

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155692	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026
NAME OF PROVIDER OR SUPPLIER Heritage Pointe of Huntington		STREET ADDRESS, CITY, STATE, ZIP CODE 1180 West 500 North Huntington, IN 46750	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect a resident's right to be free from mental abuse by a staff member when the staff member recorded a cognitively impaired resident with her personal cell phone while the resident was using the restroom and the staff member viewed the recording with others. (Resident B and CNA 3) Using the reasonable person concept, it can be determined Resident B would not expect to be video recorded while using the restroom in his home (the facility) and would experience psychosocial harm, dehumanization, and humiliation as a result of this mental abuse. Findings include:Review of a cell phone video recording, provided by the DON on 3/9/26 at 9:46 a.m., indicated the following:CNA 3 recorded a 14-second-long video. The video showed Resident B's uncovered upper left thigh while he was sitting on a toilet seat riser in the restroom. Resident B's face was not shown in the video. Resident B gripped CNA 3's left wrist with his left hand. CNA 3 proceeded to state Ow, ow, ow, ow. [NAME], let go of me. Stop. CNA 5 proceeded to remove Resident B's hand from CNA 3's wrist. Once CNA 3's wrist was freed, Resident B's left bare calf was shown before the video recording was stopped. CNA 3 and 5's faces were not shown in the video.During the video observation, the DON indicated CNA 4 notified her regarding the video recording. CNA 3 had shown CNA 4 and CNA 6 the video recording.During an interview, on 3/9/26 at 12:23 p.m., CNA 3 indicated she recorded a video of Resident B (in February 2026). Resident B kept trying to hit her. The resident was throwing a soiled brief at her and the resident just kept yelling at her. CNA 3 stated she took the video to have proof of what Resident B was doing to her. CNA 3 showed both CNA 4 and CNA 6 the video recording.During an interview, on 3/9/26 at 2:27 p.m., CNA 4 indicated CNA 3 showed both her and CNA 6 a video she took of Resident B during an incident (last month), while the resident was using the restroom. The video showed Resident B grabbing CNA 3's wrist. She did not know if the video was shown to anyone else.During an interview, on 3/10/26 at 9:50 a.m., Resident B's Representative 7 indicated Resident B would be very upset that someone recorded him in the bathroom.Review of staff statements, provided by the facility on 3/10/26 at 10:00 a.m., indicated the following:A written statement indicated that the DON received a text message at 2:25 p.m. CNA 4 informed her that CNA 3 had shown CNA 4 a video CNA 3 had taken of Resident B. CNA 4 indicated Resident B was called by his first name and CNA 5 was present in the video. The video was sent to the DON to review on 2/20/26 at 3:25 p.m. CNA 3 was interviewed and admitted to recording Resident B during care. Both CNA 3's and CNA 5's employment was terminated after reviewing the video.CNA 3's employee file was reviewed on 3/10/26 at 10:30 a.m. CNA 3 had abuse training on 9/20/25 and resident rights training on 9/22/25. CNA 5's employee file was reviewed on 3/10/26 at 10:45 a.m. CNA 5 had resident rights training on 9/25/25. During an interview, on 3/10/26 at 11:37 a.m., CNA 6 indicated CNA 3 had shown both her and CNA 4 a video recording of Resident B. The video showed Resident B using the restroom with two other CNAs present. CNA 3 showed them the video while at school. There was another girl at their table, but CNA 6 was unsure if she saw the video. CNA 3 was flashing her phone around while showing them the video of Resident B.During an interview, on 3/10/26 at 12:05 p.m., Resident B's Representative 8 indicated Resident B would have (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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>been offended and upset about the video recording. Resident B would not have liked the fact that someone recorded him while using the restroom.A facility self-reported incident, submitted to the Indiana Department of Health on 2/20/26 at 4:39 p.m., indicated CNA 3 recorded a resident during care and had shown other employees the video while off facility grounds.Resident B's clinical record was reviewed on 3/9/26 at 10:13 a.m. Diagnosis included dementia with mood disturbance, major depressive disorder, anxiety, restlessness with agitation, muscle weakness and unsteadiness on feet.Current orders included buspirone (antianxiety) 20 milligrams (mg) daily and sertraline (antidepressant) 75 mg daily.A 2/26/26, annual, Minimum Data Set (MDS) assessment indicated Resident B was cognitively impaired. Physical and verbal behavioral symptoms directed toward others occurred 1 to 3 days per week during the assessment period. Resident B required maximal staff assistance with toilet transfers. He was frequently incontinent with bowel and bladder.A current facility policy, undated, titled Employee Handbook policy Summary, provided by the Administrator, on 3/10/26 at 10:58 a.m., indicated the following: .Cell phones, tablets, iPads, smart watches, smart glasses, earbuds, headphones, or any similar personal portable electronic devices (PPEDs) may not be used in resident care areas . Employees are strictly prohibited from taking photographs or video recordings of residents or guests using any PPED or photographic device. This prohibition applies at all times under all circumstances A current facility policy, undated, titled Nursing Policy and Procedure. Dignity- Promoting/ Maintaining Resident Dignity provided by the Administrator, on 3/10/26 at 10:36 a.m., indicated the following: .All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights 410 IAC (Indiana Administrative Code) 16.2-3.1-3(t)This citation relates to Intake 2785417.</p>		