STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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 the Investigation of Complaints IN00435305 and IN00436564. Complaint IN00435305-Federal/State deficiencies related to the allegations are cited at F610. Complain IN00436564-Federal/State deficiencies related to the allegations are cited at F684 and F690. Survey dates: July 8, 9, 10, 11 and 12, 2024. Facility number: 000271 Provider number: 155402 AIM number: 100291260 Census Bed Type: SNF/NF: 72 Total: 72 Census Payor Type: Medicare: 2 Medicaid: 59 Other: 11 Total: 72 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 24, 2024.	F 0000		
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment,			

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

Joshua Davis | Executive Director | 08/09/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate allegations of a staff member working while impaired and the potential residents' physical or emotional suffering from the impaired staff member's interactions for 1 of 1 staff member reviewed for allegation of abuse. (CNA 12) Finding includes: A Facility Reported Incident (FRI), dated 5/24/24, indicated Resident B had voiced concerns by social media. The resident indicated a male employee refused drug testing when it was reported he was altered. The staff was terminated due to refusal of the testing and left the building. The facility completed resident interviews, staff interviews, skin assessments, and education as deemed necessary. The clinical record for Resident B was reviewed on 7/10/24 at 12:25 p.m. The diagnoses included, but were not limited to, fusion of the spine in the	F 0610	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	lumbar region, generalized anxiety disorder, depression, and chronic obstructive pulmonary disease. An undated note from social media was provided by the Administrator on 7/11/24. The note was a copy of the social media post by Resident B. The resident indicated a male staff had touched her in an inappropriate manner and was extremely drunk. The male staff was dismissed from his job. The FRI, dated 5/24/24, did not include the allegation of Resident B being touched in an inappropriate manner. The full investigation of the incident was requested from the Administrator on 7/9/24, and again on 7/11/24 at 1:50 p.m. The resident interviews were provided on 7/11/24 and no staff interviews were included. The staff interviews along with the complete investigation were again requested. On 7/12/24 at 10:34 a.m., the completed investigation of the incident including the staff interviews was again requested. The Administrator indicated the Clinical Support was reviewing the file. The staff interviews were not provided by the facility until 7/12/24 at 11:45 a.m. A staff statement by the Assistant Director of Nursing (ADON), dated 5/13/24, indicated Resident B's husband called her to report the resident had concerns about a male CNA who provided care to her. The resident was in her room and indicated she was okay. The resident was asked about the concerns with the male CNA, and she indicated the CNA was acting weird and she could smell alcohol on his breath. The CNA kept getting close to her and putting his hand near her chest and shoulder area. The resident denied CNA 12 had touched her inappropriately.		**F 610** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident B had no negative physical or psychosocial outcomes related to alleged incident. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents have the potential to be affected therefore an IN house audit has been completed by the DON/SSD on residents under CNA # 12 care on May 24th, 2024. No other concerns were noted form other residents he came in contact with. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. THE RDCS will educate the DON/SSD/and ED on completing in its entirety the abuse checklist list by date of compliance. Abuse reporting will be completed to staff by nursing management by date of compliance. This education will be completed at least annually and as needed going forward. No staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	The investigation documents or statement from the ADON during the interview with Resident B did not include how the resident felt or her emotional status after the interaction with CNA 12. A staff statement by the ADON, dated 5/13/24, indicated CNA 12 was brought by the nurse in Duncan Hall to the other side of the building since the nurse was questioning if the CNA was impaired. The CNA was already in the Earhart Hall by the linen closet. The CNA looked confused and then he found a pillowcase and gave it to the resident who requested it. The CNA was asked to go to the ADON office and was not walking in a straight line. CNA 12 sat down and could hardly keep his eyes open and was slurring his words. The Administrator was called and sent a Reasonable Suspicion Checklist for Drug and Alcohol Screening Form. CNA 12 continued with signs of impairment including slurred and rambling speech, typing slowly on his cellular phone, kept closing his eyes, and staring. CNA 12 indicated he would never hurt a resident. CNA 12 admitted to drinking on the job and decided to not get tested. The Administrator had set up an Uber ride to take CNA 12 home. A staff statement by RN 13, dated 5/13/24, indicated CNA 12 was oriented to the evening shift on Duncan Hall. He only assisted one resident to lay down, weighed another resident, passed one dinner tray, and toileted one resident. CNA 12 was not responding to call lights. RN 13 had to show CNA 12 where the linen closet was located 4 times and where the soiled utility room was 3 times. The CNA took a dirty brief into the clean linen room. Two residents had complained CNA 12 had run over their feet while assisting		will work past date of compliance without education being completed. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. THE ED and DON will review all investigations once completed with the checklist to ensure investigation completed in its entirety and accurately. The RDCS will review once completed as well. This will be an ongoing process. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/13/24 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	them to the bathroom. He did not act like he knew what he was doing. CNA 12 had very bloodshot reddened eyes and he was dozing at the nurse's station. RN 13 asked CNA 12 to go to the Earhart unit to assist. He had to be physically assisted to go to Earhart Hall. The ADON was informed he appeared to be impaired. The staff statements from the ADON and RN 13 did not indicate the exact amount of residents CNA 12 cared for while on duty and did not clarify how many residents were toileting since RN 13's statement indicated one resident was toileted and 2 residents had their feet ran over while being assisted to the bathroom. A staff statement by the Administrator, dated 5/14/24, indicated Resident B was interviewed about her interaction with CNA 12. Resident B indicated the CNA was acting oddly, was confused, asked the same question multiple times and was offering her assistance out of bed. Resident B was worried the CNA might try to touch her although he did not. The investigation documents or statement from the Administrator during the interview with Resident B did not include how the resident felt or her emotional status after the interaction with CNA 12. A psychiatric Nurse Practitioner note, dated 5/20/24, indicated the resident had increased depression due to the recent passing of her mother. The progress notes and facility investigation did not include the NP being informed of a possible interaction with CNA 12.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	The progress notes and facility investigation did not include a psychosocial assessment from the Social Services Director. The complete investigation provided by the facility only included three resident skin checks and 4 resident check list questions about abuse. The facility documents or investigation did not include statements from the residents about interactions with CNA 12. The facility documents or investigation did not indicate if these were the residents who complained of having their feet run over by CNA 12. During an interview, on 7/11/24 at 1:50 p.m., the Administrator indicated he was working at the facility on 5/13/24 and he had seen CNA 12 between 3:00 p.m. and 5:00 p.m. and did not notice anything unusual. Later in the day, he received a call from the ADON, and she indicated CNA 12 was not acting right. CNA 12 was staring off into space. He talked to CNA 12 on the telephone, and he refused to let the drug screen be completed. The CNA was assisted out of the facility and to his home. The ADON had talked to Resident B, and she said she was okay, and nothing had occurred. The investigation started the next day. Resident B stated CNA 12 was going to try to touch her although he did not. The resident's husband was upset about the situation, and he said CNA 12 touched the resident. Resident B again stated the staff did not touch her. He did not know if social services had documented any conversations or follow up with Resident B. The incident occurred on 5/13/24 and was not reported until 5/24/24 when Resident B put her concerns on a social media post. The resident's son had called after the social media post and after the resident was discharged to report she had past sexual abuse and would get nervous if she thought it			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	could happen again. A current policy, titled Abuse-Conducting and Investigation," dated as last reviewed on 6/17/24 and received from the Administrator at entrance, indicated "...It is the policy of this facility that allegations of abuse...are promptly and thoroughly investigated. The facility will prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progress...Resident have the right to live at ease in a safe environment without the fear of retaliation when allegations are reported...The alleged victim will be examined for any signs of injury, including a physical examination or psychosocial assessment, if needed...The facility must thoroughly collect evidence to allow the Administrator to determine what actions are necessary [if any] for the protection of residents. Depending on the type of allegation received, it is expected that the investigation would include, but is not limited to...Conducting observations of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents...Conducting interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses, practitioner, interviews with personnel from outside agencies...Conducting record review for pertinent information related to the alleged violation, as appropriate, such as progress notes...The administrator/designee will review the Incident Report for completeness and assure that the physician and resident representatives have been notified of the circumstance...The written summary of the investigation should include, but is not limited to....A review of the Incident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	Report...An interview the person[s] reporting the incident...An interview with the resident, if appropriate...Interviews with staff members on all shifts having contact with the resident at the time of the incident...Interviews with the resident's roommate, family, and/or visitors who may have information about the incident...Interviews other residents who received care of services from the alleged perpetrator...A review of all circumstances surrounding the incident...Emotional support and counseling will be provided to the resident during and after the investigation, as needed...." This citation relates to Complaint IN00435305. 3.1-28(d)			
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.			
	Based on interview and record review, the facility failed to submit a discharge MDS (Minimum Data Set) assessment upon discharge, making the assessment greater than 120 days since the last submitted assessment for 1 of 2 residents reviewed for resident assessments. (Resident 67)	F 0640	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	Finding includes: The clinical record for Resident 67 was reviewed on 7/12/24 at 3:10 p.m. The diagnoses included, but were not limited to, hypo-osmolality (nutrient levels in the blood are lower than normal), hyponatremia (low sodium level in the blood), alcohol abuse, pneumonia, cystitis (infection in the bladder), dysphagia (difficulty swallowing), and protein calorie nutrition. An admission MDS assessment, dated 2/9/24, indicated it was submitted 2/9/24 and was approved. A discharge MDS assessment, dated 5/1/24, indicated the assessment was pending and was not submitted. During an interview, on 7/12/24, the MDS Coordinator indicated the discharge assessment should have been completed and submitted. During an interview, on 7/12/24 at 3:28 pm, the Administrator indicated the facility used the RAI manual, there was no facility policy. 3.1-31(b)		maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 640** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 67 had no negative physical or psychosocial outcomes related to alleged incident. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents have the potential to be affected therefore an IN house audit has been completed by the MDS Coordinator/CRS by date of compliance to ensure no other late assessments discovered. No other	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
			issues noted. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. The ED will educate the MDS Coordinator by date of compliance on the policy for submitting assessments timely. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. THE MDS Coordinator will run the Admission/Discharge/Transfer report weekly to ensure compliance ongoing. The ED will validate monthly as well to ensure compliance ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/13/24 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	
F 0644 SS=D	483.20(e)(1)(2) Coordination of PASARR and Assessments			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
Bldg. 00	§483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to resubmit a PASARR (Preadmission Screening and Record Review) for a resident after a new mental health diagnosis and medication were added for 1 of 3 residents reviewed for PASARR. (Resident 70) Finding includes: The clinical record for Resident 70 was reviewed on 7/10/24 at 9:52 a.m. The diagnoses included, but were not limited to, major depressive disorder, moderate vascular dementia, psychotic disorder with delusions, and sleep disorder. A medical diagnosis list indicated the resident was added a diagnosis of mild major depressive disorder on 2/2/24 A physician's order, with a start date of 2/3/24,	F 0644	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	indicated the resident was prescribed sertraline (an antidepressant medication) 25 mg (milligram). A PASARR, with a notice date of 4/24/23, indicated Resident 70 was evaluated and had no mental health diagnosis or mental health medications There was no record of another PASARR being completed after the major depressive disorder diagnosis or antidepressant medication were added. During an interview, on 7/12/24 at 10:37 a.m., the Social Services Director (SSD) indicated the resident did not do another PASARR after the added diagnosis and medication. The resident should have had another PASARR completed, and it was just missed. A current policy, titled "Pre-admission Screening and Resident Review (PASARR)," dated as reviewed on 9/25/23 and received from the Administrator on 7/12/24 at 3:30 p.m., indicated "...A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later...Any resident with newly evident or possible serious mental disorder, ID or a related condition must be referred, by the facility to the appropriate state-designated mental health or disability authority for review. Examples of individuals who may not have previously been identified by PASARR to have MD, ID or a related condition include, but is not limited to: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder...." 3.1-16(d)(1)(A)		set forth in this plan of correction. We respectfully request a desk review. **F 644** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 70 had no negative physical or psychosocial outcomes related to alleged incident. A new Passar was initiated and completed immeditaley ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents have the potential to be affected therefore an IN house audit has been completed by the SSD by date of compliance to ensure no other late PASSARs have been missed. Any concerns will be addressed immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. The RVP will educate the SSD on the policy for the indications for completing the Passar including any med/diagnosis changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	3.1-16(d)(1)(B)		***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. THE SSD will audit all clinical records monthly on residents with a mental dx and/or psychoactive meds to ensure compliance ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/13/24 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to notify the physician of	F 0684	This plan of correction is prepared and executed because the	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	blood glucose levels out of the physician's parameters and to follow-up on a hospice order for a Broda chair (chair which helps accommodate residents with impaired mobility) for 3 of 3 residents reviewed for quality of care. (Resident L, C and 136) Findings include: 1. During an interview, on 7/10/24 at 10:00 a.m., Resident L indicated he had high blood sugar readings while being at the facility. The clinical record for Resident L was reviewed on 7/10/24 at 3:16 p.m. The diagnoses included, but were not limited to, mild chronic stage 2 kidney disease, hypertensive heart disease with heart failure, and type 2 diabetes with diabetic neuropathy. A current physician's order, with a start date of 7/26/23, indicated to notify the physician for blood sugars greater than 400. A facility vital log indicated Resident L had the following blood sugars: On 3/26/24, his blood sugar was 433. On 3/27/24, his blood sugar was 452. On 3/27/24, his blood sugar was 432. On 3/28/24, his blood sugar was 426. On 4/1/24, his blood sugar was 493. On 4/2/24, his blood sugar was 531. On 4/5/24, his blood sugar was 444. On 4/11/24, his blood sugar was 423. On 4/26/24, his blood sugar was 434. During an interview, on 7/11/24 at 10:53 a.m., the Administrator indicated he did not see any call outs to the physician for the high blood sugars.2. During an interview, on 7/10/24 at 12:02 p.m.,		provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 684** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident L, C, and 136 had no negative outcomes related to the alleged deficient practice. Resident L and C had MD notified immediately with no new orders. Resident 136 had her Broda chair delivered on 7/13/24 by Advacare and is getting up per request. ***How other residents having the potential to be affected by the same deficient practice will be***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	Resident C's family member indicated the resident's blood sugar readings were in the 400 and 500 range and the facility did not try to give her a different insulin. The clinical record for Resident C was reviewed on 7/10/24 at 10:37 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, generalized anxiety disorder, and generalized muscle weakness. A physician's order, dated 3/24/24, indicated to check the fasting blood sugar one time a day. A physician's order, dated 3/24/24, indicated to notify the physician for blood sugars less than 60 or greater than 400. The resident had the following blood sugar readings: a. On 5/22/24 at 6:16 a.m., the blood sugar was 429. b. On 6/4/24 at 6:13 a.m., the blood sugar was 453. c. On 6/7/24 at 6:16 a.m., the blood sugar was 448. d. On 6/9/24 at 6:12 a.m., the blood sugar was 538. e. On 6/12/24 at 6:05 a.m., the blood sugar was 436. c. On 6/13/24 at 5:34 a.m., the blood sugar was 437. A physician's order, dated 6/9/24, indicated to recheck the blood sugar at 7:30 a.m., and notify the physician if the reading was greater than 400. The progress notes showed the physician was only notified on the elevated blood sugar on 6/9/24. 3. During an observation, on 7/10/24 at 11:45 a.m., Resident 136 was lying in bed in her room with her eyes closed. During an observation, on 7/11/24 at 3:37 p.m., the		***identified and what corrective action will be taken:*** 1. Other residents have the potential to be affected therefore an IN house audit has been completed by the Nursing management team by date or compliance on residents taking insulin to ensure they have call perimeters and this is being completed. An in house audit has been completed on residents to validate their orders and assure any adaptive equipment recommended is in place and care planned and added to Kardex. Any concerns will be addressed immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed by nursing management by date of compliance to licensed nursing staff on the policy for following MD orders to include follow up and reporting to MD when blood sugars out of parameters and ensuring adaptive equipment is in place. This education will be provided annually, during orientation and as needed. No licensed nursing staff will work past date of compliance until this is completed. ***How the corrective action will be monitored to ensure the***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	resident was lying in bed in her room and her eyes were closed. During an observation, on 7/12/24 at 1:50 p.m., the resident was lying in bed in her room, her eyes were closed, and the room was darkened. The clinical record for Resident 136 was reviewed on 7/12/24 at 1:56 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis affecting the right dominant side, chronic obstructive pulmonary disease, and pressure ulcers. During an interview, on 7/11/24 at 3:37 p.m., CNA 10 indicated the resident was on hospice, was totally dependent for care, and did not get out of bed on the evening shift. During an interview, on 7/11/24 at 3:47 p.m., LPN 11 indicated the resident was fairly new and was on hospice. The family preferred for the resident not to get out of bed. A physician's order indicated to be admitted to Hospice with a diagnosis of hemiplegia and hemiparesis following a cerebral infarction. A hospice social worker note, dated 7/3/24, indicated the resident's daughter stated the resident was very social prior to her strokes and she still enjoyed having companionship although she was unable to talk as much as she would like to. During an interview, on 7/10/24 at 11:55 a.m., the Activity Director indicated the resident would get up in her Broda (chair for positioning) although she did not know what time of day she got up.		***deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. The Nursing management team will audit 5 charts weekly x 2 months, then 3 charts weekly x 2 months, then 2 charts weekly x 2 months to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/13/24 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	The resident did not have a Broda chair in her room. During an interview, on 7/12/24 at 2:19 p.m., the Hospice Registered Nurse (RN) indicated the Broda chair was ordered upon admission to hospice on 7/3/24. The hospice had some changes in leadership, and it was just missed for approval. Since the Broda chair was ordered, it was an expectation the resident would be getting up in the Broda chair. The resident had a decline in condition although was not in the active phase of dying. The facility staff and the hospice staff would determine in collaboration how long the resident would be up daily. The Broda chair would be approved today as soon as the RN got the request to the correct person in hospice. A Hospice Services Agreement, approved on 7/19/21, indicated "...Hospice will ensure that all Hospice Services are provided to Hospice Patients in a manner which meets or exceeds professional standards and principles that apply to individuals providing services in Facility. Hospice will provide all reasonable and necessary Hospice Services to Hospice Patients in a timely manner and accordance with each Hospice Patient's Hospice Plan of Care...Hospice Services will include...medical direction and management of the Hospice Patient...medical supplies, durable medical equipment...Coordination of Services...Hospice will participate, upon request, in interdisciplinary and other care planning conferences required to coordinate the Hospice Services, Facility Services, and other services provided to an individual Hospice Patient...Hospice shall retain professional management responsibility for Hospice Services provided in accordance with the Hospice Plan of Care...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	A current policy, titled "Changes in Resident's Condition or Status," dated as last reviewed on 8/9/23 and received from the Administrator on 7/12/24 at 10:55 a.m., indicated "...This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status..." This citation relates to Complaint IN00436564. 3.1-37(a)			
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 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 turn and reposition a resident every 2 hours as ordered to promote healing and to prevent future pressure injuries for 1 of 4 residents reviewed for pressure ulcers. (Resident 50) Finding includes:	F 0686	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	During an observation, on 7/8/24 at 1:26 p.m., Resident 50 was sitting up in bed waiting for her lunch tray. She was paralyzed from the waist down with her right arm severely limited in range of motion and function with severe muscle wasting. The clinical record for Resident 50 was reviewed on 7/11/24 at 3:36 p.m. The diagnoses included, but were not limited to, paraplegia, type 2 diabetes mellitus, neuromuscular dysfunction of bladder, abnormal posture, depression, colostomy, indwelling urethral catheter, seizures, stage 3 and 4 pressure ulcers of sacral region, right and left buttock stage 3 pressure ulcers, recurrent moderate major depressive disorder, generalized anxiety disorder, and chronic obstructive pulmonary disease. A physician's order, dated 11/15/22, indicated to turn the resident every two hours for comfort and wound healing. If the resident "is asleep, turn her anyway, per resident". A care plan, initiated on 11/30/22, indicated to turn the resident every 2 hours due to limited mobility, pressure ulcer, and to prevent new pressure injuries. It indicated she was dependent for bed mobility. A Skin/Wound note, dated 6/8/24 at 12:28 p.m., indicated the resident was compliant with every 2-hour turning. A care management note from the facility interdisciplinary team, dated 6/20/24 at 11:02 a.m., indicated the resident had a pressure wound to her coccyx which had been there for several years, did not get out of bed except for showers, and she was to be turned and repositioned every 2 hours		health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 686** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 50 has not had a decline in her pressure ulcer related to alleged deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents have the potential to be affected therefore an IN house audit has been completed by the Nursing management team by date or compliance on residents that are dependent on staff for adls and reviewing their care plans and Kardex for accurate information.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	to promote wound healing. The certified nursing assistant (CNA) task record, dated 6/13/24 through 7/12/24, indicated the resident required extensive assistance of 1 person for bed mobility. It indicated the task of bed mobility did not occur on some night shifts (6/16/24, 6/17/24, 6/20/24). The CNA task record, dated 6/28/24 through 7/11/24, indicated the charting of every 2-hour turns was missing on: 6/28/24 for 10:00 a.m., 12:00 p.m., 4:00 p.m., 6:00 p.m., and 8:00 p.m. 6/30/24 for 12:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., 6:00 p.m., and 8:00 p.m. 7/1/24 for 5:00 p.m., 7:00 p.m., and 11:00 p.m. 7/2/24 for 2:00 a.m., 4:00 a.m., 6:00 a.m., 4:00 p.m., and 6:00 p.m., 7/3/24 for 4:00 p.m., 6:00 p.m., and 11:00 p.m. 7/4/24 for 12:00 a.m., 2:00 a.m., 10:00 a.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m. 7/5/24 for 12:00 a.m., 2:00 a.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., and 11:00 p.m. 7/6/24 for 3:00 a.m., 5:00 a.m., 9:00 a.m., 4:00 p.m., 6:00 p.m., and 11:00 p.m. 7/7/24 for 10:00 a.m., 3:00 p.m., and 11:00 p.m. 7/8/24 for 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m. 7/9/24 for 12:00 a.m., 3:00 a.m., and 5:00 a.m. 7/10/24 for 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m., 5:00 p.m., 7:00 p.m., 9:00 p.m., and 11:00 p.m. 7/11/24 for 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m., and 8:00 a.m. A Skin/Wound note, dated 7/01/24 at 1:33 p.m., indicated the resident continued to have a slow healing sacrococcygeal wound. The resident was to be turned and repositioned every 2 hours and to utilize a wedge cushion for positioning. The		Out of those resident if they have a BIMS between 13-15 nursing management is to interview them on their care and if any concerns noted. Any issues identified will be addressed immediately ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed by nursing management by date of compliance to direct care staff on ensuring residents dependent on staff for adls will have their needs met and accurate charting to be completed in the POC for the aides. This education will be provided annually, during orientation and as needed. No licensed nursing staff will work past date of compliance until this is completed. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. The Nursing management team will observe 5 dependent residents weekly x 2 months, then 3 dependent residents weekly x 2 months, then 2 dependent residents weekly x 2 months to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	physician was updated regarding continued skin issue. During an interview, on 7/8/24 at 1:26 p.m., the resident indicated she was supposed to be turned every 2 hours, but evenings and nights often did not turn her. They waited for her to turn her call light on and ask, despite her telling them she wanted to be woken up every 2 hours during the night. She did not want to have to call and/or wake herself up with an alarm because it was far more disruptive to her sleep and made it more difficult for her. She indicated it was very important to her because she had chronic pressure wounds which she really wanted to heal and because she did not want to get any new wounds. During an interview, on 7/10/24 at 11:14 a.m., the resident indicated, on 7/9/24, she had been turned around 4:00 p.m., and then took a nap. She turned her call light on after she woke up around 8:00 p.m., and believed she was turned about 20 minutes later. She was then not turned again until roughly 1:00 a.m. and 5:00 a.m. She indicated this was a regular occurrence, especially on evening and night shift except for when certain CNAs were on duty. She had complained about this multiple times, and she had personally told CNAs she wanted to be woken up every 2 hours no matter what. It had been an on-going issue, and this was why she even had an order to turn every 2 hours even when she was sleeping. During an interview, on 7/12/24 at 9:59 a.m., the Social Services Director indicated during the resident's care plan meeting, on 6/25/24, there was a nursing concern of evening/night CNAs not always turning every 2 hours. The Director of Nursing (DON) was present at the meeting and		Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/13/24 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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

was addressing the issue. This was not the first time the resident had brought this issue up.

During an interview, on 7/12/24 at 10:23 a.m., the Director of Nursing (DON) indicated every 2-hour checks and turning had been an ongoing concern. She had re-educated the CNAs to turn even when Resident 50 was asleep and to set alarms on their phones to help them remember. The facility had several brand-new CNAs who had just completed their certifications.

During an interview, on 7/12/24 at 10:32 a.m., CNA 1 indicated they would try to turn her on even hours because it usually worked out better and to make it easier to remember. The resident had often complained that the night staff only turned her during their last round before the day shift came on. She tried to remind other staff members during their report/hand-off.

A current job description, titled "Certified Nursing Aide (CNA) Job Description: Primary," dated 11/10/16 and received from the Administrator on 7/11/24 at 1:30 p.m., indicated "...The Certified Nursing Aide is responsible for providing routine daily nursing care to assigned patients to assure patient safety and attain or maintain the highest practicable physical...well-being...Must be able to lift, turn, move, position, and transport patients...Must be able to accurately document and chart patient care...."

A policy for preventing pressure ulcers and/or routine turning of residents was requested on 7/12/24. The facility indicated they did not have a policy, and they did not provide one.

3.1-40(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to follow the physician's orders for indwelling urinary catheters for 2 of 3 residents	F 0690	This plan of correction is prepared and executed because the provisions of state and federal law	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	reviewed for indwelling catheters. (Resident C and H) Findings include: During an interview, on 7/10/24 at 12:02 p.m., Resident C's family member indicated the resident's catheter needed to be changed the day she was being discharged and the staff would not listen. The family decided to take the resident to the emergency room after her discharge from the facility so they could put in a new catheter. The clinical record for Resident C was reviewed on 7/10/24 at 10:37 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, obstructive reflux uropathy (urine backing up in the kidneys), generalized anxiety disorder, and generalized muscle weakness. A care plan, dated 12/2/23 and revised on 6/21/24, indicated the resident had obstructive uropathy and had an indwelling urinary catheter. The interventions included, but were not limited to, catheter care every shift and educating the resident and family on catheter care. A physician's order, dated 6/3/24, indicated an indwelling catheter to straight drainage, size 22 French (Fr indicates diameter of catheter) with 30 cc bulb. Change the indwelling catheter for infection, obstruction, or when the closed system was compromised. A progress note, dated 6/14/24 at 2:11 p.m., indicated Resident C was crying and stated something was wrong with her catheter. The catheter bag was on the floor with the resident sitting on the bed and the catheter tubing was taut and hematuria (blood in the urine) was noted.		require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 690** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident C has been discharged to Home. Resident H has had no negative outcomes to the related deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents have the potential to be affected therefore an IN house audit has been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	The nurse offered to deflate the balloon and reposition the Foley catheter. The resident initially refused and then the daughter stated she would take the resident to the emergency room and have a new catheter put in. The resident consented and the catheter balloon was deflated, then the indwelling catheter was advanced, and the balloon was re-inflated. The catheter was draining tea colored urine. The progress note did not include a notification to the physician of the blood in the catheter tubing. A progress note, dated 6/14/24 at 3:55 p.m., indicated the resident was discharged with her daughter and the daughter indicated she was taking the resident to the emergency room. During an interview, on 7/10/24 at 2:50 p.m., RN 9 indicated Resident C did her all her own catheter care. During an interview, on 7/10/24 at 3:31 p.m., the Director of Nursing (DON) indicated it was a nursing measure to deflate a catheter bulb, advance the catheter and to re-inflate the catheter bulb. The resident had a huge risk of infection. The facility did not need to get the deflating of the catheter bulb, advancing the catheter and re-inflation of the bulb cleared by the urologist. The facility would not notify the urologist or physician of the blood in the catheter unless it was a huge amount of blood. Usually, blood in a catheter would resolve on its own in 24 hours.2. During an observation, on 7/08/24, Resident H was in the hallway in her wheelchair with her foley catheter in a dignity bag. The clinical record for Resident H was reviewed on 7/10/24 at 9:50 a.m. The diagnoses included,		completed by the Nursing management team by date or compliance on residents that have a catheter. Orders have been received for all to include deflate the balloon, advance the catheter, and reinflate the balloon. Any issues identified will be addressed immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed by nursing management by date of compliance to direct care nursing staff on indwelling urinary catheter Management and care. Competencies will be completed on licensed nursing the above policy and best practice. This education will be provided annually, during orientation and as needed. No direct care licensed nursing staff will work past date of compliance until this is completed. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. The Nursing management team will review all new admission and readmissions and any in house residents that receive an order for catheter placement when completing the chart audit and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	but were not limited to, peripheral vascular disease, retention of urine, polyneuropathy, acquired absence of left leg above the knee, restless legs syndrome, cerebral infarction without residual deficits, and obstructive and reflux uropathy. A physician's order, dated 2/2/24, indicated indwelling catheter to straight drainage. Size: 18 Fr Bulb: 30 cc. Change for infection, obstruction, or when the closed system was compromised as needed. A progress note, dated 4/3/24 at 4:47 p.m., indicated the resident complained the Foley catheter was leaking. The nurse deflated the balloon, advanced the catheter and re-inflated the balloon. The electronic medical record did not include a physician's order for the procedure of deflating the balloon, advancing the catheter, and re-inflating the balloon of the catheter. A progress note, dated 4/4/24 at 11:24 a.m., indicated the Foley catheter was lying on the resident's bed with the balloon still inflated. A new 18 Fr 30 cc Foley catheter was placed utilizing aseptic technique. A progress note, dated 4/9/24 at 6:00 p.m., indicated the Foley catheter was found lying in the resident's incontinence brief with the balloon intact. A new 18 Fr 10 cc Foley catheter was placed utilizing aseptic technique. During an interview, on 7/10/24 at 11:35 a.m., the resident indicated her catheter was not secured in any way to her leg to prevent pulling or dislodgement.		new order review and if catheter/order present ensure resident has appropriate orders in place to include deflating balloon, advancing catheter, and reinflating balloon. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/13/24 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	The electronic medical record did not include documentation of the use of a device to secure the catheter for the resident. A current policy, titled "Indwelling Urinary Catheter (Foley) Management," dated as reviewed on 8/24/23 and received from the Administrator on 7/10/24 at 3:10 p.m., indicated "...The facility will ensure...Insertion, ongoing care, and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures...If...leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment...Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter." This citation relates to Complaint IN00436564. 3.1-41(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure transportation was available for dialysis for 1 of 1 resident reviewed for dialysis. (Resident 18) Finding includes: During an interview, on 7/9/24 at 10:06 a.m.,	F 0698	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	Resident 18 indicated she had to be hospitalized about a month ago when the facility did not have transportation to dialysis on a Saturday. The facility did not tell the resident until the last minute there was no transportation. The clinical record for Resident 18 was reviewed on 7/11/24 at 11:44 a.m. The diagnoses included, but were not limited to, dependence on renal dialysis, type 2 diabetes mellitus, end stage renal disease, congestive heart failure, right lower leg amputation at level between knee and ankle and acquired absence of the left leg below the knee. A care plan, dated as last revised on 4/9/24, indicated the resident had chronic congestive heart failure. The interventions included, but were not limited to, observing and reporting signs of congestive heart failure including shortness of breath on exertion. A care plan, dated as last revised on 5/14/24, indicated the resident received hemodialysis outside of the facility. The interventions included, but were not limited to, dialysis treatments as ordered. A care plan, dated as last revised on 7/2/24, indicated the resident was at risk for fluctuations in weight related to hemodialysis and fluid imbalances. The interventions included, but were not limited to, reporting any shortness of breath, abnormal breath sounds, and to notify the physician of increasing shortness of breath, increased anxiety or inability to lie flat. A physician's order indicated the resident was to receive dialysis on Tuesdays, Thursdays and Saturdays.		deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 698** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 18 has since recovered from alleged deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents have the potential to be affected therefore an IN house audit has been completed by the Nursing management team by date or compliance on residents that receive dialysis. Orders reviewed and transportation arrangements reviewed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	A progress note, dated 6/1/24 at 9:24 a.m., indicated the transportation to dialysis was canceled and the facility was unable to take the resident to dialysis. A progress note, dated 6/2/24 at 8:07 a.m., indicated the resident had called 911 and told 911 she could not breathe. The resident indicated she had missed dialysis the day before. A hospital note, dated 6/2/24, indicated the diagnoses were fluid overload, pulmonary edema, congestive heart failure, and acute respiratory failure with hypoxia. The resident was not able to go to dialysis on 6/1/24 due to a transportation issue. The resident had felt short of breath the entire night and was not able to breathe normally this morning. Nephrology was consulted for dialysis needs. The resident received hemodialysis on 6/2/24 with significant improvement in shortness of breath. A progress note, dated 6/4/24 at 6:34 p.m., indicated the resident had returned to the facility from the hospital stay. During an interview, on 7/12/24 at 10: 25 a.m., the Activities Director indicated the transport company used on Tuesdays and Thursday for dialysis would not provide transportation on Saturdays. The transport company who usually transported Resident 18 on Saturdays had staff on vacation and were not available for the transport on 6/1/24. There was a miscommunication and the facility only found out on 6/1/24 about 20 minutes prior to the usual pick-up time for dialysis. The facility was going to call a cab for the transport although the dialysis center was not able to assist the resident to get out of a cab and into the facility. The resident had to miss dialysis on		Any issues identified will be addressed immediately. Residents who receive dialysis on Saturdays have a specific back up plan put in place for transportation to the dialysis center. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed by nursing management by date of compliance to direct care nursing staff and involved department heads on substitution transportation plans for dialysis residents. Education is to include reporting to MD and family that resident did not receive dialysis, why, and if any changes set up by dialysis center. Education also to include if dialysis is missed licensed staff to perform respiratory UDAS every shift until dialysis is received next. This education will be provided annually, during orientation and as needed. No direct care nursing staff will work past date of compliance until this is completed. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. The Nursing management team review chart of any resident that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	6/1/24 since the facility could not find transportation to dialysis. An Agreement for Dialysis Services with U.S. Renal Care, approved on 7/19/21, indicated, "...Provider is in the business of providing dialysis services. Facility is a licensed health care facility in the business of providing skilled nursing services...Provider shall furnish the equipment, supplies, instruments and other items necessary to provide the Services...Transportation of Residents...Facility shall have the responsibility for arranging suitable transportation of the residents to and from Provider, including the selection of the mode of transportation, qualified personnel to accompany the resident and transportation equipment usually associated with this type of transfer...Facility shall...be responsible for all costs of transportation associated with the transfer of resident to and from Provider and Facility. Facility shall be responsible for, and shall provide the necessary personnel for, assisting the resident in entering into and exiting from Provider...." 3.1-37(a)		does not go to dialysis, determine why, and assess what the facility could have done differently to ensure dialysis can be received and all appropriate parties notified and respiratory UDAS completed as above ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/13/24 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, interview and record review, the facility failed to ensure an order for side rails was obtained and an assessment for side rails was completed prior to the use of side rails for 1 of 3 residents reviewed for accident hazards. (Resident D) Finding includes: During an interview, on 7/9/24 at 9:02 a.m., Resident D indicated she used the side rails for mobility assistance while in bed. During an observation, on 7/9/24 at 10:25 a.m., Resident D was in bed with the side rails in the raised position. During an observation, on 7/11/24 at 9:37 a.m., Resident D was asleep in bed with both side rails in the raised position. The clinical record for Resident D was reviewed on 7/10/24 at 9:22 a.m. The diagnoses included, but were not limited to, generalized muscle weakness, unspecified protein-calorie malnutrition, attention and concentration deficit, and insomnia.	F 0700	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 700** ***What Corrective Action will be accomplished for those residents found to have been***	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	The physician's orders did not include an order for the use of the side rails. The electronic health record did not include a side rail assessment. The electronic health record did not include a signed consent for the use of the side rails. The electronic health record did not include appropriate alternatives attempted prior to installation of the side rails. The care plan did not include the use of the side rails. During an interview, on 7/11/24 at 9:46 a.m., the Administrator indicated Resident D was given a new bed and it already had the side rails. He indicated they had missed obtaining an order or an assessment for the use of the side rails. During an interview, on 7/11/24 at 9:29 a.m., the Administrator indicated they obtained blanket consent from everyone in the facility even if they did not need the side rails at the time. A current policy, titled "Bed Rails- Safe and Effective Use of Bed Rails," dated as last revised on 12/30/22 and received from the Administrator on 7/11/24 at 10:00 a.m., indicated "...To prevent entrapment and other safety hazards associated with bed rail use...The facility must attempt to use appropriate alternative prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements...Assess the resident for risk of entrapment from bed rails prior to installation...Review the risks and benefits of bed		***affected by this deficient practice:*** 1. Resident D has had no negative outcomes from alleged deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents have the potential to be affected therefore an IN house audit has been completed by the Nursing management team by date or compliance on resident to validate side rail assessments have been completed, any resident using side rails has an order, and care plan and Kardex have been validated they are in place. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed by nursing management by date of compliance to licensed nursing staff on the policy for bed rail use. This is to include the process involved, the UDA required, the consent, updating the care plan and Kardex and charting alternatives attempted. This education will be provided annually, during orientation and as needed. No licensed nursing staff will work past date of compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	rails with the resident or resident representative and obtain informed consent prior to installation...If bed rails are determined to be appropriate for use with a resident, a reassessment of bed rail(s) use will be assessed at a minimum quarterly and potentially with a change of condition utilizing the Evaluation of Use of Bed Rails Form (Quarterly)...If a bed rail will be utilized, the risks and benefits of bed rail(s) usage will be reviewed with the resident and/or resident representative and consent will be obtained prior to installation of the bed rails or as soon a practically possible. The facility should use the Med-Pass Consent for Use of Bed Rails (LCCA-574) ...The facility will document alternative to the use of a bed rail(s) and how these alternatives did not meet the resident's assessed needs prior to the utilization of a bed rail(s). 3.1-45(2)		until this is completed. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. The Nursing management team review chart of any resident that is a new admission, readmission or a change in condition to ensure appropriate assessments, care plan, Kardex and consents in place for side rails as part of the record review the next business day to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **Compliance date: 8/13/24** The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to address an annual gradual dose reduction (GDR) for an anti-depressant and an antipsychotic for 1 of 5 residents reviewed for unnecessary medications. (Resident J) Finding includes: During an observation, on 7/8/24 at 12:30 p.m., Resident J was smiling and engaged in conversation with the surveyor. The resident was sitting up in her wheelchair, waiting for her lunch tray. During an observation, on 7/9/24 at 10:15 a.m., the resident was up in her wheelchair. The resident was smiling and eager to engage in conversation. The resident was very talkative. During all other observations, between 7/10/24 and 7/12/24, Resident J was smiling, talkative, and readily engaged in conversation. The clinical record for Resident J was reviewed on 7/10/24 at 2:29 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus with hyperglycemia and polyneuropathy, schizoaffective disorder bipolar type, affective mood disorder, major depressive disorder, malignant neoplasm of brain, mild cognitive impairment, history of falling, generalized anxiety disorder, and pain. A physician's order, dated 3/26/20, indicated bupropion (an anti-depressant) 150 milligram (mg) tablet, give 1 tablet by mouth one time a day	F 0758	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 758** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident J has had no negative outcomes from alleged deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective***	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	related to major depressive disorder. A physician's order, dated 5/3/23, indicated olanzapine (an antipsychotic) oral tablet 10 mg, give 1 tablet by mouth two times a day related to schizoaffective disorder, bipolar type. The last GDR for bupropion was contraindicated on 3/26/20. A psychosocial note, dated 3/26/2020 at 12:41p.m., indicated resident's bupropion was "up for GDR. Resident is doing well and making positive adjustments in light of recent increased precautions associated to COVID-19. GDR will be contra-indicated today due to present circumstances." There was no annual GDR recommendation for bupropion between 6/1/23 and 7/12/24. The last GDR for the olanzapine was accepted on 4/24/23. There was no annual GDR recommendation for olanzapine between 4/24/23 and 7/12/24. No other GDRs for bupropion or olanzapine were recorded in the electronic medical record. All GDRs for Resident J were requested on 7/10/24 at 2:30 p.m. During an interview, on 7/11/24 at 3:45 p.m., the Administrator indicated he had provided all available GDRs. He did not find any GDR requests from pharmacy during the monthly reviews for bupropion. The last GDR for olanzapine was 4/24/23. The Administrator indicated he believed no one had looked at bupropion again since the order said the GDR was contraindicated on 3/26/20. He did not realize it was denied due to the Covid situation at that time.		***action will be taken:*** 1. Other residents have the potential to be affected therefore an IN house audit has been completed by the Nursing management/ and SSD by date or compliance on residents to validate GDRS have accurate supporting documentation by the MD. Any issues identified will be addressed immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed by the ED to facility physicians by date of compliance on properly documenting a GDR. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. The Nursing management team/SSD will both validate monthly GDR reports to ensure being completed accurately ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	A current policy, titled "Unnecessary Medication," dated as last reviewed on 8/09/23 and received from the Administrator on 7/12/24 at 10:15 a.m., indicated "...ensure only mediations required to treat the resident's assessed condition are being used, reducing the need for and maximizing the effectiveness of medications...Gradual Dose Reduction (GDR)- This is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued...The facility's medication management process will support and promote...Selection and use of medications in doses and for the duration appropriate to each resident's clinical conditions, age, and underlying causes of symptoms...." 3.1-48(b)(2)		compliance is below 100%. Compliance date: 8/13/24 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications administered orally were separated from topical medications and eye drops, to store cleaning supplies separately from medications, correctly label OTC (over the counter) medications, date opened medications, and routinely dispose of medications after the date of expiration for 4 of 4 medication carts reviewed. (medication cart 1, medication cart 2, medication cart 3, and medication cart 4) Findings include: During a medication cart observation with Qualified Medical Assistant (QMA) 6, on 7/9/24 at 11:06 a.m., medication cart 1 was observed to have the following: a. The top right drawer had two medication cups containing one pill in each cup not labeled with the resident's names or with the medication name. b. The bottom right drawer had an unlabeled nebulizer machine (a device which turned liquid medication into a mist to be inhaled into the lungs through a mask or mouthpiece) c. The top left drawer had Smooth Nighttime eye ointment, dated opened 4/6/24. d. A Saline Nose Spray without a date opened. During a medication cart observation with QMA	F 0761	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 761** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:***	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	6, on 7/9/24 at 11:19 a.m., medication cart 2 was observed to have the following: a. The top left drawer had ear wax removal drops improperly stored next to Ferrocite oral tablets. b. The second left drawer had OTC vitamin C tablets not labeled with the dose of the medication, the administration directions, or the physician's name. c. The bottom left drawer had mupirocin ointment (an ointment put onto the skin to treat a skin infection) stored in the medication cart instead of being stored in a treatment cart. d. The bottom left drawer had sanitizer wipes stored next to oral medications. During an interview, QMA 6 indicated the sanitizer wipes should not be stored next the oral medications and the ointment should have been stored in the treatment cart. During a medication cart observation with QMA 7, on 7/9/24 at 11:34 a.m., medication cart 3 was observed to have the following: a. The top drawer had oral medications stored next to eye drop medications without a divider between the two medications. b. The second drawer had "Refresh Eye Tears" (eye drops which help with dry eye) opened, dated 3/10/24, and more than 30 days past the discard after opening date. c. The second drawer had "Polyvinyl alcohol eye drops" (eye drops which help with dry eye) opened, dated 1/19/24, and more than 30 days past the discard after opening date. During an interview, on 7/9/24 at 11:45 a.m., QMA7 indicated the eye drops were good for 90 days once opened. During a medication cart observation with RN 8,		1. No residents had negative outcomes for alleged deficient practice. Med carts were cleaned immediately. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents have the potential to be affected therefore an IN house audit has been completed by the Nursing management team and med and tx carts to endure compliance. Any issues identified were corrected immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed by the DON/Designee on medication storage/expiration and dating of medications by date of compliance to licensed nurses and QMAS. This education will be completed during orientation, at least annually, and as needed. No licensed nurses or QMAS will work past date of compliance with out this education being completed. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	on 7/9/24 at 11:49 a.m., medication cart 4 was observed to have the following: a. Glucose gel (to treat low blood sugar) unopened and past expiration date of 4/2024. A current policy, titled "...Storage and Expiration Dating of Medications, Biologics," dated as last revised on 8/7/23 and received from the Administrator on 7/12/24 at 1:47 p.m., indicated "...Topical (external) use medications or other medications should be stored separately from oral medications when infection control issues may be a consideration...Facility should ensure that test reagents, germicides, disinfectants, and other household substances are stored separately from medications...Facility should ensure that medication and biologicals that: (1) have an expired date on the label; (2) have been retained longer tan recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier...Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened...Medications with a manufacturer's expiration date expressed in month and year (e.g. May 2022) will expire on the last day of the month...When an ophthalmic solution or suspension has a manufacturers shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container...Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete,		***program will be put in place:*** 1. The Nursing management team will check 5 med/TX carts weekly x 2 months, then 3 med/tx carts weekly x 2 months, then 2 med/tx carts weekly x 2 months to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/13/24 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	damaged or missing labels or cautionary instructions...Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis. Facility should request that Pharmacy perform a routine nursing unit inspection for each nursing station in Facility to assists Facility in complying with its obligations pursuant to Applicable Law relating to the proper storage, labeling, security and accountability of medications and biologicals..." 3.1-25(j) 3.1-25(o)			
F 9999 Bldg. 00	410 IAC 16.2-5-1.4 Personnel (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall	F 9999	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk	08/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure staff had completed three (3) hours of annual dementia training for 4 of 5 staff members reviewed for annual dementia training. (CNA 2, CNA 3, QMA 4 and CNA 5) Finding includes: The staffing employee records were reviewed on 7/10/24 at 4:30 p.m. The following staff's dementia training was reviewed: CNA 2 had 1 hour of dementia training. CNA 3 had 1 hour of dementia training. QMA 4 had 1 hour of dementia training. CNA 5 had 1 hour of dementia training. During an interview, on 7/12/24 at 1:48 p.m., the Administrator indicated the staff only had one (1) hour of continued dementia training since their education system was only set up for them to get		review. **F 9999** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. No residents had negative outcomes for alleged deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents have the potential to be affected therefore an in-house audit has been completed by the HR Director by date of compliance on the Dementia training. Any issues identified will be corrected immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed by the ED to the HR Director on the requirements for Dementia Required Training for staff by date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. ED will validate monthly who has completed/who needs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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
	1 hour of training. The facility would need to change the system and make sure the staff received the 3 hours of annual dementia training required. A current policy, titled "Dementia Required Education," dated as last reviewed on 9/22/23 and received from the Administrator on 7/12/24 at 5:05 p.m., indicated "...The facility will provide training and education as indicated for dementia in accordance with local, state, and federal regulations. 1. Each facility will provide training on dementia upon hire and annually as part of the general orientation program curriculum and the annual general education requirement curriculum on the learning management software system...Indiana Facilities Staff who have regular contact with residents shall have a minimum of six (6) hour 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) hour 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...."		required Dementia Training ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/13/24 The Administrator at Heritage Healthcare is responsible in ensuring compliance in this Plan of Correction.	