resident 13, and Resident 20). Findings include: 1.A. During an interview with the Executive Director (ED), on 10/07/20 at 10:40 a.m., she indicated the facility had 4 staff members confirmed positive for COVID-19. During an interview, on 10/07/20 at 11:24 a.m., the Director of Nursing (DON) indicated residents who had close contact exposures to positive staff members were in Precautionary Isolation. Precautionary Isolation included the following: 14 day quarantine to the resident room, no communal activities, and no communal dining. She indicated essential staff, who worked in Precautionary Isolation rooms, were required to wear a surgical mask, face shield or goggles, and gloves for resident contact. During a tour of the facility, on 10/07/20 at 11:30 a.m., the following was observed: A Precautionary Isolation sign was on all of the doors in the I Hall. The sign was worded, I am in precautionary isolation. Only essential staff shall enter the room. During an interview at the time of the observation, the DON indicated residents in I Hall and Memory Lane were in precautionary isolation for exposure to COVID-19 and the residents in Rehabilitation Hall were in precautionary isolation due to a new admission status. The DON indicated staff members were not required to wear gowns in Precautionary Isolation rooms. The staff were required to wear a surgical mask and face shield or goggles for all Precautionary Isolation rooms for COVID-19 exposure and new admissions. During an interview, on 10/08/20 at 9:02 a.m., the DON and ED indicated an exposed resident with a close contact positive staff member was not considered suspected positive. The DON indicated transmission based precautions were not required for asymptomatic residents with a close contact exposure to COVID-19. Review of the list of residents in precautionary isolation, provided by the ED on 10/08/20 at 1:37 p.m., indicated 49 residents were in Precautionary Isolation. B. A sign indicated Precautionary Isolation on the entry doors to Memory Lane. C. The resident doors in the Rehabilitation Hall contained a sign that indicated Precautionary Isolation. During an interview, on 10/07/20 at 12:20 p.m., the ED indicated 41 residents were exposed to COVID-19 and placed in precautionary isolation. She indicated some of the exposed residents had a roommate. D. During a random observation, on 10/07/20 at 2:35 p.m., Resident 2 and his roommate were observed in their room with the door open. The door contained a sign that indicated Precautionary Isolation. During an interview at the time of observation, on 10/07/20 at 4:16 p.m., Certified Nurse's Aide (CNA) 6 was in I Hall with her safety goggles on top of her head. She indicated the same personal protective equipment required for precautionary isolation was also required in non-isolation rooms and included a face shield or goggles and a surgical mask. E. During an observation, on 10/07/20 at 4:21 p.m., Qualified Medical Assistant (QMA) 4 walked out of Resident 2's open door and returned to the medication cart. Resident 2 and his roommate did not have a face covering on while QMA 4 was in the room. Review of Resident 2's clinical record was completed on 10/08/20 at 9:29 a.m. [DIAGNOSES REDACTED]. Medications included, but were not limited to, [MEDICATION NAME] (antibiotic) 100 mg (milligrams) tablet, give 1 tablet by mouth two times a day for small right base infiltrate for 14 administrations. Review of an order, dated 9/10/20, indicated Resident 2 had an active PRN (as needed) COVID test in the electronic medical record. Review of a 9/24/20 progress note indicated Resident 2 had a cough, congestion, and rhonchi (coarse lungs sounds) throughout his lungs. Review of an order, dated 9/24/20, indicated Resident 2 had a chest x-ray for cough, congestion, and weakness. Review of a 9/26/20 Nurse's Note indicated Resident 2 was taken off of isolation. Review of a 9/29/20 Nurse's Note indicated Resident 2 continued antibiotic for pneumonia with diminished lung sounds throughout his lungs. During an interview, on 10/08/20 at 10:51 a.m., the DON indicated Resident 2 had a PRN COVID-19 testing order and he was not tested for COVID-19 on 9/24/20. She indicated a cough was considered symptomatic for COVID-19 and required contact and droplet isolation. She indicated a resident with pneumonia should have remained in contact and droplet precautions for the duration of the antibiotic or longer. 2. During a random tour of the facility, on 10/8/20 at 9:08 a.m., the following was observed: A. Resident 13 was seated in her wheelchair, outside of the doorway to her room, with an over-bed table in front of her. The door to her room had a sign on it to indicate she was in Precautionary Isolation; only essential staff should enter her room, and to refer to the Precautionary Isolation policy. The resident was not wearing a face covering. During an interview at the time of the observation, CNA 32 indicated the resident was in precautionary isolation and was supposed to stay in her room. She liked to sit up in her wheelchair for meals at the over-bed table and usually sat near her doorway to see what all was going on. She would usually creep out further from her room as they day went on. Residents were to wear face coverings when in hallways, and were encouraged to wear them during care, especially if the care required more than 15 minutes. Review of Resident 13's clinical record was completed on 10/8/20 at 9:43 a.m. [DIAGNOSES REDACTED]. Review of a 10/6/20 progress note indicated she had been tested for COVID-19 and the specimen had been sent to the lab. B. On the L Hallway, a medication cart was unlocked and unattended in the hallway, with the third drawer open and medication cards stacked upside down on top of the other medication cards stored inside the drawer. A set of keys were on top of cart, near the computer. A pair of safety glasses were on top of a jacket, which was on top of the cart. A fast food drink cup with a large opening at the lid with an exposed straw, in another open drawer. RN 35 walked out of Resident 20's room (Resident 20 did not have a face covering on) and approached the medication cart. She began documenting on the computer, while holding an electronic blood pressure cuff. She did not perform hand hygiene. She indicated the cart should not have been left open and unlocked, but no one had been around, so she had left it open. She was supposed to wear safety glasses into all resident rooms for direct care. Review of Resident 20's clinical record was completed on 10/8/20 at 9:59 a.m. [DIAGNOSES REDACTED]. Review of a

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) 10/6/20 progress note indicated she had been tested for COVID-19 and the specimen had been sent to the lab. Review of a current facility policy, titled USE OF PROTECTIVE EYEWEAR/GOGGLES, dated 10/2020 and provided by the Administrator on 10/7/20 at 10:40 a.m., indicated the following: .Eye protection is required when caring for residents should there be a COVID positive resident, a resident on Contact-Airborne Precautions or residents on Precautionary Isolation due to close contact with a positive case Review of a current facility policy, titled Policy for residents who have been considered a 'close contact,' updated 7/23/20 and provided by the Administrator on 10/8/20 at 9:43 a.m., indicated the following: .Close contact includes individuals who had less than 6ft of contact for a total of 15 minutes during a working shift while one or both of the parties were not wearing a mask or face covering. A close contact is considered someone who has had a possible exposure to COVID-19 .2. After contact tracing any resident who has had 'close contact' with the staff member will be placed in a 14 day precautionary isolation for monitoring of COVID signs and symptoms. 3. A precautionary isolation sign will be placed on the resident's door to indicate to staff that the resident is in isolation and being monitored for signs and symptoms of COVID .5. Direct care giver staff will wear a surgical mask and eye protection while caring (sic) someone in precautionary isolation .11. Nursing staff will complete a daily respiratory assessment with the residents. Assessments to include monitoring for SOB, fever, cough, and sore throat. The respiratory assessment will be documented in the resident's medical record Review of current CDC guidance for Responding to COVID-19 in Nursing Homes indicated the following: .Determine which residents received direct care from and which HCP (heath care provider) had unprotected exposure to HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset. Residents who were cared for by these HCP should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of HCP COVID-19 testing are known. If the HCP is diagnosed with [REDACTED].