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	02/26/2025

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 and Investigation of Complaint IN00448685. This visit included a State Residential Licensure Survey. Complaint IN00448685 - No deficiencies related to the allegations are cited. Survey dates: February 19, 20, 21, 24, 25, and 26, 2025 Facility number: 000542 Provider number: 155705 AIM number: 100267380 Census Bed Type: SNF/NF: 87 Residential: 105 Total: 192 Census Payor Type: Medicare: 5 Medicaid: 43 Other: 39 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 5, 2025.	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 this Plan of Correction. Please feel free to contact 260-375-2201 if you have questions or require additional information. Respectfully, Terrence Jent, HFA, Executive Director.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on interview and record review, the facility failed to complete post-dialysis assessments on 1 of 1 resident reviewed for dialysis. (Resident 48)	F 0698	It is the policy of Heritage Pointe of Warren to ensure that post-dialysis assessments are	03/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terrence Jent	Executive Director	03/17/2025

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	Findings include: Resident 48's clinical record was reviewed on 2/21/25 at 9:42 a.m. Diagnosis included end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, essential hypertension, hypothyroidism, and muscle weakness. Current physician orders included complete dialysis assessment under the assessment tab one time a day every Monday, Wednesday, and Friday. White dialysis communication binder with current vitals were to accompany resident to every dialysis appointment. Bed bath only due to dialysis port. Review of the clinical record indicated no dialysis assessment was completed on January 8, January 17, February 12, and February 14, 2025. Resident 45's dialysis binder indicated dialysis had been completed on these dates. During an interview, on 2/25/25 at 10:28 a.m., LPN 6 indicated once the resident returns from dialysis, the nurse would complete the post-dialysis assessment. That assessment was located under the assessment tab. During an interview, on 2/25/25 at 10:32 a.m., RN 11 indicated the dialysis assessment was completed each shift. During an interview, on 2/25/25 at 12:23 p.m., the DON indicated when a resident admitted with dialysis needs, staff placed an order to do post-dialysis assessments upon the residents return from dialysis. Resident 45's post dialysis assessments had not been completed.		completed for all residents receiving dialysis. 1 Resident #45 had no adverse effects related to missing assessments. Immediate education was provided to licensed staff regarding completion of post-dialysis assessments (Exhibit A). 2 All residents receiving dialysis have the potential to be affected. 3 To ensure the deficient practice does not recur all licensed nursing staff will be educated regarding policy and procedure for post-dialysis assessments. Dialysis policy and procedure has been reviewed and revised (Exhibit B). 4 To monitor corrective actions and avoid recurrence, the DON or her designee will complete the Survey POC QA Tool (Exhibit C). This tool will be completed daily for 30 days then monthly until 100% compliance is achieved for 3 consecutive months. The QAPI plan will be reviewed and revised as needed in scheduled QAPI meetings. 5 All systemic changes will be completed by 3/31/25.	

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	A current facility policy, titled "Dialysis Care," provided by the DON on 2/25/25 at 12:23 p.m., indicated the following: "...Post- Dialysis assessment will be documented in the resident's EMR. The assessment should include conditions of the site, vital signs, and any abnormal symptoms ...." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure shift to shift narcotic count and reconciliation was completed for 2 of 3 medication carts reviewed for medication reconciliation. (100 Hall) Findings include: 1. During a medication storage observation of the 100A new medication cart, on 2/21/25 at 10:49 a.m., accompanied by RN 4, the "Narcotic Sheet Log/ Tracking Form" was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: January 2025- lacked a narcotic card, liquid, and/or bottle count: 1/12 on evening shift 1/13 on day shift and evening shift 1/17 on evening shift and night shift 1/18 on night shift	F 0755	It is the policy of Heritage Pointe of Warren to ensure that shift-to-shift narcotic counts are completed. 1 There were no adverse effects noted to any residents. 2 Any residents receiving narcotic medications have the potential to be affected. 3 To ensure the deficient practice does not recur all licensed nursing staff will be educated regarding shift-to-shift narcotic count sheets. Narcotic Medication Count Policy has been reviewed and revised (Exhibit D). 4 To monitor corrective actions and to avoid recurrence, the DON or her designee will complete the Survey POC QA Tool (Exhibit C). This tool will be completed daily for 30 days then monthly until 100% compliance is achieved for 3 consecutive months. The QAPI plan will be reviewed and revised as needed in scheduled QAPI	03/31/2025

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	1/19 on day shift 1/20 on day shift, evening shift and night shift 1/21 on day shift and night shift 1/22 on day shift and night shift 1/23 on day shift 1/25 on day shift 1/27 on evening shift 1/31 on evening and night shift February 2025- lacked a narcotic card, liquid, and/or bottle count: 2/1 on day shift and evening shift 2/3 on day shift and night shift 2/5 on night shift 2/6 on day shift, evening shift and night shift 2/8 on night shift 2/9 on day shift 2/10 on day and evening shift 2/13 on night shift 2/14 on day shift 2/15 on night shift 2/16 on day shift and night shift		meetings. 5 All systemic changes will be completed by 3/31/25.	

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	2/17 on day shift, evening shift and night shift 2/18 on day shift and night shift 2/20 on night shift 2/21 on day shift During an interview, at the time of the observation, RN 4 indicated the narcotic shift count was completed every shift. 2. During a medication storage observation of the 100 A old medication cart, on 2/21/25 at 11:04 a.m., accompanied by LPN 5, the "Narcotic Sheet Log/ Tracking Form" was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: February 2025- lacked a narcotic card, liquid, and/or bottle count: 2/3 on evening shift 2/8 on night shift 2/9 on day shift 2/13 on evening shift 2/14 on day shift 2/15 on night shift 2/16 on day shift 2/17 on evening shift and night shift 2/18 on day shift and night shift			

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	2/19 on day shift and evening shift 2/20 on evening and night shift 2/21 on day shift During an interview, at the time of the observation, LPN 5 indicated the narcotic count was completed by the oncoming nurse and off going nurse during shift change. The narcotic sheet was not completed, and he did not sign the narcotic sheet when he took over the medication cart that morning. During an interview, on 2/21/25 at 11:56 a.m., the DON indicated staff was to complete the narcotic sheet count when the staff member took over control of the medication cart during oncoming and off going shift change. A current facility policy, titled "Counting Controlled Substances," provided by the Administrator, on 2/24/25 at 1:50 p.m., indicated the following: ... "Controlled drugs are counted at shift change or at any time keys to medication cart are given to another licensed nurse or QMA ...." 3.1- 25(b)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control A. Based on observation, interview, and record review, the facility failed to utilize infection prevention and control strategies during wound care for 1 of 1 residents reviewed for pressure ulcers (Resident 76). B. Based on observation, interview, and record	F 0880	It is the policy of Heritage Pointe of Warren to ensure that (a) utilize infection prevention and control during wound care, and (b) ensure transmission-based precautions are followed. 1 There were no adverse	03/31/2025

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	review, the facility failed to ensure transmission-based precautions were followed for 2 of 12 residents placed on transmission-based precautions (Resident 44 and Resident 45). Findings include: A. Resident 76's clinical record was reviewed on 2/24/25 at 10:05 a.m. Diagnoses included need for assistance with personal care, gastrostomy status, and encounter for surgical aftercare following surgery on the digestive system. Current physician's orders included the following: apply hydrocolloid (for wound healing) dressing to right and left buttock every day shift every Wednesday for protection related to wound and apply after shower (2/19/2025), Monitor hydrocolloid dressing to bilateral buttocks and replace if dressing is soiled or no longer intact every shift (2/12/25), and enhanced barrier precautions - wear gown/gloves to enter room while performing high contact care activities such as bathing/showering, providing personal hygiene or toileting, transferring residents from one position to another, changing bed linens, performing wound care, caring for indwelling devices. maintain for the duration of stay in the facility every shift for gastrostomy (feeding) tube (1/15/25). A current care plan indicated Resident 76 required enhanced barrier precautions related to her gastrostomy tube. Interventions included the following: Perform hand hygiene upon entering and exiting the resident's room and when donning and doffing personal protective equipment (PPE). During a wound care observation, beginning at 10:11 a.m. on 2/24/25, LPN 6 checked the resident's		effects noted to any residents. Immediate education was provided to the staff member involved regarding handwashing and PPE (Exhibit E). 2 All residents have the potential to be affected. 3 To ensure the deficient practice does not recur all clinical staff will be educated regarding infection control program. The infection control program has been reviewed. 4 To monitor corrective actions and to avoid recurrence, the DON or her designee will complete the Survey POC QA Tool (Exhibit C). This tool will be completed daily for 30 days then monthly until 95% compliance is achieved for 3 consecutive months. The QAPI plan will be reviewed and revised as needed in scheduled QAPI meetings. 5 All systemic changes will be completed by 3/31/25.	

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	physician orders, gathered wound care supplies, applied a gown and gloves, and entered the resident's room. She placed the packaged wound dressings directly on the resident's bedside table. She placed a container of normal saline wound cleanser on the packaged dressings. She moved the container of wound cleanser off the wound dressings to set directly on the bedside table. The resident stood up and requested to go to the bathroom. LPN 6 assisted the resident to the bathroom and placed the wound dressing packages and the container of wound cleanser directly on the shelf of the bathroom sink. LPN 6 assisted the resident to pull down her pants and sit down. The resident spilled a cup of ice on the floor. LPN 6 gathered the ice with paper towels, then regular towels and cleaned the ice off the floor. She placed the regular towels in a plastic bag. LPN 6 removed her gloves and washed her hands. The resident requested LPN 6 to perform the wound care while her pants were down in the bathroom. The area was cleansed with the wound cleanser, dried with a gauze dressing pad, then a hydrocolloid dressing was applied. LPN 6 assisted the resident to pull up her pants then she assisted the resident back to her chair. LPN 6 removed her gloves (she did not perform hand hygiene), gathered her supplies and the bagged dirty towels, then began removing her gown. She walked into the hallway and past the next room with her gown halfway on and halfway off. She continued to remove her gown then walked back into the resident's room to throw the gown in the trash. She placed the container of wound cleanser in her pocket. She took keys out of her pocket and went to the medication room. She placed the additional dressings in the resident's section of the wound cart. LPN 6 removed keys from her pocket, walked to and entered the soiled utility, and placed the bagged soiled towels in the			

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	laundry barrel. LPN 6 exited the soiled utility and walked to the clean utility. She washed her hands. She turned off the water faucet with a paper towel, passed the contaminated paper towel to her other hand then dried her hands again before she threw away the paper towel. During an interview on 2/24/25 at 10:30 a.m., LPN 6 indicated she should have placed a barrier under her wound supplies in the resident's room. She should have removed her gown in the resident's room before exiting and sanitized her hands immediately after glove removal. She should have thrown the paper towel away after touching the faucet and not used it to dry her hands more. During an interview, on 2/25/25 at 3:56 a.m., the Infection Preventionist (IP) indicated a barrier should be put down to place wound supplies on that may be taken back out of the resident's room. PPE should be removed prior to exiting the room. When handwashing was performed, a clean paper towel should be used to turn off the faucet then thrown away into the trash and not placed into the other hand or used after touching the faucet. A current facility policy, dated 1/1/25, titled "Infection Prevention and Control Program," found on the facility conference table on 2/26/25 at 8:30 a.m., indicated the following " ...All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services ...." A current undated facility policy and procedure, titled "HANDWASHING AND SANITIZING," found on the facility conference table on 2/26/25 at 8:30 a.m., indicated the following: " ...Handwashing/sanitizing will be practiced as			

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	follows: ... 2. Before and after resident contact ...6. Before leaving the resident in an isolation room ...Hands must be washed after removing disposable gloves ...PROCEDURE ...6. Dry hands, and turn off faucets with a clean paper towel. Discard towel ...." B.1. During an observation, on 2/25/25 at 9:58 am, Resident 44 was lying in a recliner, resting with her eyes closed at the nurses' station. During an observation, on 2/25/25 at 10:05 a.m., Resident 44's room had a sign outside the door indicating the resident was under yellow zone transmission-based precautions. Resident 44 was lying in a recliner with her feet elevated and a blanket on her at the nurses' station. She repeatedly stated, "I don't feel good." She did not wear a mask or have a mask close to her. The resident's recliner was positioned in a way where a person would have to pass within three feet of her to go between the two halls on the unit unless the person went behind the nurses' station. During an interview, on 2/25/25 at 10:26 a.m., CNA 8 indicated when a resident was on the yellow transmission precautions a surgical mask, gown, and gloves were to be worn to enter the room. If a resident was placed on yellow transmission-based precautions, they should not be out of their room, except for Resident 44 because she wouldn't stay in her bed. She had been out at the nurses station for a while. She was toileted and had just been laid down. She had been up and down all night long. She had been brought out of her room to decrease her risk of falling. During an interview, on 2/25/25 at 10:46 a.m. LPN 6 indicated when a resident was placed on the yellow transmission-based precautions, an N95			

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	mask, a gown, gloves, and a face shield or eye protection was required to enter the room. A resident on yellow transmission-based precautions should not be out of their room. Resident 44 required transmission-based precautions. She kept sitting on her bed and yelling out. The CNAs checked on her and toileted her. The CNAs said she had been up all night. The CNAs brought her out to the nurses' station to reduce her risk of falling. Resident 44's clinical record was reviewed on 2/25/25 at 2:02 p.m. Diagnoses included supraventricular tachycardia (heart condition where the heart beats faster than 100 beats per minute), saddle embolus of pulmonary artery (a large blood clot lodges at the division of the two branches of the main pulmonary artery, potentially blocking blood flow to both lungs) without acute cor pulmonale, hypertension (high blood pressure), and type 2 diabetes mellitus. Current physician's orders included droplet and contact precautions with eye protection - isolation-must wear gown, gloves, mask, eye protection. Awaiting swabs or 24 hours from symptoms every shift for respiratory symptoms (started 2/25/25 at 6:00 a.m.). A Health Status Note, dated 2/25/25 at 2:07 a.m., indicated the resident was awake at the beginning of the shift. When the resident was placed in bed, she began sitting on the side of the bed. She had been repeating "I don't feel good." The resident developed a continuous barking cough and slight wheezing upon exhalation. A rapid COVID-19 test was negative. A respiratory panel specimen was collected and was waiting to be sent out. A Behavior Note, dated 2/25/25 at 5:41 a.m.,			

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	indicated the resident continuously sat on the side of the bed and yelled out for help. The staff were unable to console her, and she did not want to be left alone. The resident was taken to the lounge to sit in a high traffic area for safety. A Nurses Note, dated 2/25/25 at 9:47 a.m., indicated the resident had been reported to be restless throughout the night and requested to rest in the recliner in the lounge. The resident was resting in the recliner in the lounge with her eyes closed. During an interview, on 2/25/25 at 3:56 p.m., the Infection Preventionist (IP) indicated when a resident was placed on yellow transmission-based precautions, they were generally waiting for test results for COVID-19, influenza, and respiratory syncytial virus (RSV). To enter a yellow transmission-based precautions, the staff member should wear a gown, gloves, N95 mask, and a face shield. A resident on yellow transmission-based precautions should stay in their room and not be at the nurses' station. B.2. During a random observation, on 2/25/25 at 12:15 p.m. CNA 9 entered Resident 45's room wearing gloves, surgical mask, and a gown. CNA 9 was not wearing a face shield or N95 mask. Signage on the door indicated the resident was on yellow transmission- based precaution and required a gown, gloves, N95 mask and face shield/goggles before entering the resident's room. During an interview, on 2/25/25 at 12:20 p.m., CNA 9 indicated she did not don an N95 mask or face shield/goggles before entering the resident's room. During an interview, on 2/25/25 at 12:22 p.m., IP			

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	indicated, before entering a resident's room on transmission-based precautions a gown, gloves, N95 mask and face shield/goggles needed to be worn. Resident 45's clinical record was completed on 2/25/25 at 12:30 p.m. Diagnosis included, but were not limited to, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, essential hypertension, anemia, chronic kidney disease, and hypocalcemia. Current physician's orders included droplet and contact precautions with eye protection-isolation-must wear gown, gloves, mask, and eye protection. Resident resides in room alone, all care and services are being provided in the resident's room, and Tamiflu (anti-viral for influenza) 30 milligrams twice a day for five days. A progress note, dated 2/24/25 at 3:43 p.m., indicated Resident 45 tested positive for Influenza A. A current facility policy, dated 9/2022, titled "Transmission-Based (Isolation) Precautions," found on the facility conference table on 2/26/25 at 8:30 a.m., indicated the following: " ...Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission ...Residents on transmission-based precautions should remain in their rooms except for medically necessary care ...." A facility sign, provided by the IP on 2/25/25 at 4:02 p.m., had a picture of traffic light with the yellow light being shown. The sign indicated			

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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
	"YELLOW ZONE" and required transmission-based precautions which was contact/droplet. PPE required was N95 mask, face shield or goggles, single gown with each encounter, and gloves. 3.1-18(a) 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00448685. Complaint IN00448685 - No deficiencies related to the allegation are cited. Survey dates: February 19, 20, 21, 24, 25, and 26, 2025 Facility number: 000542 Residential Census: 105 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed March 5, 2025.	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 this Plan of Correction. Please feel free to contact 260-375-2201 if you have questions or require additional information. Respectfully, Terrence Jent, HFA, Executive Director.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on observation, record review, and interview, the facility failed to ensure residents were evaluated for the self-administration of medications for 2 of 5 residents observed during medication administration (Resident R9 and	R 0216	It is the policy of Heritage Pointe of Warren to evaluate all residents for self-administration of medications. 1 There were no adverse	03/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Resident R10). Findings include: 1. During a medication administration observation, on 2/26/25 at 10:12 a.m., a trihexyphenidyl (for dystonia) 2 milligrams (mg) tablet was prepared by RN 12. She left the tablet in Resident 10's room. She did not observe the resident ingest the medication. RN 12 indicated the resident had an order to self-administer her medications. Resident R10's clinical record was reviewed on 2/26/25 at 11:30 a.m. Diagnoses included dystonia, other specified arthritis, hyperlipidemia, gastroesophageal reflux disease, and hypokalemia. Physician's orders included trihexyphenidyl 2 mg twice a day and 4 mg twice a day (1/23/25) and may leave prepared meds at bedside for resident to self-administer every shift per resident request for dignity (3/11/23). The clinical record lacked a medication self-administration evaluation. 2. During a medication administration observation, on 2/26/25 at 10:45 a.m., RN 12 prepared the following medications: calcium with vitamin D 600 mg/20 mcg (micrograms), docusate sodium (stool softener) 100 mg, and rivaroxaban (blood thinner) 15 mg. She delivered and left the medications in Resident 9's room. She did not observe the resident ingest the medications. RN 12 indicated the resident had an order to self-administer her medications. R9's clinical record was reviewed on 2/26/25 at 11:36 a.m. Diagnoses included paroxysmal atrial		effects were noted to residents 9 & 10. 2 All residents have the potential to be affected. A comprehensive audit of all AL residents was completed with no concerns noted. 3 To ensure the deficient practice does not recur all licensed staff will be educated regarding self-administration of medication assessments. 4 To monitor corrective actions and to avoid recurrence, the DON or her designee will complete the Survey POC QA Tool (Exhibit C). This tool will be completed daily for 30 days then monthly until 100% compliance is achieved for 3 consecutive months. The QAPI plan will be reviewed and revised as needed in scheduled QAPI meetings. 5 All systemic changes will be completed by 3/31/25.	

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	fibrillation (abnormal heart rhythm), vitamin deficiency, unspecified, constipation, unspecified, hypocalcemia (low calcium), cognitive communication deficit, cerebral infarction, unspecified, and aphasia. Physician's orders included calcium+D3 600 mg/20 mcg daily (8/1/24), docusate sodium 100 mg twice a day (8/1/24), rivaroxaban 15 mg daily (8/1/24), and may leave prepared meds at bedside for resident to self-administer (2/9/25). The resident's clinical record lacked a medication self-administration evaluation. During an interview, on 2/26/25 at 3:03 p.m., the Assisted Living Director and the DON indicated Residents R9 and R10 did not have self-administration evaluations completed. The Assisted Living Director indicated that since the medications were prepared and set up by the nurse, she did not believe self-administration evaluations were required. A current facility policy, dated 1/1/25, titled "Resident Self-Administration of Medication," provided by the Assisted Living Director on 2/26/25 at 4:15 p.m., indicated the following: " ...A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely ...."			