STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00427096. Complaint IN00427096: Deficiencies related to the allegations are cited at R273. An unrelated deficiency is cited at R055. Survey dates: February 22 & 23, 2024 Facility number: 014377 Residential Census: 115 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 27, 2024.	R 0000	This Plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report.	
R 0055	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(y)(1-4) (y) Residents have the right to be	R 0055	1. Facility immediately suspended and subsequently terminated employee responsible for violating this resident's right to privacy.	03/25/2024

	treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on interview and record review, the facility failed to ensure a resident's right to privacy for 1 of 3 residents reviewed. Staff allowed an unknown visitor into a resident's room at night, after the resident had gone to bed. (Resident B) Finding includes: During a review of state reportable incidents on 2/22/24 at 1030 A.M., an incident dated, 12/27/23 at 12:01 A.M., included that Resident B awoke to CNA 13 "rummaging" through the resident's pill bottles. During a review of the facility's investigation of the incident between CNA 13 and Resident B on 2/23/24 at 9:00 A.M., an undated written statement from Resident B included, "On the evening of (12/26/24) around 11:00 (P.M.)., I heard my (medicine) rattle and woke up. I tried to confront [CNA 13] but she came into the bedroom and		2. By termination of responsibly party, facility has ensured the deficient practice will not be repeated, therefore no further resident shall be impacted. 3. In-servicing is provided to all new hires and to all current staff semi-annually to include resident rights/privacy. Facility will also provide re-education to all staff as part of plan of correction. 4.Will monitor all grievances and address any privacy-related concerns shall any arise. Reason for IDR request: Heritage Woods of Newburgh requests an informal review of R0055. Upon facility knowledge of alleged incident, facility leadership immediately suspended scheduled CNA responsible for violation of resident's right to privacy, and investigation was initiated. Investigation findings resulted in termination of the CNA, effective immediately. ISDH review held prior to this citation on Jan. 12, 2024 reviewed the incident and discussed with facility leadership. CNA employee file was provided and reviewed during that survey.The results of survey EIY211 found Heritage Woods of Newburgh to be in compliance. All staff education was conducted on 1/31/2024 to include the Resident Right to Privacy. Heritage Woods of Newburgh	

	put me back in the bed. She left and a few moments later, she let some strange woman into my room (whom left me a blanket)... The investigation also included text message exchanges between CNA 13 and the facility administrator and DON (Director of Nursing). A message form the DON to CNA 13 dated, 12/27/23, included, "Do you know who brought [Resident B] the blanket", CNA 13 replied on 12/27/23, "Yes [DON] it was a girl that use to work there..." During an interview on 2/23/24 at 9:05 A.M., the facility administrator indicated the visitor that CNA 13 had allowed to go into Resident B's room was a former employee at the facility who had not worked for the facility in several months. During an interview on 2/23/24 at 9:45 A.M., Resident B indicated that she heard CNA 13 open her door to allow a "stranger" to come into her room at around 10:00 or 11:00 P.M. and deliver a blanket to her. Resident B indicated that she kept her doors locked at night and that CNA 13 had unlocked the door. During an interview on 2/23/24 at 1035 A.M., CNA 7 indicated that staff should never let an individual into a resident's room prior to alerting the resident or		requests an IDR based on self-correction of past noncompliance, as well as ISDH inconsistency in review of the alleged incident.	

asking the resident's permission.

On 2/23/24 at 9:00 A.M., the facility administrator supplied a copy of of an undated "new hire forms" titled, Resident Rights. The form included, "Each resident shall have the right to: ...5. Have his or her privacy respected."

Based on interview and record review, the facility failed to ensure a resident's right to privacy for 1 of 3 residents reviewed. Staff allowed an unknown visitor into a resident's room at night, after the resident had gone to bed. (Resident B)

Finding includes:

During a review of state reportable incidents on 2/22/24 at 1030 A.M., an incident dated, 12/27/23 at 12:01 A.M., included that Resident B awoke to CNA 13 "rummaging" through the resident's pill bottles.

During a review of the facility's investigation of the incident between CNA 13 and Resident B on 2/23/24 at 9:00 A.M., an undated written statement from Resident B included, "On the evening of (12/26/24) around 11:00 (P.M.)., I heard my (medicine) rattle and woke up. I tried to confront [CNA 13] but she came into the bedroom and put me back in the bed. She left and a few moments later, she

let some strange woman into my room (whom left me a blanket)...

The investigation also included text message exchanges between CNA 13 and the facility administrator and DON (Director of Nursing). A message form the DON to CNA 13 dated, 12/27/23, included, "Do you know who brought [Resident B] the blanket", CNA 13 replied on 12/27/23, "Yes [DON] it was a girl that use to work there..."

During an interview on 2/23/24 at 9:05 A.M., the facility administrator indicated the visitor that CNA 13 had allowed to go into Resident B's room was a former employee at the facility who had not worked for the facility in several months.

During an interview on 2/23/24 at 9:45 A.M., Resident B indicated that she heard CNA 13 open her door to allow a "stranger" to come into her room at around 10:00 or 11:00 P.M. and deliver a blanket to her. Resident B indicated that she kept her doors locked at night and that CNA 13 had unlocked the door.

During an interview on 2/23/24 at 1035 A.M., CNA 7 indicated that staff should never let an individual into a resident's room prior to alerting the resident or asking the resident's permission.

	On 2/23/24 at 9:00 A.M., the facility administrator supplied a copy of of an undated "new hire forms" titled, Resident Rights. The form included, "Each resident shall have the right to: ...5. Have his or her privacy respected."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (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 and distributed in accordance with professional standards for food service safety during 2 of 2 kitchen observations. Food packages were not labeled or dated and food was open to air in the walk in freezer. Finding includes: During an observation on 2/22/24 at 8:55 A.M. a walk-in-freezer contained a bag of what appeared to be breaded chicken nuggets, 2 bags of breaded fish filets, 2 bags of popcorn shrimp, and 1 bag of corn that were unlabeled and	R 0273	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. In-service education will be provided to all dietary personnel whose duties include food handling and storage. 3. In-service education will be completed by Dietary Manager with all dietary personnel and any new hires. In-service topics to include proper food storage including labeling and dating. 4. Dietary manager or designee will audit refrigerated food storage and all foods for proper labeling daily for one week, then five times weekly for two weeks, followed by two times weekly for three months to ensure no food is left opened to air in these areas. The results of the audits/reviews will be discussed at monthly QAPI meeting for three months, and then quarterly thereafter.	03/25/2024

undated. The freezer also contained a container of broccoli that was open to air.

During an observation on 2/23/24 at 9:55 A.M. a walk-in-freezer contained 2 bags of what appeared to be popcorn shrimp that were not labeled or dated.

During an interview on 2/23/24 at 10:00 A.M., the dietary manager (DM) indicated that stored food should be labeled and dated.

On 2/23/24 at 11:40 A.M., the facility administrator supplied an undated facility policy titled, Refrigerated Storage Policy and Procedure. The policy included, "a) Potentially hazardous food requiring refrigeration... shall be labeled or tagged with the date and time..."

This citation relates to Complaint IN00427096.

Based on observation, interview, and record review, the facility failed to ensure food was stored and distributed in accordance with professional standards for food service safety during 2 of 2 kitchen observations. Food packages were not labeled or dated and food was open to air in the walk in freezer.

Finding includes:

During an observation on 2/22/24 at 8:55 A.M. a walk-in-freezer contained a bag of what appeared to be breaded chicken nuggets, 2 bags of breaded fish filets, 2 bags of popcorn shrimp, and 1 bag of corn that were unlabeled and undated. The freezer also contained a container of broccoli that was open to air.

During an observation on 2/23/24 at 9:55 A.M. a walk-in-freezer contained 2 bags of what appeared to be popcorn shrimp that were not labeled or dated.

During an interview on 2/23/24 at 10:00 A.M., the dietary manager (DM) indicated that stored food should be labeled and dated.

On 2/23/24 at 11:40 A.M., the facility administrator supplied an undated facility policy titled, Refrigerated Storage Policy and Procedure. The policy included, "a) Potentially hazardous food requiring refrigeration... shall be labeled or tagged with the date and time..."

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SIGNATURE		