

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2025
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/11/2025	
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 3, 4, 5, 6, 7, 10, and 11 2025.</p> <p>Facility number: 000038 Provider number: 155095 AIM number: 100274830</p> <p>Census Bed Type: SNF/NF: 152 Total: 152</p> <p>Census Payor Type: Medicare: 10 Medicaid: 115 Other: 27 Total: 152</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed March 13, 2025</p>			F 0000	/b> ="" b="">		
F 0757 SS=D Bldg. 00	<p>483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs</p> <p>Based on interview and record review the facility failed to act timely on pharmacy recommendations for 1 of 5 residents reviewed. (Resident 105).</p> <p>Findings include:</p> <p>Resident 105's record review was reviewed on 3/6/25 at 9:16AM.</p> <p>A review of Resident 105's pharmacist</p>			F 0757	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The Resident identified did not suffer any adverse effects from deficient practice. All pharmacy recommendations for Resident # 105 are up to date.</p>		04/02/2025

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 other safeguards 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 disclosable 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2025
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/11/2025	
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>consultation reports indicated on 12/12/24 his medication Florastar, a probiotic, was suggested to be discontinued. The physician response was I have re-evaluated the therapy and wish to implement the following changes. Written in the comment section by the medical provider was "will do".</p> <p>A review of Resident 105's progress notes indicated he had a regulatory visit with a medical provider on 1/3/25 at 6:39AM. There was no note or orders to indicate the physician had been made aware of the December recommendation to discontinue the Florastar.</p> <p>A review of Resident 105's physician orders indicated the medication Florastar 250mg was discontinued on 2/19/25.</p> <p>In an interview, on 3/6/25 at 2:23PM, the Director of Nursing (DON) confirmed the medication Florastar should have been discontinued on the regulatory visit following the December pharmacy review, but it was not. The regulatory visit occurred on 1/3/25. The medication was not discontinued until 2/19/25.</p> <p>A policy was provided by DON on 3/7/25 at 11:32AM titled, "Medication Regimen Review" dated 12/1/07 with most recent revision date of 6/1/24. The policy indicated ...13. The attending physician/prescriber should address the consultant pharmacist's recommendations no later than their next scheduled visit to the facility to assess the resident per facility policy or applicable state and federal regulations ...</p> <p>3.1-48a(1)</p>				<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by deficient practice. Nurses will be educated on the drug recommendation review and unnecessary medication policy. Education will be completed by 4/2/2025.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? As above, licensed nurses are being re-educated on drug regimen review and unnecessary medication policy. The pharmacy recommendation reviews will be given to physician, NP or PA upon receipt from consultant pharmacist. The physician, NP or PA will return the recommendation to the DNS or designee after reviewing.</p> <p>How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? DNS/designee will audit follow through to ensure follow up is completed within 30 days of receipt of pharmacy recommendation. Audits will occur weekly for 2 months, then bi-weekly for 2 months then every</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2025
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 0761 SS=D Bldg. 00	<p>483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals</p> <p>Based on observation, interview and record review the facility failed to ensure medications were secured for 1 of 8 residents reviewed (Resident 120).</p> <p>Findings include:</p> <p>During an observation on 3/5/25 at 9:42 AM, an open bottle of Tums, a tube of biofreeze (topical analgesic), two tubes of barrier creams and a Symbicort (inhaled lung medication) inhaler were observed sitting on top of Resident 120's bed.</p> <p>During an interview, on 3/5/25 at 9:50 AM, Licensed Practical Nurse (LPN) 2 indicated medicines may be kept at bedside if an assessment indicates they demonstrate the ability to self-administer the medication correctly and secure it in a locked box. He indicated the medications observed on Resident 120's bed should not be left out when unattended. He indicated Resident 120 was out of the building at a medical appointment. LPN 2 collected the</p>	F 0761	<p>month for two months. The results of the audits will be shared with the QAPI committee monthly. If 100% is not achieved an action plan will be developed. The Administrator and Director of Nursing will discontinue this audit after 6 months if the facility is 100% compliant and the QAPI committee agrees that the audit is no longer needed.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The resident identified did not suffer any adverse effects from deficient practice.</p> <p>Self-administration of medication observation will be completed by 3/31/2025 for identified resident # 120 to ensure he can safely manage medication storage.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents have the potential to be affected by deficient practice. All staff are being educated on the proper storage of medication. Education will be completed by 4/2/2025. All residents who have</p>	04/02/2025	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2025

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155095		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/11/2025	
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP COD 2001 HOBSON RD FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>medications and placed them in a secure box in the room.</p> <p>Resident 120's record was reviewed on 3/7/25 at 9:06 AM. Diagnoses included chronic obstructive pulmonary disease, end stage renal disease, and chronic pain syndrome.</p> <p>A review of Resident 120's current quarterly Minimum Data Set (MDS) dated 12/22/24 indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact).</p> <p>A review of Resident 120's current care plan titled Resident chooses to self-administer medication-Tums, initiated 10/9/24, indicated the resident had a problem of wishing to self-administer medication with a goal date of 4/2/25. Interventions included completing a medication self-administration evaluation quarterly and keeping medication out of the reach of other residents.</p> <p>A review of Resident 120's current care plan titled ...potential for impaired gas exchange ...initiated 6/10/24, indicated Resident 120 had a problem of impaired gas exchange due to chronic obstructive pulmonary disease with a goal date of 4/2/25. Interventions included administering medications as ordered.</p> <p>A review of Resident 120's current care plan titled Cognitive Loss/Dementia, initiated 12/30/24 indicated Resident 120 was unable to make daily decisions without cues and supervision, with a goal date of 4/2/25. Interventions included giving feedback when an inappropriate decision was made.</p> <p>A review of physician orders dated 6/7/24 indicated Resident 120 should inhale 2 puffs of budesonide formoterol (Symbicort) twice daily and rinse his mouth after use. The order did not</p>				<p>current orders to self-administer medication will be reassessed by 4/2/2025 to ensure they are meeting the requirements for proper medication storage in their room.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>As above, nursing staff are being re-educated on proper storage of self-administered medication. The orders for self-administered medications will be re-written to provide a prompt for the nurse to annotate the medication are observed to be stored properly. Residents who have been deemed appropriate to self-administer medication will be reassessed every quarter and as needed.</p> <p>How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <p>DNS/designee will complete rounds 5 times a week for 4 weeks, then 3 times a week for 4 weeks then once weekly for 4 weeks and monthly for 3 months. The results of the audits will be shared with the QAPI committee monthly. If 100% is not achieved an action plan will be developed. The Administrator and Director of Nursing will discontinue this audit after 6 months if the facility is</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2025
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155095		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/11/2025	
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP COD 2001 HOBSON RD FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>include the medication could be kept at bedside.</p> <p>A review of physician orders, dated 1/6/25, indicated Resident 120 should take a Tums 500 mg tablet three times daily. The order indicated Tums tablets could be kept at Resident 120's bedside.</p> <p>No physician order for the use of biofreeze was available for review.</p> <p>Progress notes, dated February 1 through March 12, 2025, did not include documentation regarding self-administration of medications.</p> <p>A document titled Medication Self Administration Request/Evaluation, dated 10/29/24, indicated Resident 120 was evaluated for his ability to safely administer and store his Tums. No further self-administration evaluations were available for review.</p> <p>In an interview, on 3/6/25 at 2:23 PM, the Director of Nursing indicated residents should be assessed for the ability to self-administer and properly secure medications at bedside. She indicated only medications with specific orders to be kept at bedside should be stored at bedside in a lock box. She indicated medications should not be left out in the room unattended.</p> <p>A current policy, dated 12/1/07, provided by The Director of Nursing on 3/6/25 at 2:38 PM, indicated to ensure safe and appropriate self-administration of medications the facility should educate residents and ensure they could correctly store their medications in a locked compartment. The policy also indicated the facility should list all medications the resident may self-administer. The policy indicated the facility should routinely assess the resident's cognitive,</p>				100% compliant and the QAPI committee agrees that the audit is no longer needed.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2025
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155095		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/11/2025	
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP COD 2001 HOBSON RD FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	physical, and visual ability to carry out the responsibility of self-administration. Self-administered medications should be kept locked in a storage compartment in the resident's room, so another resident was not able to access the medications. 3.1-25 (m)						