STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/10/2025

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 a State Residential Licensure Survey. Survey dates: July 9 & July 10, 2025 Facility number: 014377 Residential Census: 119 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 14, 2025.	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 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be	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	07/25/2025

	appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. 2 On 7/9/25 at 2:15 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. Resident 6 was admitted to the facility on		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 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	

	3/27/21. The clinical record lacked a signed service plan completed since 9/26/24. During an interview on 7/10/25 at 9:35 A.M., the Director of Nursing (DON) indicated that the service plans were updated every six months. The last time the service plan was reviewed for Resident 5 and Resident 6 was in September and they did not have updated service plans completed in the past six months. During an interview on 7/10/24 at 1:57 P.M., the DON indicated that the facility did not have a policy related to service plans, but they followed the state regulations. Based on interview and record review, the facility failed to ensure service plans were completed and signed by the resident every six months for 2 of 7 residents reviewed. (Resident 5 and Resident 6) Findings include: 1. On 7/9/25 at 1:53 P.M., Resident 5's clinical record was reviewed. Resident 5 was admitted on 1/12/23. Diagnosis included, but not limited to, Diabetes Mellitus Type II The most recent Resident Service Plan documented in the		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.	

	clinical record had not been updated since 9/26/24 and lacked a signature from Resident 5. 2 On 7/9/25 at 2:15 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. Resident 6 was admitted to the facility on 3/27/21. The clinical record lacked a signed service plan completed since 9/26/24. During an interview on 7/10/25 at 9:35 A.M., the Director of Nursing (DON) indicated that the service plans were updated every six months. The last time the service plan was reviewed for Resident 5 and Resident 6 was in September and they did not have updated service plans completed in the past six months. During an interview on 7/10/24 at 1:57 P.M., the DON indicated that the facility did not have a policy related to service plans, but they followed the state regulations. Based on interview and record review, the facility failed to ensure service plans were completed and signed by the resident every six months for 2 of 7 residents reviewed. (Resident 5 and Resident 6)		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 7/25/2025.	

Findings include:

1. On 7/9/25 at 1:53 P.M., Resident 5's clinical record was reviewed. Resident 5 was admitted on 1/12/23. Diagnosis included, but not limited to, Diabetes Mellitus Type II

The most recent Resident Service Plan documented in the clinical record had not been updated since 9/26/24 and lacked a signature from Resident 5.

2 On 7/9/25 at 2:15 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. Resident 6 was admitted to the facility on 3/27/21.

The clinical record lacked a signed service plan completed since 9/26/24.

During an interview on 7/10/25 at 9:35 A.M., the Director of Nursing (DON) indicated that the service plans were updated every six months. The last time the service plan was reviewed for Resident 5 and Resident 6 was in September and they did not have updated service plans completed in the past six months.

During an interview on 7/10/24 at 1:57 P.M., the DON indicated that the facility did not have a policy related to service plans,

	but they followed the state regulations. Based on interview and record review, the facility failed to ensure service plans were completed and signed by the resident every six months for 2 of 7 residents reviewed. (Resident 5 and Resident 6) Findings include: 1. On 7/9/25 at 1:53 P.M., Resident 5's clinical record was reviewed. Resident 5 was admitted on 1/12/23. Diagnosis included, but not limited to, Diabetes Mellitus Type II The most recent Resident Service Plan documented in the clinical record had not been updated since 9/26/24 and lacked a signature from Resident 5. 2 On 7/9/25 at 2:15 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. Resident 6 was admitted to the facility on 3/27/21. The clinical record lacked a signed service plan completed since 9/26/24. During an interview on 7/10/25 at 9:35 A.M., the Director of Nursing (DON) indicated that the service plans were updated every six months. The last time			

	the service plan was reviewed for Resident 5 and Resident 6 was in September and they did not have updated service plans completed in the past six months. During an interview on 7/10/24 at 1:57 P.M., the DON indicated that the facility did not have a policy related to service plans, but they followed the state regulations. Based on interview and record review, the facility failed to ensure service plans were completed and signed by the resident every six months for 2 of 7 residents reviewed. (Resident 5 and Resident 6) Findings include: 1. On 7/9/25 at 1:53 P.M., Resident 5's clinical record was reviewed. Resident 5 was admitted on 1/12/23. Diagnosis included, but not limited to, Diabetes Mellitus Type II The most recent Resident Service Plan documented in the clinical record had not been updated since 9/26/24 and lacked a signature from Resident 5.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the	R 0243	1. **What Corrective action(s) will be accomplished for those residents found to have**	07/25/2025

	medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, interview, and record review, the facility failed to ensure the time a medication administered was accurate for 1 of 5 Resident's observed for medication administration. (Resident 4) Finding includes: During a medication administration observation on 7/10/25 at 11:00 A.M., QMA (Qualified Medication Aide) 5 administered a Norco (a pain medication) 5/325 mg (milligrams) to Resident 4. On 7/10/25 at 11:25 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, diabetes mellitus Type 2 and peripheral vascular disease. Physician orders included, but were not limited to: Norco 5/325 mg, take one tablet		**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 PRN medications 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 documenting at the time a medication is provide and documenting accurately. 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:**	

	by mouth every four hours as needed for pain; start date 6/16/25. During an interview on 7/10/25 at 11:58 A.M., QMA 5 indicated she had not documented the Norco given to Resident 4 yet. The electronic medication administration record indicated the Norco was given at 12:00 P.M. On 7/10/25 at 1:45 P.M., the Administrator provided a policy titled Medication Management, Administration, and Storage, dated 1/24, that indicated "At the time of administration, the licensed nurse or QMA administering the medication will document the administration in the medication administration record that includes: c. Date, Time." Based on observation, interview, and record review, the facility failed to ensure the time a medication administered was accurate for 1 of 5 Resident's observed for medication administration. (Resident 4) Finding includes:		a. All staff nurses and QMAs will be re-educated and in-serviced on the correct practice no later than7**/25/2025**. 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 accurate clinical documentation 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 clinical documention of PRN medications monthly for three months to ensure the 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**	

During a medication administration observation on 7/10/25 at 11:00 A.M., QMA (Qualified Medication Aide) 5 administered a Norco (a pain medication) 5/325 mg (milligrams) to Resident 4.

On 7/10/25 at 11:25 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, diabetes mellitus Type 2 and peripheral vascular disease.

Physician orders included, but were not limited to:

Norco 5/325 mg, take one tablet by mouth every four hours as needed for pain; start date 6/16/25.

During an interview on 7/10/25 at 11:58 A.M., QMA 5 indicated she had not documented the Norco given to Resident 4 yet.

The electronic medication administration record indicated the Norco was given at 12:00 P.M.

On 7/10/25 at 1:45 P.M., the Administrator provided a policy titled Medication Management, Administration, and Storage, dated 1/24, that indicated "At the time of administration, the licensed nurse or QMA administering the medication will document the administration in the medication administration record that includes: c. Date,

systematic changes be completed

1. Education and in-service will be provided to all clinical staff by 7/25/2025.

	Time."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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