STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Healthcare	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food items were labeled with the date received, the reach-in refrigerator was maintained at a safe temperature, and temperature logs were up to date. This deficient practice had the potential to affect 68 of 69 residents who received food from the kitchen.Findings include:1. During the initial kitchen tour with [NAME] 2, on 7/30/25 at 10:21 a.m., the following pre-packaged food items were found to be not labeled with the date received:a. six (6) packages of gravy mixb. three (3) containers of cream of wheatc. eight (8) bags of brown sugard. four (4) packages of brownie mixe. one can of sauerkrautf. one can of peasg. one can of marinara sauceh. one can of cheddar cheese sauce During an interview, on 7/30/25 at 10:43 a.m., [NAME] 2 indicated he dated items with the date received when he put away new food items and then labeled them with the date opened when the item was opened.During an interview, on 7/31/25 at 9:58 a.m., the Dietary Manager indicated the pre-packaged food items should have been labeled with the date received at the time they were taken out of the shipping box and placed on the shelves.2. During the initial kitchen tour with [NAME] 2, on 7/30/25 at 10:25 a.m., the reach-in refrigerator had a temperature of 60 degrees Fahrenheit.During a follow-up visit to the kitchen, on 7/30/25 at 12:30 p.m., the reach-in refrigerator had a temperature of 60 degrees Fahrenheit.During an interview, on 7/30/25 at 12:30 p.m., [NAME] 2 indicated the refrigerator temperature should not be 60 degrees Fahrenheit, and he called for maintenance.During an interview, on 7/31/25 at 9:30 a.m., the Dietary Manager indicated the refrigerator should not have been 60 degrees Fahrenheit the previous day. He was unsure of the length of time the refrigerator had been at an elevated temperature, but the temperature logs indicated it had been less than 12 hours.3. The temperature logs for the reach-in refrigerator did not have entries for the day shift on the following dates: 7/2, 7/3, 7/4, 7/5, 7/6, 7/8, 7/9, 7/10, 7/11, 7/12, 7/14, 7/15, 7/16, 7/17, 7/18, 7/19, 7/22, 7/23, 7/24, 7/25, 7/26, 7/29 and 7/30/25.The temperature logs for the reach-in refrigerator did not have entries for the evening shift on the following dates: 7/3 and 7/20/25.During an interview, on 7/31/25 at 9:30 a.m., the Dietary Manager indicated the temperature logs should have been completed twice a day on each shift.The refrigerator/freezer temperature log, labeled 3-door Reach-in and dated July 2025, indicated .the refrigerator temperature should be at or below 41 F. If the temperatures are not within these ranges, notify the Director of Food and Nutrition Services or Maintenance immediately.A current facility policy, titled Food Safety, dated 5/1/25 and received from the Executive Director on 8/1/25 at 9:23 a.m., indicated .Pre-packaged food.container is labeled with the name of the contents and date.Food is labeled with the date received.Ambient temperatures in refrigerators/coolers are to remain at or below 41 F to significantly slow growth of microorganisms.Temperatures are recorded at least twice daily on the Refrigerator/Freezer Temperature Log.any problems will be reported immediately to the Director of Food and Nutrition Services/Maintenance.3.1-21(i)(3)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Healthcare	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)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure pureed foods were prepared according to the recipe to ensure the nutritive value, flavor, and appearance were conserved for 5 of 5 residents reviewed for a pureed diet.Findings include:During an observation, on 7/30/25 at 10:48 a.m., [NAME] 2 was observed to add 5 cooked and seasoned hamburger patties to a food processor. He added an unmeasured amount of water, turned on the processor, and mixed until a pudding consistency was obtained. He did not refer to a recipe during the observation.During an interview, on 7/30/25 at 10:48 a.m., [NAME] 2 indicated he was unsure if there was a recipe for purees. He did not know where it was and thought it may have been in with the regular recipes. He usually thinned things with broth or water. He indicated he had already prepared the peas by adding 5 servings of peas to the blender and used milk to thin the peas to get the desired consistency.During an interview, on 7/31/25 at 9:30 a.m., the Dietary Manager indicated the puree recipes were stored in the regular recipe book and the recipes should have been followed.The recipe, titled PU Beef Patty 2 oz SPD, labeled recipe #364, indicated:1. Prepare according to regular recipe.2. Place food in processor, process until smooth.3. Reheat to a minimum temperature of 165F for 15 seconds. Hold at minimum required temperature or higher for service. Follow hot-holding temperature of 135F or 140F based on facility policy. The recipe, titled [NAME] Peas Fzn, labeled recipe #488, indicated:1. Prepare according to regular recipe.2. Drain green peas and place the peas in food processor.3. Process until smooth and product reaches an applesauce consistency.4. Reheat to a minimum temperature of 165F or higher for 15 seconds. Hold at minimum required temperature or higher for service. Follow hot-holding temperature of 135F or 140F based on facility policy. A current facility policy, titled Food Preparation, dated as revised 4/29/25 and provided by the Executive Director on 8/1/25 at 9:23 a.m., indicated .Recipes are provided by the Director of Food and Nutrition Services and followed by the food service associates.3.1-20(i)(4)3.1-21(a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Healthcare	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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the facility and resident rooms were maintained for 8 of 33 rooms reviewed for environment. (room [ROOM NUMBER], 16, 23, 18, 21, 32, 36, 103).Findings include: During an observation, on 7/30/25 beginning at 12:21 p.m., the following were observed.1. In room [ROOM NUMBER], the wall under the window had a large area with no paint. 2. In room [ROOM NUMBER], the wall had paint peeled off under the window and on the right side by the bathroom door.3. In room [ROOM NUMBER], the wall had black scuff marks and missing paint on the lower portion of the wall.4. In room [ROOM NUMBER], the bottom of the door had black scuff marks.5. In room [ROOM NUMBER], the lower part of the door had scuff marks and chipped paint on the door trim.6. The eye washing station door trim had peeling paint.7. The soiled utility room door trim had peeling paint.8. In room [ROOM NUMBER], the door had chipped paint and scuff marks on the trim.9. In room [ROOM NUMBER], the door had chipped paint on the trim. 10. In room [ROOM NUMBER], there were several small holes on the wall above the dresser. During an environmental tour, on 8/5/25 at 2:09 p.m., the Executive Director (ED) indicated there was peeling paint, holes, and scuff marks on the walls. During an interview, on 8/4/25 at 11:45 a.m., the Certified Nursing Assistant (CNA) 2 indicated the walls in room [ROOM NUMBER] had been messed up for over a year. During an interview, on 8/4/25 at 12:31 p.m., the resident in room [ROOM NUMBER] indicated someone had just patched some holes. A current facility policy, titled Plant Operations - General Policy, dated as last reviewed on 5/15/25 and received from the ED on 8/5/25 at 2:43 p.m., indicated .A safe, clean, and structurally sound environment shall be achieved in the facility through the development and implementation of the Plant Operation Program, the development and training of personnel, and the evaluation of goals in the department of assure correlation with the goals of the facility 3.1-19(f)(5)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Healthcare	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the resident and resident's representative received notification in writing of the facility's bed hold policy and the reason for the resident's transfer and discharge to the hospital for 1 of 2 residents reviewed for hospitalization. (Resident 3) Findings include:The clinical record for Resident 3 was reviewed on 8/1/25 at 11:45 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, chronic kidney disease, diabetes mellitus, cerebral infarction, cognitive communication deficit and gastrostomy. A nursing progress note, dated 7/28/25 at 10:20 a.m., indicated the hospital called and informed the facility Resident 3 was admitted to the Intensive Care Unit with aspiration pneumonia.There was no documentation in the electronic medical record to indicate the resident and resident's representative was provided information in writing regarding the reason for the resident's transfer to the hospital and the facility's bed hold policy. During an interview, on 8/1/25 at 2:27 p.m., the Executive Director (ED) indicated the bed hold policy, and the transfer and discharge summary were provided to the Emergency Medical Team and not the resident or the resident's representative. A current facility policy, titled Transfer and Discharges, dated as last updated 4/22/25 and received from the ED on 8/1/25 at 2:39 p.m., indicated .The facility will follow the limited conditions under which CMS has outlined how the facility may initiate transfer or discharge of the resident, the documentation that must be included in the medical record, and who is responsible for making the documentation. The facility will also provide transfer/discharge notice to the resident/responsible party in accordance with federal regulations A current facility policy, titled Bed-Hold Policy, dated as last updated 4/22/25 and received from the ED on 8/1/25 at 2:39 p.m., indicated .The Bed-hold policy should be given upon admission, upon transfer of a resident to the hospital (if in an emergency within 24 hours), or the resident goes on therapeutic leave of absence. The facility will provide written information to the resident or resident representative the nursing facility policy on bed-hold periods and the residents return to the facility to ensure that residents are made aware of the facility's bed-hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility .Before a nursing facility transfers a resident to a hospital .the nursing facility must provide written information to the resident or resident representative 3.1-12(a)(6)(A)(i)3.1-12(a)(6)(A)(ii)3.1-12(a)(6)(A)(iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Healthcare	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level I was completed on or prior to admission for 1 of 3 residents reviewed for PASARR. (Resident 10)Findings include:The clinical record for Resident 10 was reviewed on 8/1/25 at 2:56 p.m. The diagnoses included, but were not limited to, mild intellectual disabilities, dementia, depression, post-traumatic stress disorder (PTSD), anxiety, and bipolar disorder. Resident 10 was admitted to the facility on [DATE].A physician's order, dated 1/15/25, indicated to administer duloxetine (an antidepressant medication) 30 milligrams (mg) once a day. An initial PASARR Level I was not completed until 6/26/25.During an interview, on 8/5/25 at 11:30 a.m., the Executive Director (ED) indicated the PASARR was not completed in the correct time frame. A current facility policy, titled Pre-admission Screening and Resident Review (PASARR), dated 10/2022 and received by the ED on 8/5/25 at 1:03 p.m., indicated .the facility will ensure that potential admissions are to be screened for possible serious mental disorders .the initial pre-screening is referred to as PASARR Level 1, and is completed prior to admission to a nursing facility 3.1-16(d)(1)(A)3.1-16(d)(1)(B)3.1-16(d)(2)(A)3.1-16(d)(2)(B)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Healthcare	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)
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 and record review, the facility failed to ensure physician's orders were followed related to medications hold parameters for 1 of 5 residents reviewed for quality of care. (Resident 5)Findings include:The clinical record for Resident 5 was reviewed on 8/1/25 at 9:52 a.m. The diagnoses included, but were not limited to, atrial fibrillation, atherosclerotic heart disease, presence of a coronary angioplasty implant and graft, and occlusion and stenosis of the carotid artery.A care plan, dated 6/6/19, indicated Resident 5 had altered cardiovascular status related to coronary artery disease, atrial fibrillation, hypertension, and a history of myocardial infarction. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 4/15/25, indicated to administer carvedilol (a medication used to treat high blood pressure and heart failure) 6.25 milligram (mg) by mouth twice a day and to hold the medication for a systolic blood pressure less than 100 or a heart rate less than 60.A physician's order, dated 5/23/25, indicated to administer diltiazem extended release (a medication used to treat high blood pressure and chest pain) 180 mg by mouth twice a day and to hold the medication for a systolic blood pressure less than 100 or a heart rate less than 60.A Medication Administration Record (MAR), dated 5/1/25 through 5/31/25, indicated the following:a. Diltiazem was administered on the evening of 5/23/25 with a heart rate of 58.b. Carvedilol was administered on the morning of 5/23/25 with a heart rate of 59. A MAR, dated 6/1/25 through 6/30/25, indicated the following:a. Diltiazem was administered on the evening of 6/10/25 with a heart rate of 59, on 6/19/25 with a heart rate of 43, and on 6/29/25 with a heart rate of 56.b. Carvedilol was administered on the evening of 6/9/25 with a heart rate of 58, on 6/10/25 with a heart rate of 43, on 6/19/25 with a heart rate of 43, and on 6/29/25 with a heart rate of 59.During an interview, on 8/4/25 at 3:21 p.m., Registered Nurse 2 indicated medications should not have been given outside of physician's ordered parameters. If a resident's blood pressure was outside of the parameter, she would hold the medication and notify the physician.During an interview, on 8/4/25 at 3:30 p.m., the Director of Nursing indicated Resident 5's carvedilol and diltiazem should not have been administered outside of the physician's ordered parameters.A current facility policy, titled Administration of Medications, dated as reviewed on 9/16/24 and received from the Executive Director on 8/5/25 at 9:28 a.m., indicated .Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration.Right Assessment. Note the resident's history and any parameters around drug administration.3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Healthcare	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, the facility failed to ensure smoking evaluations were completed quarterly to evaluate the resident's capabilities and deficits for 1 of 6 residents reviewed for accident hazards. (Resident 23) Findings include:The clinical record for Resident 23 was reviewed on 8/1/25 at 2:05 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, atrial fibrillation, anxiety disorder, major depressive disorder, right above the knee amputation, hypertension, and vascular dementia.A care plan, dated 4/13/23, indicated the resident was non-compliant with the smoking policy, smoked in his room and/or pocketed his cigarette butts. Interventions included, but were not limited to, instruct Resident 23 of the smoking risks and the facility policy on smoking and to make certain cigarette butts were disposed of properly in cigarette butt receptacle.The electronic medical record did not contain smoking safety evaluations for 2024. The last documented smoking evaluation was 1/2023.A quarterly smoking safety evaluation was completed on 8/1/25 after the start of the survey. The evaluation indicated Resident 23 had not demonstrated the ability to safely smoke without supervision and had exhibited poor safety awareness when smoking. During an interview, on 8/5/25 at 2:15 p.m., the Executive Director (ED) indicated the facility had not noticed the smoking safety evaluations were not completed quarterly and they should have been. The last smoking evaluation was completed on 1/2023. A current facility policy, titled Smoking Facility, last updated 5/27/25 and received from the ED on 8/1/25 at 2:43 p.m., indicated .The facility will provide a safe environment for residents who smoke tobacco products .The facility will provide supervision to all residents who smoke tobacco products, as determined by their smoking assessment and identified in their care plan interventions .Smoking emergency drills will be conducted annually and as indicated thereafter .All residents who smoke will have a smoking assessment completed with appropriate care plan interventions documented .Residents who currently smoke will have a smoking assessment completed upon admission, readmission, with significant change, and quarterly by a licensed nurse 3.1-45(a)(1)3.1-45(a)(2)