STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155104	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Center	1201 W Buena Vista Rd Evansville, IN 47710

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure services provided by the facility met professional standards of quality for 2 of 3 closed records reviewed, and 1 of 4 residents observed for medication administration. Blood pressure medication and an inhaler were not administered as indicated in the physician's orders, and a urinary catheter was not placed as ordered. (Resident L, Resident F, Resident M) Findings include: 1. On 6/5/26 at 2:33 P.M., Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, obstructive and reflux uropathy and hydronephrosis. The current Quarterly Minimum Data Set (MDS) Assessment, dated 5/11/26, indicated Resident M was cognitively intact and had an indwelling catheter. Current physician orders included, but were not limited to:May change foley catheter every 21 day and as needed (prn) due to occlusion one time a day every 21 day(s) for obstructive uropathy foley maintenance, dated 3/26/26. Foley catheter size 16 fr (french)/10cc (cubic centimeters) due to diagnosis of urinary retention related to obstructive uropathy, dated 4/22/26. The current care plan for indwelling catheter due to obstructive uropathy was revised 5/5/26. Interventions included, but were not limited to:Change catheter as per medical doctor (MD) orders. Monitor and document intake and output every shift. The clinical record indicated that the resident was sent to the hospital on 6/3/26 for altered mental status. The hospital record indicated that there was a computed tomography (CT) scan of the pelvis and abdomen completed on 6/3/26 at 5:15 P.M. The results indicated the Foley catheter balloon was insufficiently inflated within either the prostatic or distal membranous urethra and should be removed or repositioned. A nursing progress note, dated 6/3/26 at 2:45 A.M., indicated that a 16 fr 30 cc balloon Foley catheter was placed because there was not a 16 fr 10 cc balloon Foley catheter available. Interview on 6/10/26 at 10:03 A.M., the Director of Nursing (DON) indicated she was not aware that CT results showed that Resident M's Foley catheter balloon was improperly inflated. She indicated that there was no notification to her by the night shift staff that they had to use a different sized catheter balloon. She indicated that MD orders should always be followed and she should have been notified if there was a problem. On 6/10/26 at 3:07 P.M., the Administrator provided a current Foley Catheter Orders policy, revised 5/20/26, that indicated .orders must include the following: size of the foley, amount of fluid to inflate, diagnosis . On 6/10/26 at 3:09 P.M., the Administrator provided a current Charting and Documentation revised 7/2022, that indicated .documentation of procedures and treatments will include care-specific details including: the date and time procedure/treatment was provided, the name and title of the person who provided care, the assessment and/or any unusual findings obtained during the procedure/ treatments, how the resident tolerated the procedure, .notification of family, physician, or other staff if indicated . (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Observation on 6/8/26 at 8:35 A.M., Licensed Practical Nurse (LPN) 4 entered Resident F's room and administered medications. LPN 4 assisted Resident F with taking two puffs of the Breyna inhaler but did not offer Resident F to rinse her mouth following the inhaler administration. On 6/8/26 at 10:30 A.M., Resident F's clinical record was reviewed. Physician orders included, but were not limited to:Breyna Inhalation Aerosol 160-4.5 MCG/ACT (micrograms per puff) administer two puffs every 12 hours rinse mouth after use; Start date 5/20/26 On 6/9/26 at 9:15 A.M., the Breyna (budesonide and formoterol fumarate) aerosol insert was reviewed and indicated warnings and precautions: Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk [of oral infection] . On 6/10/26 at 2:46 P.M., the Administrator provided an undated policy titled Medication Administration that indicated All medications and biologicals will be administered only with physicians orders. 3. On 6/8/26 at 10:58 A.M., Resident L's clinical record was reviewed. Diagnosis included, but was not limited to, hypertension. The most recent quarterly Minimum Data Set (MDS) Assessment, dated 3/19/26, indicated no cognitive impairment and independent with all activities of daily living (ADLs). Physician orders included, but were not limited to: hydralazine 25mg (milligrams) three times a day for hypertension. Hold if systolic blood pressure <110, dated 8/7/25. Resident L's Medication Administration Record (MAR) for April 2026 and May 2026 indicated, but was not limited to, the following administrations of Hydralazine: 4/14/26 at 2:30 P.M. blood pressure 122/74, medication not given due to out of parameters. 4/17/26 at 2:30 P.M. blood pressure blank, medication administration blank. 5/1/26 at 2:30 P.M. blood pressure indicated N/A, medication administered. 5/2/26 at 8:30 A.M. blood pressure 108/68, medication administered. 5/5/26 at 2:30 P.M. blood pressure marked X, medication not given due to out of parameters. Resident L's clinical record lacked a blood pressure reading for 4/17/26 at 2:30 P.M., 5/1/26 at 2:30 P.M., and 5/5/26 at 2:30 P.M. On 6/10/26 at 10:17 P.M., Qualified Medication Aide (QMA) 3 indicated when a medication was not given, the reason code would be entered into the MAR. She indicated a checkmark was entered when given. On 6/10/26 at 12:30 P.M., the Director of Nursing (DON) indicated she could not find a reason for the administration of hydralazine or lack of administration in Resident L's clinical record. On 6/10/26 at 2:41 P.M., a current non-dated Licensed Nurse job description was provided that indicated Administers medication and performs treatments as ordered by the physician . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Intake 2990683 and Intake 3036667. 410 Indiana Administrative Code (IAC) 16.2-3.1-35(g)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were followed for 1 of 3 residents reviewed for urinary catheters and 1 of 1 residents reviewed for wounds. (Resident N and Resident R). Foley catheter tubing was observed on the ground and gloves were not changed between touching soiled surfaces and clean surfaces. Findings include: 1. On 6/4/26 at 11:59 A.M., Resident N was observed sitting in his wheelchair outside in the courtyard. A Foley catheter bag and tubing were hanging under the wheelchair. The tubing was observed touching the ground. At 12:14 P.M., Resident N wheeled himself inside. The catheter tubing dragged the ground into the building and continued to touch the floor once inside the facility. On 6/5/26 at 2:08 P.M., Resident N's clinical record was reviewed. Diagnoses included, but were not limited to, postpolio syndrome, benign prostatic hyperplasia (BPH), and paraplegia. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 3/19/26, indicated Resident N was cognitively intact, was dependent on staff (staff does all the effort) for transfers, had an indwelling catheter, and did not have a urinary tract infection (UTI). A care conference was completed on 2/11/26 where care plans were reviewed. Current care plans included, but were not limited to:I have diagnosis of BPH and require a Foley Catheter, dated 6/6/23 Current physician orders included, but were not limited to:Foley catheter 16 french (fr)/10 cubic centimeters (cc) due to diagnosis of urinary retention related to obstructive uropathy, dated 2/8/26 Interview on 6/10/26 at 12:48 P.M., the Infection Preventionist (IP) indicated catheter tubing should not be resting on or dragging the floor, and that it should be elevated off the floor or other surfaces. On 6/10/26 at 2:08 P.M., the Administrator provided a current Foley Catheter Orders policy, revised 5/20/26, that indicated Prevent infection by ensuring bag is below bladder level and that drainage bag and tubing are always off the floor. 2. On 6/8/26 at 10:24 A.M., Resident R's clinical record was reviewed. Diagnoses included, but were not limited to, tracheostomy and quadriplegia. The current 5-day Minimum Data Set (MDS) Assessment, dated 4/29/26, indicated Resident R was cognitively intact and had wounds, a tracheostomy, and gastrostomy tubes. Current physician orders included, but were not limited to:Right Heel treatment: wash with soap and water, pat dry, apply betadine-soaked gauze to wound and cover with bordered gauze dressing every day shift for pressure, dated 6/4/26. Left Heel treatment: clean with soap and water apply betadine wound, cover with bordered gauze dressing every day shift, dated 5/21/26.Observation on 6/9/26 at 10:14 A.M., the Wound Nurse donned gloves and removed the dressing on Resident R's left foot. She picked up the iPad and placed it next to the resident's foot. The Wound Nurse removed the soiled gloves, sanitized her hands, and donned new gloves. She cleaned the wound, and without changing gloves, took a picture of the wound with the iPad. The Wound Nurse removed the soiled gloves, sanitized her hands, and applied a new (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing to the resident's left foot. Without changing gloves, the Wound Nurse picked up her cell phone to use the inbuilt flashlight to observe the wound on the right leg and touched the iPad to take pictures of the wound on the resident's right leg. She removed the soiled gloves, sanitized her hands, donned new gloves, and cleaned and dressed the resident's right leg. The Wound Nurse removed the soiled gloves and sanitized her hands. She proceeded to preview pictures on the iPad with clean hands without cleaning the iPad. Interview on 6/10/26 at 12:48 P.M., the Infection Prevention Nurse (IP) indicated staff should not be using the same gloves to touch a wound or wound dressing and then touch phone, tablet, or computer. The staff should change gloves in between soiled and clean tasks. On 6/10/26 at 3:05 P.M., the Administrator provided a current Cleaning Equipment policy, revised 10/2020, that indicated .each piece of equipment coming in direct contact with the resident is disinfected with an approved disinfectant . This citation relates to Intake IN3036667. 410 Indiana Administrative Code (IAC) 16.2-3.1-18(b)(1)410 IAC 16.2-3.1-18(l)