STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF HUNTINGTON	1180 WEST 500 NORTH HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: February 19, 20, 21, 22, 23, and 26, 2024. Facility number: 002910 Provider number: 155692 AIM number: 200345390 Census Bed Type: SNF: 10 SNF/NF: 61 Residential: 49 Total: 120 Census Payor Type: Medicare: 7 Medicaid: 31 Other: 33 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 1, 2024.	F 0000		
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jodie Stanley	Health Facility Administrator	03/14/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on observation, interview, and record review, the facility failed to ensure a current copy of the resident's advance directive was in their clinical record for 1 of 1 residents reviewed for	F 0578	!--[endif]-->Immediate action(s) taken for the resident(s) found to have been affected include: On February 22, 2024, a current	03/15/2024

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	advance directives. (Resident 54) Review of Resident 54's clinical record was completed on 2/21/24 at 3:08 p.m. Diagnoses included unspecified dementia, episodic paroxysmal anxiety, depressive disorder with severe psychotic symptoms, and body dysmorphic disorder. A current, 4/3/23, physician order indicated the following: Description - DNR Advance Directive Status: Verified With Family Only. During a review of a 4/12/23 care plan, on 2/21/24 at 3:30 p.m., it indicated the resident desired to be a DNR (do not resuscitate) and her wishes would be honored. Instructions were to get a signed DNR with a physician's signature. Code status was to be reviewed as needed. There was no advance directive document in the resident's electronic health record. During an interview on 2/22/24 at 9:06 a.m., the DON provided a document titled "Treatment Option Declaration - Patient with Capacity," signed by Resident 54. The document indicated the resident chose supportive care with no CPR (cardiopulmonary resuscitation), had designated a health care representative, and signed and dated the document on 2/22/24. The DON indicated she was unable to find the original document and had provided a new one to the resident. There was no physician's signature. A current facility policy/procedure, dated 7/2022, provided by the Administrator on 2/26/24 at 5:00 p.m., indicated the following: "...Advance Directives & Residents' Rights - It is the policy of this facility to support and facilitate a resident's		copy of resident #54's advanced directive was placed in their medical record. On February 29, 2024, a chart audit was conducted on all current resident's advanced directives to identify any residents that may have been affected. All residents other than Resident #54 were found to have current advance directives in their electronic medical records. * Identification of other residents having the potential to be affected were accomplished by: The facility has determined that all residents have the potential to be affected. An Admission Acknowledgements form is completed on all new admissions to ensure that all residents admitted to the facility receive and understand the information on advanced directives "Prepare for your Care" *** Actions taken/systems put into place to reduce the risk of future occurrence include:** All Social Service and Admissions staff were in-serviced regarding the facility policy for "*Advance Directives and Resident Rights Regarding Treatment*". *** How the corrective action(s) will be monitored to ensure the practice will not recur:** The Social Services Directors will complete weekly audits of advance directives for all new	

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	right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Definitions: 'Advance Directive' is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated. Policy Explanation and Compliance Guidelines:...1) On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive...3) Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff...9) Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care...." 3.1-4(ii)(5)		admissions for 4 consecutive weeks, then monthly for 3 months. Validation audits will be reviewed by the administrator and Quality Assurance Committee until consistent substantial compliance has been achieved as determined by the committee.	
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 apply a dynamic elbow brace per physician's order for 1 of 1 resident reviewed for range of motion. (Resident 50).	F 0684	Immediate action(s) taken for the resident(s) found to have been affected include: All orders for splints have been	03/18/2024

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	Findings include: Resident 50 clinical record was reviewed on 2/24/24 at 9:08 a.m. Diagnoses included dementia and spastic hemiplegia affecting left nondominant side (muscle tightness and involuntary contractions in extremities on left side of body). Current orders included the resident to wear dynamic elbow splint to left upper extremity; put on at 8 a.m. and remove at 12 noon. During an observation, on 2/22/24 at 8:45 a.m., she was lying in bed and was not wearing her dynamic elbow brace. The brace was laying on the recliner. During an observation, on 2/22/24 at 10:10 a.m., she was lying in bed and was not wearing her dynamic elbow brace. The brace was laying on the recliner. During an observation, on 2/22/24 at 11:24 a.m., she was lying in bed without wearing her dynamic elbow brace. The brace was laying on the recliner. During an interview, on 2/22/24 at 11:26 a.m., the Resident representative indicated when he arrived, the resident was lying in bed and was not wearing her dynamic elbow brace. During an observation, on 2/22/24 at 11:52 a.m., she was eating lunch without wearing her dynamic elbow brace. During an interview, on 2/23/24 at 10:07 a.m., CNA 12 indicated the resident did not wear her brace while lying in bed. Her dynamic elbow brace was applied once she got into her chair.		reviewed to ensure that physician orders are being followed. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **Actions taken/systems put into place to reduce the risk of future occurrence include:** Inservice education for all licensed nursing staff regarding Splinting Interventions, Use of Assistive Devices, and Prevention of Decline in Range of Motion will be completed. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services or designee will monitor the provision of all splints as ordered and provided for residents in the facility to ensure proper and consistent use every week for 4 consecutive weeks. If 100% compliance is achieved after 4 weeks, checks for proper and consistent use of splints will be done bi-weekly weeks for two (3) months or until 100% compliant. Discrepancies will be promptly reported to the Administrator and the QA Committee for review and recommendations.	

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	During an observation, on 2/23/24 at 1:30 p.m., she was sitting in her wheelchair wearing her dynamic elbow brace to her left arm. During an interview, on 2/23/24 at 1:31 p.m., QMA 13 indicated the resident wore her dynamic elbow splint once she was out of bed. During an interview, on 2/26/24 at 4:12 p.m., RN 14 indicated she constantly wore her dynamic elbow brace, even when she was lying in bed. During an interview, on 2/26/24 at 4:17 p.m., the DON indicated she expected the resident to be wearing her dynamic elbow brace between 8 a.m. and noon per physician order. During an interview, on 2/26/24 at 4:40 p.m., the DON indicated the resident usually refused to wear her dynamic elbow brace. During her record review, on 2/26/24 at 4:45 p.m., clinical record lacked indication of the residents refusal to wear the dynamic elbow brace. Review of the current policy, revised 1/23, titled "Splinting Interventions," provided by the Administrator on 2/26/24 at 2:40 p.m., indicated the following: "...1. Verify physician's order for splint; which extremity, and frequency of splinting...." 3.1-37(a)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (a) Each facility shall have specific procedures	F 9999	*Immediate action(s) taken for the resident(s) found to have been affected include:	03/15/2024

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	written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure criminal histories were obtained for 3 of 5 new employee records reviewed. (CNA 6, 7, and 8) Employee records were reviewed on 2/22/24 at 9:29 a.m. CNA 6's and CNA 7's records contained a check of the National Sex Offender Registry database. The records lacked criminal background histories. CNA 8's employee record was reviewed on 2/22/24 at 3:32 p.m. The record contained a check of the National Sex Offender Registry database and lacked a criminal background history. During an interview, on 2/22/24 at 4:27 p.m., the Administrator indicated the process for checking the new employees' criminal histories had been changed a few months ago by the corporation. The Human Resources person was new and had not realized the search parameters needed to include more information than a check of the National Sex Offender Registry database. A current facility policy, dated 6/2022, titled "Screening & Hiring of New Employees," provided by the Administrator on 2/26/24 at 2:40 p.m., indicated " ... criminal conviction record checks are conducted on all personnel making application for employment with this company		On February 22, 2024, all employee records were reviewed to determine what employees needed a criminal history check completed. Criminal History checks were immediately initiated for those employees noted to not have had one in their employee file. *Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. The corporate preemployment checks contract was expanded to include Indiana Criminal History checks on February 22, 2024. ***Actions taken/systems put into place to reduce the risk of future occurrence include:** The facility Human Resource Generalist was in-serviced regarding the facility policy for "*Hiring and Screening of New Employees"* by Administration. ***How the corrective action(s) will be monitored to ensure the practice will not recur:** The Human Resources Generalist will complete weekly audits for 1 month then monthly for 3 months on all new employee records to ensure all preemployment criminal history checks are completed. Any Criminal History Checks that come back with findings will be	

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	...The Human Resource department will conduct all applicable background investigation(s) on each individual making application for employment with this company ...."		reviewed with the Administrator. Audit records will be reviewed by the Administrator and Quality Assurance Committee until consistent substantial compliance has been achieved as determined by the committee.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: February 19, 20, 21, 22, 23, and 26, 2024 Facility number: 002910 Residential Census: 49 Heritage Pointe of Huntington was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed March 1, 2024.	R 0000		