STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155705	A. BUILDING 00 B. WING	02/28/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: February 22, 23, 24, 27 & 28, 2023 Facility number: 000542 Provider number: 155705 AIM number: 100267380 Census Bed Type: SNF/NF: 82 Residential: 88 Total: 170 Census Payor Type: Medicare: 3 Medicaid: 42 Other: 37 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 6, 2023.	F 0000		
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for			

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

Brenda Johns | HFA | 03/16/2023

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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	each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview, and record review, the facility failed to ensure residents with diagnoses of dementia, received locomotion and seating assistance, pre-meal stimulation, toileting assistance, and mask wearing assistance, in a manner to promote dignity for 6 of 6 residents reviewed for assistance to promote dignity. (Residents 4, 34, 37, 47, 57 and 77)	F 0550	- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Honoring resident's rights and maintaining dignity is required for	03/25/2023

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	Findings include: 1. During a pre-meal and meal observation on 2/24/23 on the 1B Memory Care unit, the following was observed: At 11:01 a.m., an unknown staff member wheeled Resident 47 down the hallway to the dining area. The unknown staff member told the resident she would be eating soon. The resident was placed, in her wheelchair, facing the table as if ready to dine. At the time the resident was placed at the table, there was a trivia/conversational activity occurring in the adjoining common area/TV lounge. The resident was not asked if she would like to join the activity. With the exception of passing water, the resident was not offered any form of sensory stimulation, nor was she conversed with, until her meal was served. She sat at the table and spoke random words. Occasionally, she sat with her eyes closed and her chin resting almost on her chest. She sat alone at the table for a period of approximately 45 minutes, when the activity ended and other residents entered the dining area. The resident did not interact with any table mates. She spoke to staff when offered a drink. No stimulation was introduced into the environment when the other residents arrived in the dining area. The resident sat facing the table, without stimulation, until 12:02 p.m. (one hour and 1 minute from when she was placed at the table) when her meal was served. During a pre-meal and meal observation on 2/27/23 on the 1B Memory Care unit, the following was observed: At 11:44 a.m., an unknown staff member wheeled		all residents. Therefore, all residents have the potential to be affected. - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Upon identification of issue a CD player was immediately placed in the dining room, and staff was verbally counseled regarding activity stimulation prior to meals, toileting assistance and resident assistance with mask usage. Activity personnel verbally counseled on seeking assistance for residents in order to meet their needs. - What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A policy was developed "Promoting/Maintaining Resident's Dignity During Mealtime", which includes assistance with masks, toileting, seat preference and activity stimulation prior to meals. Attachment: A All staff assisting with meals will complete an educational in-service on the facility's new policy. Attachment: B pages 1-3	

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	Resident 47 from the table where she had been involved in an activity, and placed her wheelchair facing the table, as if ready to dine. With the exception of passing water, the resident was not offered any form of sensory stimulation, nor was she conversed with, until her meal was served. While the resident sat awaiting her meal, she spoke random words or set with her eyes closed and her chin to her chest. There was no auditory stimulation such as music, nor diversionary materials offered, as she waited. Her meal was served at 12:34 p.m. (a period of 50 minutes since she was placed at the table). Resident 47's clinical record was reviewed on 2/23/23 at 1:43 p.m. Current diagnoses included dementia, cognitive communication deficit, anxiety, depression, and hallucinations. A 2/25/23, annual, Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, used a wheelchair, and required extensive assistance from the staff for purposefully movement. A current care plan problem/need, last reviewed on 2/25/23, indicated the resident had a risk for psychosocial well-being issues. An approach to this need was to encourage the resident to participate in activities to encourage socialization. A current care plan problem/need, last reviewed on 2/25/23, indicated the risk for an altered mood and tearfulness. An approach to this need was to provide and encourage in meaningful activities. A current care plan problem/need, last reviewed on 2/25/23, indicated a potential for increased restlessness especially when anxious. An approach to this need was to provide meaningful		- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Weekly dining room observations will be completed to ensure compliance. Audits will be completed per the following schedule: 2 dining room observations weekly for 12 weeks, then monthly for 3 months. If 100% compliance is not obtained additional interventions including audits will be extended per the QA committees recommendations.	

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	activities. 2. During a pre-meal and meal observation on 2/24/23 on the 1B Memory Care unit, the following was observed: At 11:09 a.m., an unknown staff member escorted Resident 34 down the hallway to the dining area. The resident walked with a rolling walker. The unknown staff member told the resident she would be eating soon. The resident was assisted to sit in a chair, and face the table, as if ready to dine. At the time the resident was placed at the table, there was a trivia/conversational activity occurring in the adjoining common area/TV lounge. The resident was not asked if she would like to join the activity. She sat at the table, drank water, and looked around. She sat alone at the table for a period of approximately 40 minutes, when the activity ended and other residents entered the dining area. The resident spilled her water at 11:43 a.m. Staff spoke to her as they cleaned up the water and then left. No stimulation was introduced to the environment when the other residents arrived in the dining area. The resident sat facing the table, without stimulation, until 12:18 p.m. (one hour and 9 minute from when she was placed at the table), when her meal was served. Resident 34's clinical record was reviewed on 2/28/23 at 11:35 a.m. Current diagnoses included, dementia with behavioral disturbances, anxiety, and cognitive communication deficit. A 1/4/23, quarterly, MDS assessment indicated the resident required extensive assistance from the staff for purposeful movement on the unit. A current care plan problem/need, reviewed on			

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	1/4/23, indicated a risk for impaired cognitive function and impaired thought processes which could fluctuate related to dementia. A care plan problem/need, last reviewed on 1/4/23, indicated the resident was at risk for altered moods due to anxiety, worry, and fretfulness. 3. During a pre-meal and meal observation on 2/27/23 on the 1B Memory Care unit, the following was observed: At 11:42 a.m., an unknown staff member hand held walked Resident 77 from the hallway and sat her facing the table as if ready to dine. With the exception of passing water, the resident was not offered any form of sensory stimulation, nor was she conversed with, until her meal was served. While the resident sat awaiting her meal, she drank water or looked around. There was no auditory stimulation such as music, nor diversionary materials, offered as she waited. Her meal was served at 12:10 p.m. (a period of 28 minutes since she was placed at the table). Resident 77's clinical record was reviewed on 2/23/23 at 1:46 p.m. Current diagnoses included, dementia, anxiety, and Alzheimer's disease. A 2/9/23, quarterly, MDS assessment indicated the resident had severe cognitive impairment and required extensive assistance from the staff to purposefully move about the unit. A current care plan problem/need, last reviewed on 2/9/23, indicated impaired cognitive functioning. Approaches to this problem were to encourage activities and provide a home like environment.			

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	4. During a pre-meal and meal observation on 2/27/23 on the 1B Memory Care unit the following was observed: At 11:39 a.m., an unknown staff member wheeled Resident 57 from the hallway and placed her wheelchair facing the table, as if ready to dine. With the exception of passing water, the resident was not offered any form of sensory stimulation, nor was she conversed with, until her meal was served. While the resident sat awaiting her meal, she spoke random words or sat with her eyes closed and her chin to her chest. There was no auditory stimulation such as music, nor diversionary materials, offered as she waited. Her meal was served at 12:18 p.m. (a period of 49 minutes since she was placed at the table). Resident 57's clinical record was reviewed on 2/23/23 at 1:53 p.m. Current diagnoses included, dementia, depression, and Parkinson's disease. A 12/7/22, significant change, MDS assessment indicated the resident had severe cognitive impairment, used a wheelchair, and required extensive assistance from the staff for purposeful movement. A current care plan problem/need, reviewed on 12/7/22, indicated a risk in communication problems related to dementia and Parkinson's disease. 5. During a pre-meal and meal observation on 2/27/23, on the 1B Memory care unit, the following was observed: At 12:00 p.m., an unknown staff member wheeled Resident 37 from the hallway and placed her geri chair facing the table, as if ready to dine. At 12:05			

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	p.m., Resident 37 was observed to have rubbed her mask over her eyes. The dependent resident sat, without assistance to remove the mask from her eyes, until 12:35 p.m. (a period of 30 minutes). As the resident sat with the mask over her eyes, staff members provided services at her table, or walked within inches of her table, at the following times: 12:17 p.m., 12:20 p.m., 12:24 p.m., 12:28 p.m., and 12:30 p.m. As well as having the mask over her eyes, the resident was not offered any form of sensory stimulation, nor was she conversed with, until her meal was served. There was no auditory stimulation such as music, nor diversionary materials, offered as she waited. Her meal was served at 12:35 p.m. (a period of 35 minutes since she was placed at the table). Resident 37's clinical record was reviewed on 2/28/23 at 11:30 a.m. Current diagnoses included, dementia, Alzheimer's disease and expressive language disorder. A 12/14/22, quarterly, MDS assessment indicated the resident rarely or never understood others and was totally dependent on staff for all mobility in a wheelchair and required total assistance with activities of daily living. A current care plan problems/need, last reviewed on 12/14/22, indicated a risk for a communication deficit, the need for total assistance with all activities of daily living, and a risk for additional cognitive decline. During an interview, on 2/27/23 at 12:36 p.m., CNA 4 indicated Resident 37 was unable to remove the mask from over her eyes, and would require staff assistance to do so. 6. During an activity observation on 2/27/23, on			

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	the 1B Memory Care unit, the following was observed: At 10:08 a.m., Resident 4 was asked if he would like to participate in a cash drawer activity. At 10:20 a.m., the resident indicated he needed to use the restroom, before wheeling away from the table. Activity Assistant 1 was in the immediate area when the resident made the request. Activity Assistant 1 was not observed requesting any assistance from direct care staff at this time. At 10:26 a.m., the resident was wheeling about and heading towards the currently vacant part of the unit. At 10:35 a.m., the resident was once again in the activity, and had not been toileted. At 10:51 a.m., the resident asked about the bathroom again and rolled away from table. Activity Assistant 1 was in the immediate area when the resident made the request. Activity Assistant 1 told the resident the staff would be with him soon. At 10:56 a.m., the resident continued to ask about the restroom. Activity Assistant 1 again told the resident someone would help him soon. At 10:59 a.m., an unknown nursing department employee walked through the area, and was not asked by the activity assistant to tend to the resident's request. At 11:01 a.m., an unknown staff member assisted the resident to move to a different table than where he was earlier, to sort money again. The resident had not been to the bathroom.			

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	At 11:06 a.m., the resident was rolling away from the activity area again. At 11:07 a.m., Activities Assistant 1 was with the resident, outside the bathroom door. She informed him he could not go alone and help would come. She repeatedly said "just a minute." At 11:08 a.m., the resident was again asked about the cash drawer activity, this time by a therapy staff member. At 11:09 a.m., the resident was escorted to the restroom by CNA 9 (a period of 49 minutes since his first request to go to the bathroom). Resident 4's clinical record was reviewed on 2/28/23 at 11:23 a.m. Current diagnoses included, dementia, anxiety, constipation, chronic kidney disease, and delusional disorder. A 1/3/23, quarterly, MDS assessment indicated the resident had severe cognitive impairment, required extensive assistance from staff for purposeful movement and toileting, had an indwelling catheter, was occasionally incontinent of urine and frequently incontinent of bowel. A current care plan problems/needs, last reviewed on 1/3/23, indicated a diagnosis of constipation. The goal for this need was to have a normal bowel movement at least every day. An approach to this need was to encourage resident to sit on toilet to evacuate bowels if possible. A current care plan problems/needs, last reviewed on 1/3/23, indicated the resident had impaired cognitive function or impaired thought processes related to dementia, delusional disorder. A goal			

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	for this need was the resident will be able to communicate basic needs on a daily basis through the review date. A current care plan problems/needs, last reviewed on 1/3/23, indicated the resident had an ADL (activities of daily living) self-care performance deficit. A goal for this need was the resident will maintain current level of function in ADL's through the review date. During an interview, on 2/27/23 at 11:22 a.m., CNA 9 indicated Resident 4 had not been wet when she just checked him. He had a catheter, but needed to be reminded that he had one. This helped him if he was worried. Also, he thought he needed to have a bowel movement, and sometimes just passed significant gas. He did ask to go to the bathroom for bowel movements, and could remain continent of bowel during the daytime if he was taken to sit on the commode. During an interview on 2/28/23 at 9:56 a.m. with RN 2, who was the charge nurse on 1B Memory Care unit, indicated the residents should not be taken to the dining room any sooner than 30 minutes before a meal. Some form of stimulation should be offered before meals. They had a CD player to play music prior to meals, but it had been misplaced since the remodel. Resident 4 should have been taken to the bathroom when he asked in order to assist with bowel continence. During an interview, on 2/28/23 at 10:04 a.m., CNA 3 indicated residents should not be taken to the dining room any earlier than 30 minutes before a meal. The staff should provide stimulation when the residents wait for meals, such as putting music on the CD player. If Resident 4 asked to go to the restroom, he should be reminded he had a catheter			

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	for urine and take him if he says he needed to have a bowel movement. During an interview on 2/28/23 at 10:10 a.m. with the Administrator, who was also the Memory Care director, she indicated the following residents should be escorted to meals approximately 30 minutes or less before meals. The environment should offer sensory stimulation, like music or trivia as they await meals. She had not been told the staff could not find the CD player following the remodel. There were other CD players in the facility that could be used. Resident 4 should be taken to the restroom if he requested, or reminded he had a catheter to reduce his concern. A mask should be promptly removed from a resident's eyes if they rub their face and move it over their eyes. A current facility document, titled "Healthcare Meal times and locations of dining rooms," left on the conference table on 2/22/23 as part of a survey readiness binder, indicated the following: "... Lunch-12:00 p.m. ...Dining rooms are located on each unit...1B...." A current, 9/2022, facility policy, titled, "Resident Rights," provided by the Administrator on 2/28/23 at 11:27 a.m., indicated the following: "...Respect and dignity. The resident has a right to be treated with respect and dignity...." 3.1-3(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure qualified staff provided a resident transfer for 1 of 1 residents observed. (Resident 29) Findings include: During an random observation on 2/27/23 at 3:36 p.m., in the resident lounge on the 2 B Memory Care unit, Hostess 6 was observed assisting a Certified Nursing Assistant (CNA) to transfer Resident 29 from a recliner to a wheelchair. The two staff members held the resident under the axillary (armpit) area and lifted her to a standing position. The resident appeared unsteady and her knees buckled, but was able to maintain a standing position with assistance of staff. The resident was then pivoted to a wheelchair. Staff had not used a gait belt. Resident 29's clinical record was reviewed on 2/23/23 at 11:54 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart failure, pain in bilateral knees, muscle weakness, and need for assistance with personal care. A quarterly Minimum Data Set (MDS) assessment, dated 2/17/23, indicated the resident had severe cognitive impairment, required extensive assistance of two staff for transfers, and was only able to stabilize when standing with staff assistance. A Morse Fall Scale assessment, dated 2/18/23,	F 0689	- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; One resident identified as potentially affected however upon chart review no affects noted 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(s) will be taken; DON/designee to verbally question all hostess personnel about assisting with resident transfers in order to determine if the alleged deficient practice has occurred elsewhere and potentially affected any other residents. - What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Hostess job description modified to clearly define prohibited task of transferring a resident. Attachment: E All hostess personnel completing	03/25/2023

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	155705	A. BUILDING 00 B. WING	02/28/2023

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HERITAGE POINTE OF WARREN	801 N HUNTINGTON AVE WARREN, IN 46792

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	indicated the resident was a high fall risk. The assessment included the resident had difficulty rising from a chair, had an impaired gait, and had a history of previous falls. During an interview, on 2/27/23 at 3:39 p.m., Hostess 6 indicated she was not a CNA, but had assisted with transfers to help staff. She would not transfer a resident on her own. During an interview, on 2/28/23 at 11:30 a.m., the Director of Nursing (DON) indicated Hostess 6 was not trained to assist with transferring a resident and should not have assisted. Staff should use a gait belt for all resident transfers. A current, undated, facility policy titled "Job Description for Nursing Hostess," provided by the Administrator on 2/28/23 at 12:40 p.m., indicated the following: "...Responsibilities:...Nursing hostess may not provide/perform/assist with the following direct resident care: assisting with ambulation, feeding of a resident, ADL's [Activities of Daily Living], or toileting assistance...." A current, undated, facility policy titled, "Positioning/Transfer, Assisting Resident To/From Wheelchair or Chair to Bed," provided by the Administrator on 2/28/23 at 12:40 p.m., indicated the following: "Procedure:...1....Use gait belt....6. Grasp gait belt on each side of resident's waist, and ask resident to stand on the count of three." 3.1-45(a)(2)		re-education of job description. - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Weekly observations of hostess personnel will be completed to ensure compliance. Audits will be completed weekly for 12 weeks, then monthly for 3 months. Attachment: F Audits will be performed with supervising charge nurse/supervisor or designee. If 100% compliance is not obtained additional monitoring including audits will be extended per the QA committees recommendations.	

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure a physician order and baseline care plan was in place for oxygen use for 1 of 1 residents reviewed for respiratory care. (Resident 232) Findings include: During an interview, on 2/22/23 at 9:30 a.m., Resident 232 indicated she had recently admitted to the facility from the hospital. She planned to ask staff for lip balm because her mouth and lips felt dry. During the interview, her lips had visible dryness and cracking. She had oxygen on at two liters per minute, by nasal cannula. A humidification bottle (used to humidify oxygen) was sitting on a counter in her room, and there was no humidification bottle connected with her oxygen tubing. During an observation on 2/23/23 at 1:57 p.m., she was sitting in a recliner in her room, with oxygen on per nasal cannula. A humidification bottle was on the counter, and not connected through the oxygen tubing. Resident 232's clinical record was reviewed on	F 0695	- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Orders for all residents utilizing oxygen (as evidenced by oxygen supplier's most current invoice) reviewed to ensure orders are in place and care-plan is appropriate with oxygen listed. - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Deficiency was a result of an acute care hospital not informing facility of residents return and lack of physician's orders upon return. No other residents noted to be affected Primary care provider contacted	03/25/2023

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	2/24/23 at 9:52 a.m. Diagnoses included, but were not limited to, pulmonary hypertension. Current physician orders did not include an order for oxygen. Her baseline care plan did not include use of oxygen. An Admit/Readmit Screener, dated 2/18/23 at 10:21 p.m., indicated she had admitted to the facility from the hospital. She had shortness of breath with exertion, and had oxygen at 2 liters per minute per nasal cannula. During a medication administration observation, on 2/27/23 at 10:42 a.m., Resident 232 was sitting in a recliner, with oxygen on per nasal cannula at two liters per minute. A humidification bottle was on the counter in her room, and no humidification was connected with oxygen tubing. During an interview, on 2/27/23 at 10:49 a.m., LPN 7 was unable to locate an order for oxygen. She indicated if a resident received oxygen, she would have expected to find an order. Review of a current, undated, facility policy, titled "Oxygen, Administration Of," provided by the Administrator on 2/27/23 at 12:03 p.m., indicated the following: "...Purpose: To facilitate normal breathing, as ordered by a physician...Procedure: 1. Check doctor's orders...5. The flow of oxygen is started and regulated, per order, and according to facility policy...." Review of a current facility policy titled, "Resident Care Plan," with a revised date of 10/2016 and provided by the Administrator on 2/28/23 at 12:37 p.m., indicated the following: "...A baseline care		for clarification and new order was received and documented. Care-plan updated to reflect oxygen needs. - What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing department supervisor and charge nurse will conduct a room inspection of all admissions/readmissions to ensure medical equipment needs are documented in the EHR, including a physician order and appropriate care-plan. Admission assessment edited to automatically trigger care-plan for those residents utilizing oxygen. New admission audit created for nursing supervisor and charge nurse to simultaneously conduct a room inspection of all admissions/readmissions to ensure all medical equipment needs are documented in the EHR, including physicians order. Attachment: C - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and	

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	plan for each resident will be developed, within 48 hours of admission, which includes the instructions needed to provide effective and person-centered care that meets professional standards of care. * Includes initial goals, physician orders...." 3.1-47(a)(6)		by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. New admission audits will be reviewed by nursing management/designee for 6 months. If 100% compliance is not obtained additional monitoring including audits will be extended per the QA committees recommendations.	
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 22, 23, 24, 27 & 28, 2023 Facility number: 000542 Residential Census: 88 Heritage Pointe of Warren was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000		

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	Quality review completed March 6, 2023.			