STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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 Complaint IN00399724. Complaint IN00399724 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: February 16, 17, 20, 21, 22 and 23 of 2023. Facility number: 000038 Provider number: 155095 AIM number: 100274830 Census Bed Type: SNF/NF: 143 Total: 143 Census Payor Type: Medicare: 22 Medicaid: 102 Other: 19 Total: 143 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 27, 2023	F 0000	Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employees, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests paper compliance in lieu of a post survey review on or after March 20, 2023.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review the facility failed to ensure timely assessments for weight loss for 1 of 4 residents reviewed. (Resident 118) Findings include: Resident 118's recorded review began on 02/22/23 at 10:12 AM. Diagnosis included dysphagia, dehydration, and anorexia. Resident 118's physician orders included; ice cream at lunch, update weight due to weight loss, daily weight x7 to establish baseline weight, mirtazapine 15mg tablet at bedtime for anorexia, offer bedtime snack, weekly weights x4, and ensure plus.	F 0692	**What corrective actions will be accomplished for those residents to have been found by the deficient practice?** Heritage Park has been able to obtain resident 118's weight per *Resident Weight Monitoring* policy. Resident has had no adverse effects r/t 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?** All newly admitted and re-admitted	03/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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 118's record indicated he was in hospital from 12/5/22 to 12/21/22 and from 1/5/23 to 1/7/23. A review of the Medication Administration Record (MAR) dated February 2023 indicated on night shift there were 2 times the bedtime snack was not documented as offered. There was no documentation of readmit weight or refusal on 12/21/22. There were no weights documented from 11/7/22 to 1/3/23. Weight was documented on 11/7/22 as 221. On 1/3/23 weight was documented as 184. A 37-pound (16%) weight loss in 2 months. Progress noted indicated Resident 118 was seen by a physician on 12/5/23 prior to discharge to the hospital for increased weakness and lab results. No order for routine weights was documented. The Physician saw Resident 118 on 12/22/23 after return from hospitalization on 12/21/22. Resident 118's weight was not addressed during the assessment, nor documentated on return to the facility. Resident 118 was seen by the physician on 12/27/22. Resident 118's poor appetite and intake were not mentioned. Resident was seen on 12/29/22 for lab follow up. His weight was not addressed. Resident 118 was seen on 1/2/23 for follow up. During the assessment on 1/2/23 physician addressed the apparent weight loss and requested a weight. Resident 118 had an interdisciplinary team meeting on 1/2/23 regarding an are to his right		residents or residents who experience a change in condition have the potential to be affected by this alleged deficient practice. All nurses completing resident admissions, nurse managers, and designee weighing residents have received education on *Resident Weight Monitoring* policy. All newly admitted or readmitted residents or residents experience a change in condition related to weight loss since 2/23/23 have been reconciled and charts audited for a recorded admission weight. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Facility designated a staff member to obtain/oversee weights who will report to DNS/ADNS. All nurses completing admissions will be educated on the *Resident Weight Monitoring* policy. DNS/designee will review resident vitals report for any missing weights. Missing weights will be placed on CQI form and communicated to designee obtaining weights. DNS/Designee will ensure weights are completed as ordered. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Ongoing compliance with this corrective action will be monitored monthly in the QAPI program	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	upper great toe. During this meeting it was documented there were no nutritional concerns. Resident 118 was seen by the physician on 1/3/23 for a follow up visit. The physician documented the facility had obtained an updated weight. He suspected the redident had a large weight loss. The loss was obvious in his face and his abdominal area. A lot of this was likely due to the prolonged hospitalization for oral intake and recent GI surgery. Resident 118 was reviewed by the RD (Registered Dietician) on 1/5/23. It was documented he had intermittent periods of NPO (nothing by mouth) status while hospitalized and meal intakes were decreased. There was no documentation of Resident 118's current weight or a plan to stabilize his weight. Resident 118's chart was reviewed on 1/23/22 by the dietician who documented Resident 118's weight was stable. Resident 118 was reviewed by the interdisciplinary team on 2/8/23 regarding significant weight loss. Resident 118's nutritional assessments were as follows: Dated 10/11/22, Resident 118 was trending weight loss Dated 10/21/22, Resident 118 had no significant weight loss There was no documentation of nutritional assessments available for the months of November or December.		overseen by the executive director. The *resident weights* quality assurance tool will be completed weekly X one month, monthly X six months, and then quarterly thereafter with results reported to the QAPI committee overseen by the executive director. If 95% is not achieved an action plan will be developed. Compliance date: 3/20/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	Dated 1/3/23, Resident 118 had less than 75% intake on breakfast, lunch, and dinner, Ensure and Remeron were ordered, and weight loss discussed. A Dietician review dated 1/5/23 indicated he refused his readmission weight, his weight loss was attributed to hospitalization and medical issues. The review noted Resident 118 was not having decreased appetite. On 1/13/23, meal intake was above 75%, the resident was still on ensure twice daily, and there was no weight loss. In an interview on 2/22/23 at 11:02AM, the Regional Registered Dietician and the facility RD (Registered Dietician) indicated anytime a resident was in the hospital over 24hrs they were to be weighed weekly x4 weeks on return. The RD indicated there were no weights documented upon Resident 118's return from the hospital on 12/21/22. In an interview 2/22/23 at 12:16PM, the Regional RN (Registered Nurse) indicated there were no weights documented for Resident 118 upon return from the hospital or for the following week. A current policy titled Resident weight monitoring indicated "... residents will be weighed no less thean monthly or per physician's orders. " and "... upon admission, the resident's weight... will be recorded." 3.1-46			
F 0697 SS=D	483.25(k) Pain Management			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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	§483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 non-pharmacological interventions were implemented and pain level was assessed prior to administering pain medication for 1 of 2 residents reviewed. (Resident 57) Resident 57's record was reviewed on 2/21/2023 at 11:26 AM. Diagnoses included cerebral infarction due to unspecified occlusion or stenosis of unspecified precerebral arteries, type 2 diabetes mellitus with hyperglycemia, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, end stage renal disease, gout, unspecified, presence of cardiac and vascular implant and graft, unspecified, dependence on renal dialysis, and type 2 diabetes mellitus with diabetic chronic kidney disease. A Minimum Data Set (MSD) assessment, dated 01/11/2023, indicated Resident 57 had a brief interview for mental status (BIMS) score of 11 (moderate cognitive impairment). A physician's order, dated 9/24/2021, indicated to give Acetaminophen tablet 325 milligrams (mg) (over the counter medication to treat pain or fever), give 650mg oral (by mouth) every 6 hrs. (hours) prn (as needed). Do not exceed 4 grams of Acetaminophen from all other sources. A physician's order, dated 6/23/2022, indicated to	F 0697	**What corrective actions will be accomplished for those residents to have been found by the deficient practice.** Nursing staff have been educated on assessing and documenting resident's pain level prior to administering a PRN pain medication. Nursing staff have been educated on providing and documenting non-pharmacological interventions per care plan for resident 57 prior to administering a PRN pharmacological intervention. No adverse effects noted for resident 57 ruled 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?** All residents who receive PRN pain medications have the potential to be affected by this alleged deficient practice. All licensed nurses have received education on providing and documenting resident's non-pharmacological interventions prior to administering PRN medication. Licensed nursing staff have been educated on	03/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	give Hydrocodone-Acetaminophen Schedule II tablet 5-325mg (opioid pain medication), give 5-325mg orally 6 hrs. prn. Resident 57's orders did not include an order to implement non-pharmacological interventions prior to administering a pain medication. A current care plan, dated 6/14/2021, indicated Resident 57 was at risk for pain related to: tooth extractions (removals), decreased mobility, CVA (stroke) with right side hemiparesis (weakness on the right side of the body), coronary artery disease (heart disease), diabetes mellitus type II (an impairment in the way the body regulates and uses sugar), end stage renal disease (kidneys not functioning), anemia (low red blood cell count), dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), depressive episodes, gastro esophageal reflux disease (heartburn), dry eye syndrome, gout (a form of arthritis, which brings on sudden, severe attacks of pain, swelling, redness, and tenderness in one or more joints, most often the big toe), obstructive uropathy (when urine cannot drain through the urinary tract) with a suprapubic catheter (tube inserted into the bladder through the lower abdomen to drain urine), peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the arms and legs), cardiomyopathy (a disease of the heart muscle which causes the heart to lose its ability to pump blood efficiently), and hyperlipidemia (high concentration of fat in the blood). The goal indicated Resident 57 would be free from adverse effects of pain. The interventions included: administer medication as ordered, assist with positioning to comfort, document effectiveness of prn medications, notify the medical doctor (MD) if		assessing and documenting resident's pain level prior to administering a PRN medication. All residents taking PRN pain medications have been reconciled and physician orders modified to reflect pain assessment and non-pharmacological intervention as indicated. — What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All resident's PRN medication orders will be modified to include pain assessment and non-pharmacological interventions prior to administering a PRN medication. All licensed nurses will be educated on providing a non-pharmacological intervention prior to administering a PRN pain medication per plan of care, educated on assessing a resident's pain level prior to administering a PRN pain medication, and educated on documenting the pain level. IDT will review any new order for PRN pain medication to ensure it includes pain assessment and non-pharmacological intervention per care plan **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Ongoing compliance with this corrective action will be monitored	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	pain was unrelieved and/or worsening, observe for adverse effects of pain medication including, but not limited to, over sedation, constipation, skin rash, nausea/vomiting, loss of appetite, change in mental status, stomach upset, document abnormal findings and notify the MD, observe for nonverbal signs of pain: changes in breathing, vocalizations (speaking out loud), mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture, and offer non pharmacological interventions such as quiet environment, rest, shower, back rub, repositioning. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated January 2023, indicated Resident 57 received Acetaminophen 650mg on 1/2/23 at 5:40 PM, 1/5/23 at 5:41 PM, 1/7/23 at 3:49 AM, 1/11/23 at 5:10 AM, 1/12/23 at 7:14 PM, 1/16/23 at 5:07 AM, 1/17/23 at 2:49 AM, 1/18/23 at 3:48 AM and 5:47 PM, 1/19/23 at 4:12 AM and 6:09 PM, 1/21/23 at 4:40 AM, 1/22/23 at 4:12 AM, 1/26/23 at 5:04 AM, 1/27/23 at 5:05 AM, 1/30/23 at 7:46 PM, and 1/31/23 at 4:59 AM. The MAR and TAR, dated February 2023, indicated Resident 57 received Acetaminophen 650mg on 2/1/23 at 4:01 AM, 2/6/23 at 4:48 AM, 2/8/23 at 4:33 AM, and 2/9/23 at 6:52 PM. Resident 57's MARs and TARs, dated January 2023 and February 2023, contained no documentation regarding the nonpharmacological interventions attempted prior to administering Acetaminophen to Resident 57. Resident 57's MARs and TARs, dated January 2023 and February 2023, contained no documentation of Resident 57's pain level prior to		monthly in the QAPI program overseen by the Executive Director. The *pain management* quality assurance tool will be completed weekly x one month, monthly x 6 months and then quarterly thereafter with results reported to the QAPI committee overseen by the Executive Director. If 95% is not achieved an action plan will be submitted. Compliance date: 3/20/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	administering Acetaminophen. The MAR and TAR, dated January 2023, indicated Resident 57 received Hydrocodone-Acetaminophen 5-325mg on 1/8/23 at 2:35 PM, 1/24/23 at 2:38 PM and 8:10 PM, 1/27/23 at 7:29 PM, 1/28/23 at 11:19 AM, 1/29/23 at 8:33 AM and 4:09 PM, 1/30/23 at 3:36 PM, and 1/31/23 at 12:10 PM. The MAR and TAR, dated February 2023, indicated Resident 57 received Hydrocodone-Acetaminophen 5-325mg on 2/1/23 at 5:01 PM, 2/3/23 at 7:29 PM, 2/5/23 at 10:07 AM, and 2/5/23 at 6:38 PM. Resident 57's MARs and TARs, dated January 2023 and February 2023, contained no documentation regarding the nonpharmacological interventions attempted prior to administering Hydrocodone-Acetaminophen to Resident 57. Resident 57's MARs and TARs, dated January 2023 and February 2023, contained no documentation of Resident 57's pain level prior to administering Hydrocodone-Acetaminophen. A review of Resident 57's vital sign documentation, dated January 2023, indicated no documentation of pain level. Resident 57's vital sign documentation, dated February 1- 21, 2023, contained documentation of Resident 57's pain level at "0 of 10" on 2/21/2023 at 8:06 AM. No other documentation of pain level was found in the February 2023 vital sign section of Resident 57's record. A review of Resident 57's progress notes, dated 1/1/23-2/22/23, indicated no documentation of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	nonpharmacological interventions attempted prior to administering Acetaminophen. A review of Resident 57's progress notes, dated 1/1/23-2/22/23, indicated no documentation of Resident 57's pain level prior to administering Acetaminophen. A review of Resident 57's progress notes, dated 1/1/23-2/22/23, indicated no documentation of the nonpharmacological interventions attempted prior to administering Hydrocodone-Acetaminophen. A review of Resident 57's progress notes, dated 1/1/23-2/22/23, indicated no documentation of Resident 57's pain level prior to administering Hydrocodone-Acetaminophen. In an interview on 2/22/23 at 10:10 AM, LPN 7 indicated if a resident had several pain medications ordered, she would administer the medication based on the resident's pain level. She would administer the stronger pain medication if the resident had a high pain rating. LPN 7 indicated she would document the resident's pain rating, based on a scale 1-10, location of the pain, and a description of the pain. LPN 7 indicated she would reassess the resident's pain 30-45 minutes after administering the pain medication and would document the effectiveness. LPN 7 indicated that documentation of pain assessment was done on the MAR or in a progress note with each administration of a pain medication. In an interview on 2/22/23 at 3:46 PM, the Regional Nurse indicated documentation of a resident's pain level was not done in the vital sign section of the resident's record. She indicated an agency nurse might have documented Resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	57's pain level in the vital sign area due to documenting a resident's pain level in the vital sign section in other facilities. The Regional Nurse indicated a resident's pain assessment was done on the MAR. In an interview on 2/23/23 at 9:50 AM, the Regional Nurse indicated implementing nonpharmacological interventions before giving pain medication was considered a standard of care. She indicated the nonpharmacological interventions were not documented because nurses do not document interventions that were considered standard of care. The Regional Nurse indicated that nurses did not have the time to document all interventions that are considered standard of care. 3.1-37(a)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on interview and record review the facility failed to ensure trauma informed care was implemented for 1 of 3 residents reviewed. (Resident 72). Findings include: Resident 72's recorded review began on 02/22/23	F 0699	What corrective actions will be accomplished for those residents to have been found by the deficient practice? Director of social services and social services designee have been educated on behavior management and trauma informed care polices by home office social	03/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	at 09:25 AM. The record indicated diagnosis included bipolar disorder, post-traumatic stress disorder (PTSD), anxiety disorder, and panic disorder. Resident 72 went to Bowen Center for psychiatric services with phycologist Dr.Ahmed, in November of 2022. A facility note indicated the appointment was for pain management. Dr Ahmed was not a pain management doctor. The next appointment at Bowen Center with same psychologist was in January of 2023. Office visit notes were not available at time of survey. In an interview , on 2/22/23 at 2:16PM, the ADON (Assistant Director of Nursing) indicated Resident 72's notes from the visit in January 2023 were not available due to the need for a medical request to be sent to Bowen Center to release the records . The necessary paperwork had not been filed. There was no request for information to provide continuity of care for psychological disorders to Resident 72. Resident 72 had the following orders: any/all changes of psych meds must be approved by Dr. Ahmed at Bowen Center, divalproex delayed release 500mg tabled twice daily for bipolar disorder, bupropion 75mg tablet twice a day for depressive disorder, Celexa 20mg and 40 mg tablets (to give 60mg) daily for depressive episodes, hydroxyzine 50mg twice daily for anxiety disorder, and monitoring for significant side effects of the medications listed. Resident 72's current MDS (Minimal Data Set) assessment indicated the following: Section C BIMS (Brief Interview for Mental Illness) score was 15, signified no cognitive disfunction.		enrichment and wellness support regional. The trauma informed care screening tool, diagnoses review, and referral to appropriate behavioral health professional for trauma assessment has been completed. Resident 72's specific problems related to PTSD triggers, symptoms, goals, and person-centered preventative interventions have been incorporated into the plan of care. Caregivers have been educated on resident 72's trauma informed care. No adverse psychosocial effects noted for resident 72 ruled 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?** All residents may have experienced trauma and have the potential to be affected by this alleged deficient practice. All residents will have a chart review completed for diagnoses indicating a history of trauma and will have referral to behavior health professional as indicated. All residents will have a trauma screen completed and if screen indicates the need for a behavior health professional, the resident will be referred accordingly. After the behavioral professional completes the assessment, triggers, symptoms, goals, and approaches will be incorporated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	Section D Mood indicated he felt down, depressed, or hopeless 7-11 days; and was moving or speaking slowly or fidgeting for 7-11 days; in previous 14 days of assessment. Section E Behavior, indicated no hallucinations, delusions, aggression, threatening, physical symptoms, rejection of care, or wandering in previous 14 days of assessment. Section I Active Diagnosis indicated medical diagnosis, anxiety disorder, depression, bipolar disorder, schizophrenia, and post-traumatic stress disorder. Schizophrenia was not listed in Resident 72's chart under diagnosis, face sheet, CCD (Continuity of Care Document), and physician orders sheet. Schizophrenia was listed in physician provider progress notes. Resident 72's current care plan indicated the following problems with the goal and interventions: Problem: Resident was at risk for potential physical aggression, psychotic features, mood changes. Diagnosis PTSD, Bipolar, Schizoaffective disorder and receives mood stabilizing medications. Goal: would not display changes in mood, psychotic features, physical aggression through next review. Approaches: document behavior, assess any physical cause, provide personal space, provide reassurance/comfort/validate feelings. Problem: Resident preference to keep his room door open, feels claustrophobic when door is shut too long due to diagnosis bipolar, anxiety, PTSD, and schizoaffective disorder. Goal was to Honor resident's preferences to keep door open when		into the plan of care. Caregivers will be educated on updated resident care plans related to trauma informed care. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The director of social services and social services designee will receive annual and as needed education on the trauma informed policy. All residents will be assessed for potential trauma upon admission, annually, and upon significant change. Residents who answer positively to a trauma screen or who have a diagnosis that could indicate trauma will be referred to behavioral health for a trauma assessment. The trauma assessment will include person centered triggers and interventions to prevent re-traumatization which will be incorporated into the plan of care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Ongoing compliance with this corrective action will be monitored monthly in QAPI program overseen by the executive director. The trauma informed care quality assurance tool will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	using his c pap machine while sleeping over next review. Approach was to honor resident's preferences and keep room door open for resident. Problem: Resident had been determined mentally ill per level 2 assessment. Level 2 diagnosis was bipolar, depressive disorder, and PTSD. Goal was Resident would have mental health needs met through next review. Approach was to provide mental health services, rehab services, socialization, leisure, recreation, and supportive counseling from staff. There were no documented specific problems related to PTSD triggers, symptoms, goal, approaches. In an interview on 02/22/23 at 11:08 AM, SS 2 (Social Services) indicated the level 2, anxiety, physical aggression, and mood changes were care planned. SS2 indicated Resident 72 should have been care planned specifically for PTSD and indicated she would do so. SS2 indicated the care plan was a tool to address needs of the resident and inform staff best way to provide care. SS2 indicated Resident 72 presented with shortness of breath, was easily agitated, had control issues, breathing rate would increase, became easily angered, and panicked when having psych issues. SS2 indicated Resident 72 had confided in her just last week regarding the PTSD cause. She indicated the only symptom Resident 72 was able to link to the PTSD was "waking up from a bad night". He did not identify any triggers and expressed a feeling of safety overall. SS2 was able to link Resident 72's dislike of staff touching and need to shower self in front regardless of thoroughness. SS2 indicated Resident 72 no longer saw facility psych provider because he did not trust them to not change his medications. SS2		completed weekly X one month, monthly X six months, and then quarterly thereafter with results reported to the QAPI committee overseen by the executive director. If 100% is not achieved an action plan will be developed. Compliance date: 3/20/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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 Dr. Ahmed attempted to put Resident 72 back on Seroquel in November and he has not been able to do so. On 2/22/23 at 1:53 PM, a current policy and procedure titled "Trauma Informed Care", revised October 2022, was provided by ADON indicated; "Resident who are trauma survivors receive culturally competent trauma-informed care ... and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. For the resident to feel safe in their environment and trust caregivers despite past trauma ...trauma informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies and procedures and practices to avoid re-traumatization. ...3...this plan of care will incorporate individual experiences, customary routines, and cultural preferences of the individual's needs. On 2/22/23 at 1:53 PM, a current policy and procedure titled "IDT (inter disciplinary team) Comprehensive Care Plan Policy", revised October 2019, was provided by ADON indicated ..." The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial needs ... On 2/22/23 at 1:53 PM, a current policy and procedure titled "Behavior Management", revised August 2011, was provided by ADON indicated;"7. Direct care staff will be educated as to the interventions for resident reviewed by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	IDT". No state rule applies.			
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview, and record review the facility failed to document mental health diagnoses and identify triggers of the resident's behaviors for 3 of 3 residents reviewed for behavioral and emotional health services (Residents 25, 100, 126). Findings include: 1. On 2/17/23 at 9:37 AM Resident 25 was observed to have a flat affect. The resident made brief eye contact then looked away. She did not respond verbally. On 2/17/23 at 11:34 AM a record review indicated Resident 25's diagnoses included Alzheimer's, bipolar disorder, insomnia, restlessness and agitation, anxiety, unspecified psychosis, suicidal ideations, depressive disorder, and conversion disorder with mixed symptom presentation.	F 0742	**What corrective actions will be accomplished for those residents to have been found by the deficient practice?** Residents 25, 100, and 126 have mental health diagnoses documented and have identified the triggers of resident's behaviors. Triggers for behaviors have been care planned, which includes a clear problem statement and a person-centered preventative intervention. Residents have had no adverse effects ruled 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?**	03/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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 quarterly Minimum Data Set (MDS) dated 1/25/23 indicated the resident had no cognitive deficit. The MDS indicated the resident did not display any behaviors. A care plan problem for mood state dated 8/15/22 indicated the resident was at risk for signs and symptoms of depression. The focus indicated the resident had diagnoses of depression and a history of suicidal ideations. The care plan did not include identification of triggers as an intervention. The care plan did not include interventions for suicidal ideations. A care plan problem for mood state dated 8/15/22 indicated the resident was at risk for signs and symptoms of anxiety. Signs and symptoms included worried facial expressions, repetitive movements, sweating, shaking/tremors, irritability, racing thoughts, insomnia, increased worry, poor appetite, and tearfulness. The care plan interventions did not include identification of triggers. A hospital discharge summary dated 8/15/22 indicated the resident voiced suicidal ideations during her hospital stay. A social service assessment dated 8/19/22 indicated the resident had a history of suicidal ideation. During an interview on 2/22/23 at 11:35 AM, the Social Service Assistant indicated a diagnosis of conversion disorder should be on the care plan. She indicated triggers for behaviors should be attempted to be identified and placed on the care plan. She indicated a history of suicidal ideation should be on the care plan. She indicated racing		All residents with mental health diagnoses have the potential to be affected by this alleged deficient practice. The director of social services and social services designee have been educated by the social enrichment and wellness support regional on the behavior management policy, assessing and care planning the resident's triggers. All residents with mental health diagnoses have been identified, mental health diagnoses documented, residents with mental health diagnoses assessed for triggers, and care planned as indicated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All residents with mental health diagnoses will have diagnoses documented, assessed for triggers, and will have triggers care planned as indicated. The director of social services and social services designee will receive ongoing education on behavior management policy and mental health diagnoses as needed. The IDT will complete chart reviews for all newly admitted residents and residents with change in condition affecting mental health and pull forward mental health diagnoses to identify triggers and update plan of care. How the corrective action(s) will be monitored to ensure the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	thoughts, sweating, irritability, insomnia, and tearfulnessshould be on the cae plan. She indicated staff should attempt to determine the resident's triggers of symptoms and/or behaviors. She indicated behaviors were monitored at monthly behavioral reviews. During an interview on 2/23/23 at 9:33 AM, the Social Service Director (SSD) provided a social service assessment. The social service assessment dated 2/22/23 at 5:19 PM indicated the resident had a history of talking about suicide but had made no comments or attempts in the last 7 months. The assessment did not include conversion disorder as a diagnosis. She provided 3 behavioral health monthly reviews. The first behavioral health monthly review had an observation date of 12/9/22 at 5:16 PM, but the recorded and completed dates were 2/22/23 at 5:17 PM. The second behavioral health monthly review had an observation date of 1/6/23 at 5:14 PM, but the recorded and completed dates were 2/22/23 at 5:15 PM. The third behavioral health monthly review had an observation date of 2/22/23 at 5:18 PM with recorded and completed dates of 2/22/23 at 5:19 PM. The monthly reviews did not include suicidal ideation or conversion disorder as diagnoses. She provided page 6 of the resident's care plan. She reviewed a care plan problem dated 8/15/22. The care plan focus indicated the resident was at risk for signs and symptoms of depression, had diagnoses of depression and a history of suicidal ideation. She indicated there were no care plan interventions for suicidal ideations. She indicated there should have been interventions for suicidal ideation. She provided a psychiatric Nurse Practitioner progress note. She indicated since the NP's primary diagnosis for Resident 25 was Alzheimer's she believed all other mental disorders and behaviors could be covered under		practice will not recur? Ongoing compliance with this corrective action will be monitored monthly in QAPI program overseen by the executive director. The behavior management quality assurance tool will be completed weekly X one month, monthly X six months, and then quarterly thereafter with results reported to the QAPI committee overseen by the executive director. If 100% is not achieved an action plan will be developed. Compliance date: 3/20/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	dementia on the resident's care plan. 2. A record review on 2/17/23 at 12:04 PM indicated Resident 100 had a diagnosis of adjustment disorder. A quarterly MDS assessment dated 2/22/23 indicated the resident had mild cognitive deficit. The MDS indicated the resident had a diagnosis of adjustment disorder. The MDS indicated the resident exhibited behaviors of verbal aggression towards others. A care plan problem for psychosocial wellbeing dated 11/17/22 indicated the resident had unsettled relationships with staff related to recent allegations of abuse. The care plan indicated the resident had a diagnosis of adjustment disorder and had explosive outbursts directed at staff. The care plan interventions did not include attempts to identify triggers to the resident's behaviors. During an interview on 2/22/23 at 11:35 AM, the Social Service Assistant indicated triggers for behaviors should be attempted to be identified and placed on the care plan. She indicated all residents are screened upon admission. During an interview on 2/23/23 at 9:55 AM, the SSD presented page 5 of the resident's care plan. She reviewed a problem of psychosocial wellbeing. The problem indicated the resident had unsettled relationships with staff due to allegations of abuse. The resident was followed by psychiatric services, and the resident had a diagnosis of adjustment disorder. She indicated the care plan interventions did not include attempting to identify triggers for the resident's behavior.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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. A record review on 2/17/23 at 1:45 PM indicated Resident 126 had diagnoses of unspecified dementia, anxiety, restlessness and agitation, insomnia, psychotic disturbance, mood disturbance, and adjustment disorder with mixed disturbance of emotions and conduct. A care plan problem dated 7/11/22 titled behavioral symptoms related to anxiety indicated the resident exhibited worried facial expressions, repetitive movements, shortness of breath, nausea, sweating, tremors, irritability, restlessness, and insomnia. Interventions did not include to attempt to identify triggers of the resident's symptoms. The resident's care plan did not address adjustment disorder. A quarterly MDS assessment dated 12/6/22 indicated the resident had severe cognitive deficit. The MDS indicated the resident did not exhibit any behaviors. The MDS indicated the resident's diagnoses included non-Alzheimer's dementia, anxiety, and adjustment disorder with mixed disturbance of conduct and emotions. During an interview on 2/22/23 at 11:35 AM the Social Service Assistant indicated a diagnosis of adjustment disorder should be on the care plan. She indicated triggers for behaviors should be attempted to be identified and placed on the care plan. She indicated racing thoughts, sweating, irritability, insomnia, nausea, shortness of breath, and tearfulness should be on the care plan. She indicated all residents are screened upon admission. She indicated the assessments could be located under the observation tab and would be titled "ASC Social Service Assessment." She indicated staff should attempt to determine the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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's triggers of symptoms and/or behaviors. She indicated behaviors were monitored at monthly behavioral reviews. A review of the resident's record did not indicate a social service assessment had been completed. On 2/23/23 at 9:55 the SSD provided a social service assessment dated 2/22/23 at 4:17 PM. The assessment indicated the resident had current diagnoses of adjustment disorder, dementia, anxiety, and insomnia. During an interview on 2/23/23 at 11:00 am the SSD provided a psychiatric Nurse Practitioner progress note dated 1/24/23 at 8:39 AM. She indicated since the NP did not list the resident's diagnosis of adjustment disorder, she believed all other mental disorders and behaviors could be covered under dementia on the resident's care plan. A current policy titled "Behavioral Health" dated 10/22 provided by the Assistant Director of Nursing (ADON) on 2/22/23 at 1:53 PM indicated residents will be referred to behavioral health providers based on person centered assessment for situations such as mental health disorders, psychotropic medication management, behavior intervention development, substance use disorders, trauma assessment/care plan development and/or adjustment or mood issues. A current policy titled "Behavior Management" dated 7/1/22, revised 8/22 and 10/22 provided by the SSD on 2/23/23 at 9:33 AM indicated care plans should include individualized interventions that are proactive and responsive. The policy indicated residents with known behaviors would have a monthly review to determine if			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 00 B. WING	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(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
	interventions for behaviors are current and effective. 3.1-43(a)(1)			