STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155705	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF WARREN	801 N HUNTINGTON AVE WARREN, IN 46792

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: March 4, 5, 6, 7, 8, and 11, 2024 Facility number: 000542 Provider number: 155705 AIM number: 100267380 Census Bed Type: SNF/NF: 82 Residential: 90 Total: 172 Census Payor Type: Medicare: 1 Medicaid: 59 Private: 22 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 20, 2024.	F 0000	Please consider this Plan of Correction to be the facility's credible allegation of compliance. We respectfully request consideration for a desk review, as we have achieved substantial compliance with the applicable requirements set forth in the Plan of Correction. Please feel free to call 260-375-2201 if you have further questions. Respectfully, Terrence Jent, HFA, Executive Director.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terrence Jent	Executive Director	03/29/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent the development of a pressure ulcer for a dependent resident for 1 of 3 residents reviewed for pressure ulcers. (Resident 28) Finding includes: Resident 28's clinical record review was completed on 3/6/24 at 3:03 p.m. Diagnoses included unspecified dementia, intervertebral disc degeneration of the lumbar region, type 2 diabetes mellitus, generalized muscle weakness, unsteadiness on feet, other reduced mobility, and need for assistance with personal care. Current physician orders, dated 1/26/24, included the following: float heels while in bed every night shift for offloading, apply skin preparation (skin protectant) to bilateral heels every shift for protection, and apply pressure relief boot to right foot at all times except during transfers. A current physician order, dated 2/1/24, included a weekly foot inspection on evening shift. A Braden Scale (for predicting pressure sore risk), dated 12/11/23, indicated the following: the ability to respond meaningfully to pressure-related discomfort was slightly limited because the resident could not always communicate discomfort or the need to be turned, skin was exposed to moisture often, and friction and shear	F 0686	1 Resident #28 was not harmed by the alleged deficient practice. Resident #28 has had an updated Braden assessment to reflect the risk for skin breakdown. The pressure ulcer has healed, and the resident skin remains intact. All appropriate interventions have been implemented and the care plan has been updated accordingly. 2 All dependent residents have the potential to be affected by the alleged deficient practice. The DON/Designee has completed a Braden assessment for all residents that require extensive assistance or greater bed mobility. The care plan for each has been reviewed and updated with the appropriate interventions to assist in the prevention of skin breakdown. 3 DON/Designee has educated all licensed nurses regarding the prevention of pressure ulcers with the Pressure Ulcer/Skin condition Assessment policy, with emphasis on completion of the Braden assessment to identify residents at risk for skin	04/01/2024

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	was a potential problem due to the resident moved feebly or required minimal assistance. The resident was at risk for pressure ulcers. An annual Minimum Data Set (MDS) assessment, dated 12/11/23, indicated the resident's cognitive status was severely impaired. Rejection of care behaviors were not exhibited. He required substantial/maximal assistance from staff for rolling left and right, lower body dressing, putting on and taking off footwear, and for transfers. He was dependent for toileting. The resident was at risk for pressure ulcers. Skin treatments included, pressure reducing device for bed, pressure reducing device for chair, and application of ointments/medication other than to feet. A significant change MDS assessment, dated 2/20/24, indicated the resident's cognitive status was severely impaired. Rejection of care behaviors were not exhibited. He was dependent for transfers, toileting, lower body dressing, putting on and taking of footwear. The resident required substantial/maximal assistance to roll left and right. He had one unstageable pressure ulcer with coverage of the wound bed by eschar. Skin treatments included a pressure reducing device for chair, bed, nutrition or hydration intervention to manage skin problems, and pressure ulcer care. A current care plan, dated 12/13/18, indicated the resident had an activity of daily living self-care performance deficit related to pain, weakness, and decreased mobility. Interventions included the resident typically required extensive assistance of one staff member for bed mobility (revised 12/13/23) and the resident required a Hoyer (mechanical lift) with two staff members to provide assistance for all transfers (revised 2/2/24).		breakdown for preventative measure implementation. 4 DON/Designee will review 5 dependent residents for preventative measures implemented 4 x wk x 4 wks, then 2 x wk x 4 wks, then 1x wk x 4 wks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	A current care plan, dated 12/13/18, indicated the resident was at risk for pressure ulcers related to pain, weakness, and decreased mobility. The resident had an unstageable pressure ulcer of the right medial heel. Interventions included the following: identify/document potential causative factors and eliminate/resolve where possible (12/13/18), provide a pressure reducing mattress to protect the skin while in bed (12/13/18), float heels in bed as the resident tolerates (1/29/24), and apply a pressure relief boot to right foot at all times except during transfers as resident tolerates (1/27/24). A current care plan, dated 1/26/24, indicated the resident had an unstageable pressure injury (full-thickness wound covered in eschar [darkened dead tissue] or slough [creamy yellow/white dead tissue] with the wound bed unable to be observed) to the right medial heel. Interventions included the following: administer treatments as ordered and monitor for effectiveness (1/26/24), follow facility policies/protocols for the prevention/treatment of skin breakdown (1/26/24), and the resident requires a pressure relief boot to the right foot at all times, except during transfers (1/26/24). A Physician Note, dated 1/16/24 at 9:30 a.m., indicated the resident slept more and had experienced a slight decline since the last visit. Review of the residents Activity of Daily Living Bed Mobility documentation from 1/16/24 to 1/25/24 indicated the resident required extensive assistance to total dependence on staff for bed mobility for 24 out of 30 shifts. The clinical record lacked indication of new interventions for pressure ulcer prevention			

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	implemented when the resident experienced the physical decline, prior to the development of the resident's pressure ulcer on 1/26/24. Review of a Nurse's Note, dated 1/26/24 at 6:46 a.m., indicated a blister-like pressure ulcer to the residents right heel was identified. A request for a pressure relief boot order was made in the communication to the physician . A wound note, dated 1/26/24 at 8:21 a.m., indicated the resident's Stage 2 pressure ulcer (partial-thickness wound) to the right medial heel measured 2.7 centimeters (cm) length by 2.7 cm width. New orders were received for skin preparation, pressure relief boot, and floating heels. A wound note, dated 2/1/24 at 7:58 a.m., indicated the resident returned from a short hospital stay. The Stage 2 pressure ulcer remained, blister like, unchanged in size, but now purple in color. A Nurse's Note, dated 2/5/24 at 2:41 a.m. , indicated the resident was sent out for a hospitalization due to left leg swelling and a faint pedal pulse. A Nurse's Note, dated 2/8/24 at 10:56 p.m., indicated the resident returned from a hospitalization and the pressure ulcer to his right heel remained intact and was black. A wound note, dated 2/9/24 at 1:51 a.m., indicated the pressure ulcer to the right heel presented as an unstageable pressure ulcer with black eschar noted to the wound bed. A wound note, dated 2/19/24 at 4:55 p.m., indicated the resident's unstageable pressure			

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	ulcer to the right medial heel measured 3 cm length by 2.7 cm width. It remained stable with back eschar. During a wound observation on 3/7/24 at 10:45 a.m., the resident was laying in bed on his right side. A pressure relief boot was on the resident's right foot. His left foot rested against the mattress, did not have a pressure relieving boot in place, and his heels were not floated during the observation. The wound to the right medial heel was intact, circular, black, and approximately the size of a quarter. LPN 7 indicated the resident had one pressure relief boot in place on his right foot and his heels were not floated. The resident had a decline in mobility prior to the development of the pressure ulcer and was spending more time in bed. She thought the pressure ulcer developed because the resident was usually positioned on his left side facing the restroom with his legs bent at the knee. This allowed his right heel to rest against the bed. Staff had encouraged him to lay on his right side since the pressure ulcer developed. Prior to the development of the pressure sore, the pressure ulcer prevention intervention was a standard pressure relief mattress on his bed. After the pressure ulcer developed, they added new interventions for floating bilateral heels and the pressure relief boot. The pressure ulcer developed in the facility. During an interview on 3/8/24 at 9:51 a.m., CNA 9 indicated the resident required extensive assistance of two staff members for repositioning in bed. He was unable to turn on his own and required staff assistance with putting on and taking of any footwear. She indicated the resident should be repositioned every two hours, have his heels floated when he is in bed, and pressure relief boots in place on his feet. The resident was			

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	always cooperative with care. Some staff members were not floating the resident's heels or using both pressure relief boots for his care to prevent pressure ulcers. During an interview on 3/8/24 at 10:02 a.m., CNA 8 indicated the resident required staff assistance to turn in bed prior to his pressure ulcer development because he kept his legs bent at the knees. Prior to the development of the pressure ulcer, interventions were in place for pressure ulcers to included a pillow between his legs at the knees and non-skid socks on his feet. Since the pressure ulcer developed, she placed the pressure relief boots on his feet but she was not floating his heels. She indicated the CNA's did not have an area to document when heels were floated. During an interview on 3/8/24 at 3:50 p.m., the DON indicated she could not comment when pressure ulcer prevention measures should have been implemented if a resident had a decline in their mobility. During an interview on 3/11/24 at 3:20 p.m., the Infection Preventionist indicated a resident should be promptly reassessed for pressure ulcer risk when a resident has shown a decline with decreased mobility so pressure relief interventions could be implemented. This typically would trigger when a change of condition form was completed, but she was unable to provide this information for the resident. From 1/16/24 until the resident developed the pressure ulcer on his heel, staff charted the resident required extensive to total dependence for bed mobility. The resident was at risk for pressure ulcers due to weakness prior to the development of the pressure ulcer. His wound was facility acquired.			

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	A wound note, dated 3/11/24 at 12:08 p.m., indicated the resident continued with a pressure ulcer to the right medial heel. Eschar was no longer intact. The pressure ulcer was classified as a healing Stage 3 (full-thickness wound with involvement of tissue beneath) pressure injury and measured 2.3 cm length x 2 cm width. A current facility policy, dated 2/1/24, titled "Pressure Injury Prevention and Management,"provided by the Administrator on 3/8/24 at 12:29 p.m., indicated the following: "Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries... Policy Explanation and Compliance Guidelines: ... 2. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate... 3. Assessment of Pressure Injury Risk... b. ...Examples of risk factors include, but are not limited to: i. Impaired/decreased mobility and decreased functional ability...." 3.1-40(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a			

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	resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to ensure gastrostomy tube placement was confirmed prior to medication administration according to facility policy for 1 of 1 resident reviewed for tube feedings. (Resident 1) Findings include: Resident 1's clinical record was reviewed on 3/6/24 at 10:32 a.m. Diagnoses on the resident's profile included, but were not limited to, post-immunization acute disseminated encephalitis (swelling in the brain and spinal cord that causes damage to the sheath covering the nerve fibers), and dysphagia (difficulty swallowing), A physician's order, dated 5/13/2019, indicated check G-tube placement prior to bolus and medication administration and to maintain NPO (nothing by mouth), no exceptions.	F 0693	1 Resident 1 was not harmed by the alleged deficient practice. The physician and responsible party were notified that the resident did not have placement of the enteral tube verified prior to medication administration. The care plan was reviewed and updated. LPN 19 was provided immediate education regarding medication administration with enteral tube. LPN 19 has also completed return demonstration education. 2 All residents with enteral tube feeding have the potential to be affected. Each resident has been audited to ensure order in place to verify tube placement prior to each medication administration.	04/01/2024

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	A physician's order, dated 7/11/21, indicated administer medications via g-tube, medications may be mixed together and mixed with 30 mL sterile water. Flush with 30 mL before and after medication administration, every shift. An annual MDS assessment, dated 2/7/24, indicated the resident had paraplegia (paralysis affecting the legs), a PEG tube (percutaneous endoscopic gastrostomy or g-tube), anxiety, and a seizure disorder. She was cognitively intact. A current care plan, dated 5/14/19, indicated the resident required tube feedings, (nothing by mouth, no exceptions), related to dysphagia, chewing problems, and swallowing problems. Interventions included check for tube placement and gastric contents/residual volume per facility protocol and record. During a medication administration observation, on 3/7/24 at 11:01 a.m., LPN 19 crushed the resident's medications, placed a bolus syringe in the resident's feeding tube, and flushed with 360 milliliters (mL) sterile water. She added a liquid medication, flushed with more water, added the crushed medications to the syringe, and flushed with more water. During an interview at the time of the observation, she indicated she had failed to check for residual gastric contents to confirm placement. She would have typically checked for residual before administering medications. During an interview with LPN 20, on 3/11/24 at 10:51 a.m., she indicated placement of the feeding tube should be confirmed prior to administering anything through the tube.		3 DON/designee have educated all licensed nurses and QMA's regarding the gastric tube feeding policy. 4 DON/Designee will observe 2 members of the clinical staff that are licensed/certified to administer medications, during medication administration of an enteral tube to verify proper procedure completed with placement verification, weekly x 12 weeks. The DON will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	During an interview with the Director of Nursing, on 3/11/24 at 10:56 a.m., she indicated she would refer to the facility's policy for feeding tube care before she could say what was the process. A current, undated, facility policy titled "Tube Feedings, Nasogastric and Gastrostomy", provided by the DON on 3/8/24 at 9:58 a.m., indicated the following: "...8) Apply gloves and pull back slightly on the syringe, place the barrel of the syringe into the tube. Listen to the abdomen with the stethoscope while slowly pushing a small amount of air into the abdomen and listening for the air bolus. If air bolus is not heard, pull back on the syringe a little more to see if any residual is noted. If no air bolus or residual assessed, notify physician,. 9) If physician order is to check for placement by checking for residual and the amount of feeding to be given is based on residual, do not check placement with air bolus. Follow order as directed." Under the heading "Medication Administration", the second step indicated "Check placement of the tube, and flush the tube prior to the medication administration with 30 cc of tap water, or as ordered...." 3.1-44(a)(2)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing in-service education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (q) Each facility shall maintain current and accurate personnel records for all employees. The	F 9999	It is the policy of Heritage Pointe of Warren to maintain files in an organized way and ensure that in-service training is planned in advance for all personnel. All residents are at risk from the deficient practice. The HR Generalist has completed an audit of identified employee files that	04/01/2024

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	personnel records for all employees shall include the following: (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed provide complete and accurate records for 6 of 10 employee records reviewed (LPN 10, CNA 11, CNA 14, LPN 15, RN 17, CNA 18). Findings include: Employee records were reviewed on 3/7/24 at 2:10 p.m., and indicated the following: LPN 10, RN 17, and CNA 18's records lacked annual resident rights in-service training. CNA 14's records lacked resident rights in-service training upon hire. LPN 10, RN 17, and CNA 18's records lacked annual abuse in-service training.		require documents or in-service education. The HR Generalist, or her designee, will make all required corrections to identified files by 4/1/2024. The Administrator, or his designee, will audit 5 employee files daily for 2 weeks and weekly for 4 weeks. The Administrator, or his designee, will report on audits monthly to the QAPI committee. QAPI committee will determine if audits are necessary to continue after 6 months with 100% compliance achieved.	

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	CNA 11's records lacked a criminal background history. CNA 14, and LPN 15's records lacked signed job descriptions. Review of the clinical schedule, from 3/4/24 through 3/11/24, included the following: LPN 10's hire date was 8/29/22. Days worked included 3/4/24, 3/6/24, and 3/7/24. CNA 11's hire date was 1/3/24. Days worked included 3/8/24, 3/9/24, and 3/10/24. CNA 14's hire date was 1/3/24. Days worked included 3/6/24, and 3/8/24. LPN 15's hire date was 1/25/24. Days worked included 3/11/24. RN 17's hire date was 8/15/97. Days worked included 3/4/24, 3/5/24, 3/8/24, and 3/11/24. CNA 18's hire date was 7/21/21. Days worked included 3/8/24, and 3/9/24. During an interview, on 3/7/24 at 2:30 p.m., Human Resource indicated she knew the records were incomplete, and there were no other records to be submitted. A current undated facility policy titled "Policy for Maintaining Employee Records", provided by the Administrator on 3/11/24 at 4:35 p.m., indicated the following: " ...initial orientation of all staff must be conducted and documented in the personnel file shall include the following: a review of resident rights and other pertinent portions of the facility policy manual; Each facility shall			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155705	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF WARREN	801 N HUNTINGTON AVE WARREN, IN 46792

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	maintain current and accurate personnel records for all employees ...."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 4, 5, 6, 7, 8, and 11, 2024 Facility number: 000542 Residential Census: 90 Heritage Pointe of Warren was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed March 20, 2024.	R 0000	Please consider this Plan of Correction to be the facility's credible allegation of compliance. We respectfully request consideration for a desk review, as we have achieved substantial compliance with the applicable requirements set forth in the Plan of Correction. Please feel free to call 260-375-2201 if you have further questions. Respectfully, Terrence Jent, HFA, Executive Director.	