

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER Heritage Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Soldiers Home Rd West Lafayette, IN 47906	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>Based on observation, interview, and record review, the facility failed to ensure narcotic medications were free from theft of an employee for 1 of 3 residents reviewed for misappropriation of property. (Resident B) The deficient practice was corrected on 2/10/2026, prior to the start of the survey, and was therefore past noncompliance. Findings include: During an interview, on 2/26/26 at 1:10 p.m., the Director of Nursing (DON) indicated, on the morning of 2/3/26, RN 2 informed her Resident B was missing a narcotic medication. RN 2 had completed a narcotic count with RN 3, on 2/2/26 at 10:00 p.m., and Resident B had two (2) narcotic cards for oxycodone (a medication used for pain). The next morning at 6:00 a.m., RN 2 returned to the facility for another shift and realized Resident B no longer had two (2) medication cards. RN 3 had indicated to RN 2 that Resident B had been given pain medication during the night, but RN 3 was not aware of a missing narcotic card. RN 3 then left the facility. The DON then reviewed the medication card with RN 2 and found the medication card and the documentation sheet for the narcotic medication was missing. The top of the narcotic card was found in the medication disposal box, but no medications were found. The narcotic log sheet was not found. The pharmacy was notified and had indicated Resident B was missing a card of narcotic medications with five (5) pills. During an interview, on 2/18/26 at 12:08 p.m., Resident B indicated he was not aware of the missing medications and did not remember receiving a pain pill on 2/3/26 at 2:00 a.m. The clinical record for Resident B was reviewed on 2/16/26 at 4:10 p.m. The diagnoses included, but were not limited to, diabetes mellitus, fracture of the lower end of the left femur, chronic kidney disease, and non-traumatic subarachnoid hemorrhage. A physician's order, dated 1/27/26, indicated to administer oxycodone hydrochloride (HCL) immediate release (IR) 5 milligrams (mg) as needed every 6 hours for pain. During an interview, on 2/16/26 at 2:32 p.m., RN 2 indicated she completed a narcotic count, on 2/2/26 at 10:00 p.m., with RN 3. There were two (2) narcotic cards and log sheets for Resident B during the count. When she came back to work, on 2/3/26 at 6:00 a.m., she completed the narcotic count again with RN 3. She discovered a narcotic card and log sheet for Resident B was missing. RN 3 had indicated Resident B had required pain medication throughout the night and then left the facility without signing to indicate the narcotic count was completed and accurate. RN 2 immediately notified the DON, and the DON completed a recount with her. Resident B was missing a narcotic medication card and log sheet. During an interview, on 2/26/26 at 1:10 p.m., the Director of Nursing (DON) indicated after it was discovered a narcotic medication was missing, all medication carts in the facility were checked and no additional discrepancies were found. RN 2 and 3 were suspended pending the investigation. RN 2 was cleared and returned to work. RN 3 denied taking the medication and quit after being questioned. The facility then terminated RN 3. All staff were educated on the policies for abuse and routine reconciliation of controlled substances on 2/3/26. The facility audits of the medication carts are ongoing. A pharmacy review was scheduled for 2/18/26. The missing medications for Resident B were replaced by the facility. A current facility policy, titled Abuse- Identification of Types, dated as</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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last reviewed 5/6/25 and provided by the Executive Director on 2/16/26 at 4:00 p.m., indicated .Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent This deficient practice was corrected by 2/10/26 after the facility implemented a systemic plan that included the following actions: all narcotic sheets were audited, residents were interviewed, RN 3 was terminated and deemed ineligible for rehire, all nurses were re-educated on abuse and the management of controlled substances, and the pharmacy was scheduled to completed a house wide audit of narcotic medications.This citation relates to Intake 2734631.3.1-28(a)		