STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House Rehabilitation & Health Care Center	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)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Bases on interview and record review, the facility failed to honor resident's choice of schedules related to morning showers for 1 of 6 residents reviewed for Self Determination. (Resident 62)Findings include:The clinical record for Resident 62 was reviewed on 01/22/2026 on 10:10 AM. The resident's diagnoses included, but were not limited to, Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroyed memory, thinking skills, and eventually the ability to carry out simple tasks) and depression. A Quarterly Minimum Data Set Assessment, dated 11/18/2025, indicated Resident 62 was not cognitively intact and needed substantial to maximal assistance with personal hygiene. An activities of daily living care plan, date 11/01/2018 and reviewed on 1/22/2026, indicated for Resident 62 was to be offered showers twice per week with partial baths in between. A preference assessment, dated 11/19/2025, indicated it was very important for Resident 62 to have bathing preferences met. Resident 62 preferred to have a shower twice a week in the mornings. During an interview and observation, on 1/20/2026 at 1:36 PM, with Family Member 2 and Resident 62, the family member indicated he did not believe the resident received her showers in the mornings like she should have based on her preferences. Review of shower sheets, dated 11/22/2025 through 1/17/2026, indicated Resident 62 received 11 showers in the evening and 7 without a timeframe assigned to indicated what time of day. A policy entitled, Preferences for Daily Routine, was provided by the Executive Director on 1/23/2026 at 7:21 PM. The policy indicated, .The information from the worksheet will be shared with the interdisciplinary team so that each department can address the resident's preferences .3.1-3(u)(1)

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess a resident's oral status for 1 of 2 residents reviewed for dental status and services. (Resident 66)Findings include:The clinical record for Resident 66 was reviewed on 1/20/26 at 1:20 p.m. The resident's diagnosis included, but was not limited to, dysphagia (difficulty or discomfort in swallowing).The Annual MDS (Minimum Data Set) assessment, dated 1/6/26, indicated the resident was cognitively intact. The resident had no dental conditions, including no obvious or likely cavity or broken natural teeth. An interview was conducted with Resident 66 on 1/20/26 at 1:23 p.m. The resident indicated she needed to see the dentist, because she had a bunch of bad, broken teeth. An observation and interview were conducted with Resident 66 on 1/22/26 at 12:51 p.m. The resident pointed to an upper tooth in the front of her mouth and indicated it was broken. She indicated the tooth did not hurt, but it was uncomfortable when she ran her tongue across it. Her tooth had been broken a good while. The tooth had became loose and fell into her mouth while she was eating two to three weeks ago. Some of the staff knew she lost the tooth. An interview with the Minimum Data Set Coordinator (MDSC) was conducted on 1/22/26 at 12:56 p.m. The MDSC indicated she completed the dental section of the Annual MDS assessment. Her process for completing the dental section of the MDS assessment was to have Resident 66 show her her oral cavity. An observation of Resident 66's oral cavity was made with the MDSC on 1/22/26 at 12:56 p.m. Resident 66 opened her mouth and indicated one of her top teeth was broken. The MDSC indicated this was what her mouth looked like, when she assessed it for the Annual MDS assessment dated [DATE]. The MDSC indicated she could modify the assessment to capture the broken tooth.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents' assistance with bathing related to Activities of Daily Living for 2 of 4 residents reviewed for ADL for Dependent Residents. (Resident 4 and Resident 10)Findings include:1. During an observation and interview with Resident 4 on 1/21/26 at 10:30 a.m., the resident indicated they could not remember the last time they received a shower or when their hair was washed last. During an observation the resident's hair appear shinny and oily. The clinical record for Resident 4 was reviewed on 1/21/2026 2:35 p.m. The resident's diagnosis included, but was not limited to, muscle weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 12/4/25, indicated Resident 4's cognition was intact. The resident had bilateral impairment to both lower extremities. The resident used a walker/wheelchair for ambulation. A Preferences for Customary Routine and Activities document, dated 11/25/25, indicated Resident 4 chose to bathe at least twice per week in the a.m. and was preferred a shower. A plan of care, dated 3/5/25, indicated Resident 4 required assistance with all Activities of Daily Living (ADLs) related to not being able to care for self at home. The interventions included, but were not limited to, assist with bathing as needed per resident preference, offer showers two times per week, and assist with grooming/hygiene as needed. The shower sheets for Resident 4 were reviewed on 1/23/26 at 10:45 a.m. The resident received a shower on 1/9/26, and 1/21/26. Review of the Electronic Health Record (EHR) indicated Resident 4 received only partial bed baths, no showers for the dates of 1/10/26, 1/11/26, 1/13/26, 1/15/26, 1/17/26, 1/18/26, and 1/19/26. The shower sheets and EHR both indicated Resident 4 did had not received a shower or complete bed bath from 1/10/26 through 1/20/26. No refusals were documented for showers on the shower sheets or EHR. 2. The clinical record for Resident 10 was reviewed on 1/21/2026 1:40 p.m. The resident's diagnoses included, but were not limited to, rhabdomyolysis (rapid breakdown of damaged skeletal muscle, releasing harmful proteins and electrolytes in the blood) and acute respiratory failure. The admission Minimum Data (MDS) assessment, dated 1/11/26, indicated Resident 10 was cognitively intact, had no behaviors exhibited of refusals of care, and required substantial/maximal staff assistance with shower/bathing. During an observation and interview with Resident 10 on 1/20/26 at 2:11 p.m., the resident indicated they went three days with the same t-shirt on over the weekend and had only been to the shower room for a shower one time since admission on [DATE]. Resident 10 indicated someone had come into his room the day before and indicated someone would be in today, 1/20/26, to help him get cleaned up. The resident indicated no one had been in yet to offer to help him clean up and shower. The resident indicated he preferred showers. Resident 10 was observed with greasy, disheveled hair. A progress note, dated 1/21/26, indicated the resident preferred to shower on 1/22/26. During an interview with Resident 10 on 1/21/26 at 1:57 p.m., the resident indicated staff had washed them briefly. The staff washed his genital area (privates/crotch area), but he was not provided a washcloth to wash his face and did not go to the shower room as he had preferred. The EHR for Resident 10 indicated the resident only received one shower on 1/10/26. A complete bed bath was given on 1/14/26. No showers were documented as offered or refused from 1/14/26 through 1/20/26. A Preferences for Customary Routine and Activities document, dated 1/7/26, indicated Resident 10 preferred to shower twice per week in the a.m. During an interview, on 1/23/2026 at 2:06 p.m., the Executive Director indicated that it was the expectation of the facility to offer two showers (or bathing as preference) unless a resident's preference stated otherwise. The Shower Policy was provided by the Executive Director on 1/22/26 at 12:10 p.m. It indicated .4. Transport resident to shower room.11. Help resident shampoo and rinse hair.12. Assist with washing and rinsing entire body.12. Document procedure. 3.1-38(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview, observation, and record review, the facility failed to identify a skin alteration (Resident 24), and failed to check placement of a resident's ear protectors for comfort/prevent skin breakdown (Resident 6) for 2 of 2 residents reviewed for quality of care. Findings include: 1. The clinical record for Resident 24 was reviewed on 01/23/2026 on 11:57 AM. The resident's diagnosis included, but was not limited to, dementia (a decline in mental abilities). A Quarterly Minimum Data Set Assessment, dated 12/18/2025, indicated Resident 24 was cognitively intact and needed sub to max assistance for personal hygiene. Review of Resident 24's shower records indicated on the following dates the resident received partial bed baths on 1/18/2026, in the evening; on 1/19/2026 in the morning and evening; and on 1/20/2026 in the morning. During an interview and observation, on 1/20/2026 at 12:05 PM, Resident 24 indicated a week or so ago she had went out of the facility with a family member. While she was out, she had a cigarette and sustained a burn to her middle and index fingers. Resident 24 then showed two areas of redness with a thick scab in the middle on the inside of each finger. During an interview, on 1/20/2026 at 1:30 PM, Executive Director confirmed she was unaware of the area to Resident 24's left hand. A nursing progress note, dated 1/20/2026, indicated Noted scabs to left 1st and 2nd finger. Resident reports it is from cigarette burn while out with family member. The resident's clinical record lacked documentation related to the resident's left 1st and 2nd finger prior to 1/20/26. A policy entitled, Bed Bath, was provided by the Executive Director on 1/23/2026 at 7:31 PM. the policy indicated .Wash, rinse, and pat dry shoulder, underarm, arm, hand, and fingers . and to .Report any unusual findings to charge nurse . 2. The clinical record for Resident 6 was reviewed on 1/20/26 at 1:00 p.m. The resident's diagnoses included, but were not limited to, chronic respiratory failure and chronic obstructive pulmonary disease (a progressive lung condition characterized by long-term airflow obstruction, making it hard to breath). The current at risk for skin breakdown care plan, starting on 8/29/17 and last revised 1/22/26, indicated an approach was preventive treatment as ordered. The physician's order indicated staff were to administer oxygen at three liters per nasal cannula twice a day, starting 10/12/25, and ear protectors (cushioned ear protectors designed specifically for oxygen tubing to protect the skin during oxygen therapy) were to be placed on the oxygen tubing with special instructions to check placement every shift, starting 10/12/25. An observation and interview was conducted with Resident 6 on 1/20/26 at 1:12 p.m. The resident was receiving oxygen per nasal cannula, but the oxygen tubing lacked ear protectors. The resident (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated her ears felt better when she was wearing the ear protectors. An observation and interview were conducted with Resident 6 on 1/22/26 at 2:23 p.m. The resident was lying in bed receiving oxygen per nasal cannula, the oxygen tubing lacked ear protectors. Resident 6 indicated she wanted some ear protectors, because it was more comfortable for her to wear them. The January, 2026 treatment administration record (TAR) was reviewed on 1/22/26 at 2:23 p.m. The TAR indicated Registered Nurse (RN) 3 had already signed off on checking the placement of Resident 6's ear protectors on 1/22/26 for the first shift, 7:00 a.m. to 7:00 p.m. An interview was conducted with RN 3 on 1/22/26 at 2:24 p.m. She indicated Resident 6 fiddled with her oxygen tubing sometimes and the ear protectors would come off. She did not verify the placement of Resident 6's ear protectors when she signed off on the TAR today. An observation of Resident 6 was made on 1/22/26 at 2:28 p.m., after RN 3 retrieved the ear protectors from the medication supply room. RN 3 applied the ear protectors to Resident 6's oxygen tubing. Resident 6 was receptive to having them applied. The Skin Management Program policy was provided by the ED (Executive Director) on 1/22/26 at 12:10 p.m. It indicated, It is the policy of [name of facility] to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable.PROCEDURE FOR ALTERATIONS IN SKIN INTEGRITY – PRESSURE AND NON-PRESSURE 1. Alterations in skin integrity will be reported to the MD/NP [Nurse Practitioner,] the resident and/or resident representative as well as to the direct care staff. 2. Treatment order will be obtained from MD/NP.4. All newly identified areas after admission will be documented on the New Skin Event.6. A plan of care will be initiated to include resident specific risk factors and contributing factors with appropriate interventions implemented. 3.1-37(a)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to timely address a resident's missing bottom denture, as care planned, for 1 of 2 residents reviewed for dental status and services. (Resident 6) Findings include: The clinical record for Resident 6 was reviewed on 1/20/26 at 1:00 p.m. The resident's diagnosis included, but was not limited to, edentulous (having no teeth). An observation and interview was conducted with Resident 6 on 1/20/26 at 1:10 p.m. The resident was wearing an upper denture, but no bottom denture was present. The resident indicated she did not have bottom dentures, but she would like some. She hadn't seen a dentist. The current care plan, dated 8/16/24 last reviewed 11/11/25, indicated the problem was that Resident 6 reported throwing away her bottom denture, because the denture did not fit. An approach was for staff to monitor her eating and to get her set up with dental care, starting 8/16/24. The resident's clinical record lacked a dental consultation scheduled after the care plan intervention on 8/16/24. An interview was conducted with the Social Services Director (SSD) on 1/22/26 at 2:40 p.m. The SSD indicated she was responsible for setting up dental appointments for the residents. She reviewed Resident 6's clinical record and indicated she was only enrolled in podiatry services. She did not see any dental notes or a dental consent on file for Resident 6. She was unsure of how things were handled prior to April, 2025, when she began working at the facility. The facility was unable to provide any verification dental care was provided related to addressing Resident 6's missing bottom dentures. The Dental Services/Missing Dentures policy was provided by the ED (Executive Director) on 1/23/26 at 9:05 a.m. It indicated, The facility will assist with providing services to replace lost or damaged dentures regardless of responsibility. The facility will assist in scheduling and transporting residents to dental appointments as needed. 3.1-24(a)(3)3.1-24(b)