STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE REHABILITATION & HEALTH CARE CENTEI	281 S COUNTY ROAD 200 EAST CONNERSVILLE, IN 47331

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00451373 and IN00450713. Complaint IN00451373 - Federal/State deficiencies related to the allegations are cited at F677 and F697. Complaint IN00450713 - Federal/State deficiencies related to the allegations are cited at F677 and F697. Survey dates: January 21, 22, 23, 24, and 27, 2025 Facility number: 000225 Provider number: 155332 AIM number: 100267670 Census bed type: SNF/NF: 87 Total: 87 Census payor type: Medicare: 12 Medicaid: 59 Other: 16 Total: 87 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 30, 2025.	F 0000		
F 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacey Ware	Executive Director	02/13/2025

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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Bldg. 00	Based on observation, interview, and record review, the facility failed to assist dependent residents with dressing, personal hygiene, eating, and applying heel guards for 3 of 6 residents reviewed for Activities of Daily Living (ADL) assistance (Resident K, Resident G and Resident Q). Findings include: 1. During an observation and interview with Resident K's family member on 1/22/25 at 12:13 p.m., they indicated the resident had several bras in the drawer and the family had asked the facility, multiple times, to put a bra on the resident. Resident K had always been particular about wearing a bra. Resident K's family member indicated the facility was not brushing the resident's hair either. The resident had a doctor's appointment earlier in the week and the family met her at the appointment. The resident's hair was not combed when at the appointment. The family member indicated they had talked to the Social Service Director (SSD) about the staff not combing her hair and not putting a bra on her and it had improved for a few days, and then they stopped doing it again. The family member indicated it was very important to the resident for these things to be done. An observation at the time of the interview indicated Resident K's hair was not combed and she did not have a bra on. During an observation on 1/23/25 at 11:00 a.m., Resident K was dressed, she did not have a bra on, and her hair was not brushed. During an observation on 1/24/25 at 11:23 a.m., Resident K was in therapy with two other	F 0677	=" " a=" ">This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 2/13/25. =" " a=" "> What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident K care plan and profile was updated with her preference to wear bra on 1/24/25 and to have hair combed every day. Resident G heel guards were placed on her and staff were educated on where to find them if not in the room prior to a.m. care. Resident Q was immediately assisted with her meal by staff upon witnessing her eating with her fingers during survey observation of the same. **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:** Any dependent resident needing assistance with ADL care has the potential to be affected by the alleged deficient practice. All certified staff are to be educated by the CEC or designee on ADL care for dependent	02/13/2025

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	residents. Resident K did not have a bra on, and her hair was not brushed. During an observation and interview with Resident K on 1/24/25 at 11:55 a.m., the resident pulled her shirt down and indicated she did not have a bra on. Resident K indicated she wanted to wear a bra, but "they" said they do not wear them here. "They are the boss". During an interview with the SSD on 1/24/25 at 12:48 p.m., they indicated Resident K's family reported to her, in December 2024, that it was important to the resident to wear and bra and have her hair combed. The SSD indicated she did talk with the staff about the importance of putting a bra on the resident and combing her hair. It was the responsibility of the Certified Nurse Aides (CNA's) and nurses to ensure these were completed for the resident. During an observation and interview with the SSD on 1/24/25 at 12:54 p.m., they verified Resident K did not have a bra on and her hair was not brushed. The SSD requested approval from the resident to look in her drawer for a bra and the resident agreed. The resident had three bras in her drawer. The clinical record for Resident K was reviewed on 1/23/25 at 11:48 a.m. The diagnoses included, but were not limited to, left femur fracture, osteoporosis, dementia, major depressive disorder, and muscle weakness. The plan of care for Resident K, dated 12/4/24, indicated the resident required assistance with ADL care. The resident had functional changes and weakness. The interventions included, but were not limited to, assisting with dressing and		residents as it relates to dressing, hair combing, eating and hygiene by 2/13/25. Dependent residents with orders for heel guards were reviewed for continued necessity and proper application. DNS or designee will educate all licensed staff on heel guard placement for dependent residents including review of skin management policy by 2/13/25. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** IDT was educated on 2/10/25 by ED and MDS coordinator to observe ADLs and profile interventions during daily Care Companion rounds. Resident profiles and ADL trigger sheets were added to Care Companion binders. All licensed/certified staff educated by CEC or designee on ADL care for dependent residents related to dressing, eating, hair combing hygiene and heel guard placement by 2/13/25. Daily ADL observational rounds will be conducted on dependent residents by DNS/designee using audit tool to ensure ADL care is provided per resident preference, and to ensure heel guards are in place, and residents are fed per care plan. **How the corrective action(s)**	

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	grooming. The Significant Change Minimum Data Set (MDS) assessment for Resident K, dated 1/14/25, indicated the resident was moderately impaired for daily decision making. The resident did not exhibit behaviors that included rejection of care. It was somewhat important to choose what clothes to wear. The resident required partial to moderate assistance with upper body dressing and substantial to maximal assistance with personal hygiene, including combing hair. 2. The clinical record for Resident G was reviewed on 1/22/25 at 11:00 a.m. Her diagnoses included, but were not limited to, dementia and chronic kidney disease. The 12/24/24 Quarterly MDS assessment indicated she was dependent on staff for putting on and taking off footwear. The physician's orders indicated heel guards to bilateral feet at all times, starting 5/11/24. The at risk for skin breakdown care plan indicated she had an inability to care for herself and was unaware of her needs. The goal was for her to be free from skin breakdown. An intervention was heel guards to bilateral lower extremities at all times, starting 6/24/24. An observation of Resident G was conducted on 1/22/25 at 11:09 a.m. She was sitting in her wheelchair in the dining room. She was not wearing heel guards. An observation of Resident G was conducted on 1/24/25 at 12:33 p.m. She was sitting in her wheelchair in the dining room. She was not wearing heel guards.		**will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** The CEC/designee will be responsible for the completion of the Accommodation of Needs and Preferences QA Tool on dependent residents weekly x 4, then monthly x 6 months, and quarterly thereafter. Results will be reviewed by the QAPI committee overseen by the ED with a compliance threshold of 95%. If the threshold is not achieved an action plan will be developed. Deficient practices will result in disciplinary action up to and including termination of employment.	

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An observation of Resident G was conducted, on 1/27/25 at 11:31 a.m., with Licensed Practical Nurse (LPN) 4. She was sitting in her wheelchair in the dining room. She was not wearing heel guards.

An observation of Resident G's room was conducted with LPN 4 on 1/27/25 at 11:34 a.m. LPN 4 looked in Resident G's closet and drawers for heel guards but was unable to locate any.

An observation of the clean linen room was conducted, and an interview was conducted with the Assistant Director of Nursing (ADON), on 1/27/25 at 11:39 a.m., to look for heel guards. The ADON located a plastic bag, containing heel guards, in the room. The ADON removed a pair and handed them to LPN 4 for her to apply to Resident G.

The Skin Management Program policy was provided by the Director of Nursing (DON) on 1/27/25 at 12:45 p.m. It indicated, "Interventions to prevent wounds from developing and/or promote healing will be initiated based upon the individual's risk factors to include but not limited to the following ...Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.) ..."

3. The clinical record for Resident Q was reviewed on 1/24/2025 at 1:45 p.m. The medical diagnoses included dementia and pain.

An Annual Minimum Data Set assessment, dated 1/9/2025, indicated Resident Q was cognitively impaired and needed partial to moderate assistance with the daily activity of eating.

A care plan, last revised 5/30/2024, indicated to assist Resident Q with eating as needed.

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	During an observation on 1/24/2025 at 12:21 p.m., Resident Q was sitting at a table in the dining room with a plate of pureed food. Resident Q was using her fingers to feed herself without staff at the table with her. An interview conducted with CNA 2, on 1/24/2025 at 12:45 p.m., indicated Resident Q often needed assistance with eating and will sometimes eat with her fingers. An interview conducted with CNA 3, on 1/24/2025 at 1:30 p.m., indicated Resident Q needed assistance with eating and has been noted to eat with her fingers. An interview conducted with the Administrator, on 1/27/2025 at 1:00 p.m., indicated the facility did not have a policy for assisting residents with eating. The expectation of the facility was that staff would ensure residents' hands were clean, the diet was as ordered, set up the meal for the resident, and then assist the resident with the meal as needed. Once assistance was initiated, staff would stay at the table with residents through the meal. A policy entitled, "AM [morning] Care", was provided by the Director of Nursing on 1/27/2025 at 10:45 a.m. The policy indicated for staff to assist with dressing, as well as combing and styling a resident's hair as preferred. This citation relates to Complaints IN00450713 and IN00451373. 3.1-38(a)(2)(A) 3.1-38(a)(2)(D) 3.1-38(a)(3)(A)			

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F 0697 SS=D Bldg. 00	3.1-39(a)(3)(B) 483.25(k) Pain Management Based on interview and record review, the facility failed to ensure effective pain management was provided for a newly admitted resident who experienced pain for 1 of 3 residents reviewed for pain medication administration. (Resident D) Findings include: A hospital discharge summary for Resident D, dated 12/31/24, provided by the Director of Nursing (DON) on 1/27/25 at 1:25 p.m., indicated Resident D was ordered Dilaudid 4 mg (milligram) tablet by mouth every four hours as needed for pain. An Epic Care Link provided by the DON, on 1/27/25 at 2:30 p.m., indicated Resident D was administered Dilaudid 4 mg by mouth, at 3:22 p.m., while at the hospital before arrival to the facility. The clinical record for Resident D was reviewed on 1/27/25 at 12:13 p.m. The diagnoses included, but were not limited to, amputation of right foot and toes, diabetes mellitus type 2, and diabetic neuropathy. Resident D was admitted to the facility, on 12/31/24 at 5:30 p.m., from the hospital. The admission physician order for Resident D, dated 12/31/24, indicated the resident was ordered Dilaudid 4 mg every four hours as needed. The admission assessment for Resident D, dated 12/31/24 at 8:17 p.m., indicated Resident D verbalized experiencing pain rated 10 out of 10 on the pain scale. Per the Long-Term Care Facility Resident Assessment Instrument 3.0 User's	F 0697	=”” p=””> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 02/13/2025. It is the standard of this facility to ensure effective pain management is provided to a newly admitted resident experiencing pain. **What corrective action will be accomplished for those residen ts found to have been affected By deficient practice?** —— Resident D received PRN Dilaudid 01/01/25 at 1:10 am per his request and was noted to be somewhat effective. **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 new admissions experiencing pain have the potential to be affected by the alleged deficient practice. All new admissions for the last 30 days were reviewed to ensure effective pain management. The DNS or designee in-serviced facility	02/13/2025

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	Manual Version 1.19.1 published by the Centers for Medicare and Medicaid Services, the numeric pain scale indicated 0 being no pain and 10 as the worst pain one could imagine. This indicated a 10 would be concurrent with very severe or horrible pain. Pain was recorded as almost constantly, sharp, shooting, and stabbing, and analgesic therapy made it better. Resident D was documented as being alert and oriented to person, place, time, and situation. There was no documentation in the EHR to indicate follow up after Resident D expressed being in pain rated 10 out of 10 on 12/31/24 at 8:17 p.m. A progress note in the Electronic Health Record (EHR), dated 12/31/24 at 11:19 p.m., indicated the following, "...resident [Resident D] became very anxious, asking aide to get him out of bed because he felt too confined in room...was on the phone saying he didn't think he was able to stay here d/t [due to] this and being unable to sleep...." The Medication Administration Record (MAR), dated 1/1/25 at 1:10 a.m., indicated Resident D was experiencing pain and received Dilaudid 4 mg. This documentation indicated Resident D was experiencing pain from 8:17 p.m. on 12/31/24, until 1:10 a.m. on 1/1/25, (4 hours and 53 minutes). The MAR, progress notes, and assessments for Resident D, dated 12/31/24 until 1/1/25, did not indicate any documentation of implementation of any non-pharmacological pain interventions. A care plan for Resident D, dated 1/2/25, indicated they were at risk for pain related to recent surgical procedure, functional changes, and neuropathy. Resident would be free from adverse effects of		nurses on the Pain Management and Receipt of Interim/STAT/Emergency Deliveries Policies. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DNS or designee in-serviced facility nurses on Pain Management and Receipt of Interim/STAT/Emergency Deliveries policies. The DNS or designee will review all new admissions the next business day utilizing the IDT Admission Review Tool to ensure all ordered medications received from pharmacy. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete the Pain CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. The CQI committee will determine the need for further review. The results of these audits will be reviewed by the CQI Committee, if a threshold of 100% is not achieved, an action plan will be completed. Deficiency in this practice will result in disciplinary	

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	pain, and administer medications as ordered. Also, to observe for non-physical signs of pain, i.e. vocalizations and mood/behavior changes. During an interview on 1/27/25 at 12:44 p.m., Resident D indicated he did not receive any pain medications for over six hours after arriving at the facility. He had a pain level of 10 out of 10. During an interview with the Regional Director of Clinical Support (RDCS) and DON on 1/27/25 at 2:00 p.m., they indicated Resident D had an admission assessment completed at 8:20 p.m. After he had voiced his pain level, he was offered Tylenol because the facility did not have Dilaudid 4 mg tablets in the Emergency Drug Kit (EDK). Resident D refused the Tylenol, so at 8:30 p.m., a STAT (without delay) order was placed to the pharmacy. The DON indicated it usually takes four hours for emergent deliveries. The DON indicated there was a problem getting the medications timely from the pharmacy. The DON indicated the facility did not have any documentation of when the pharmacy was contacted, nor that Tylenol was offered or refused by Resident D. Resident D's clinical record indicated there were no physician orders for Tylenol inputted until 1/7/25. A Pain Management Policy was provided by the Executive Director (ED) on 1/27/25 at 1:55 p.m. The policy indicated the following,"... It is the policy of [name of corporation] to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, including pain management...Pain medications will be prescribed and given based upon the intensity of the pain...."		action up to and including termination.	

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