

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  Heritage House Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 281 S County Road 200 East Connersville, IN 47331	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>25054</p> <p>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).</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>During an observation on 1/24/25 at 11:23 a.m., Resident K was in therapy with two other residents. Resident K did not have a bra on, and her hair was not brushed.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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 grooming.</p> <p>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.</p> <p>30344</p> <p>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.</p> <p>The 12/24/24 Quarterly MDS assessment indicated she was dependent on staff for putting on and taking off footwear.</p> <p>The physician's orders indicated heel guards to bilateral feet at all times, starting 5/11/24.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.) .</p> <p>45291</p> <p>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.</p> <p>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.</p> <p>A care plan, last revised 5/30/2024, indicated to assist Resident Q with eating as needed.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This citation relates to Complaints IN00450713 and IN00451373.</p> <p>3.1-38(a)(2)(A)</p> <p>3.1-38(a)(2)(D)</p> <p>3.1-38(a)(3)(A)</p> <p>3.1-39(a)(3)(B)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>50436</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>The admission physician order for Resident D, dated 12/31/24, indicated the resident was ordered Dilaudid 4 mg every four hours as needed.</p> <p>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 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.</p> <p>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.</p> <p>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</p> <p>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).</p> <p>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.</p> <p>(continued on next page)</p>		

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