STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, record review, and interview, the facility failed to ensure the physician was notified of dietary recommendations for a resident with weight loss for 1 of 6 residents reviewed for nutrition (Resident 41). Finding includes:Resident 41's clinical record was reviewed on 2/9/26 at 10:10 a.m. Diagnoses included protein-calorie malnutrition and dementia. Current orders included regular diet with a half peanut butter and jelly sandwich at lunch and supper, may offer finger foods (1/7/26) and weekly weight - notify physician for five-pound gain or loss (2/2/26). An admission Minimum Data Set (MDS) assessment, dated 1/9/26, indicated the resident was severely cognitively impaired. She required supervision/touching staff assistance with eating. A current care plan indicated the resident was at nutritional risk (revised 1/5/26). Interventions included diet/supplements as ordered (12/22/25). A dietician progress note, dated 2/3/26 at 4:25 p.m., indicated the resident had a weight loss of 4.4 pounds and a recommendation to add a high-calorie supplement shake at breakfast related to the weight losses. Review of Resident 41's recorded weights indicated the resident weighed 138.2 pounds on 12/22/25, 128 pounds on 2/1/26, and 126 pounds on 2/9/26.She had experienced an 8.83 percent weight loss over seven weeks. During an observation, on 2/11/26 at 8:09 a.m., Resident 41 sat in the assisted dining room eating breakfast. Her meal did not include a high-calorie supplement shake. During an interview, on 2/11/26 at the time of the observation, Restorative Aide 6 indicated the resident did not receive a high-calorie supplement shake today. Restorative Aide 5 assisted residents daily in the assist dining room and did not recall the resident receiving a supplement shake with her meals. The nurse passed out the supplement shakes. During an interview, on 2/11/26 at 8:16 a.m., LPN 7 indicated she did not see where Resident 41 was supposed to receive a high-calorie supplement shake. During an interview, on 2/11/26 at 8:18 a.m., the Staff Development Nurse indicated when the dietician made recommendations, they were emailed to the DON, the ADON, and herself. They looked at the dietician's recommendations and sent them to the physician. She was uncertain what had happened with the dietician's recommendation for high-calorie supplement shakes for Resident 41. During an interview, on 2/11/26 at 8:55 a.m., the ADON indicated she received emails from the dietician with her recommendations. She reviewed the recommendations and printed them off for the physician. When she had printed off the recommendations, for some reason, Resident 41's had not printed, so the order had not been given for the supplement shake. She indicated she had recognized that the resident had a 2-pound weight loss in the past week. A current, undated facility policy, provided by the Administrator on 2/11/26 at 4:59 p.m., titled Notification of Physician of Dietitian Recommendations, indicated the following: .It is the policy of this facility to notify the attending physician of all dietitian recommendations that require a change in the resident's diet, nutritional supplements, or plan of care.Nursing staff shall notify the attending physician of the dietitian's recommendations in a timely manner. 3.1-22(b)(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, a staff member failed to report a resident's allegation of abuse to the administrator for 1 of 1 residents reviewed for abuse (Resident 69) Finding includes:Resident 69's record was reviewed on 2/9/26 at 9:33 a.m. Diagnoses included macular degeneration, hearing loss unspecified ear, and insomnia. A quarterly Minimum Data Set (MDS) assessment, dated 11/13/25, indicated the resident was moderately cognitively impaired. A progress note, dated 1/12/26 at 5:11 a.m., indicated the resident woke up with a headache. She refused pain medication. She rubbed the top of her head and said it hurt when she rubbed her head. No injury was noted. The resident said she did not have any pain when she went to bed. She woke up with the pain. A progress note, dated 1/12/26 at 5:50 a.m., indicated the CNA told the nurse the resident had told her that she remembered what happened. The loud speaking NNN that was just in her room had been swinging something around and hit the resident in the head with it. The nurse went into the room at that time. The resident's eyes were closed and her mouth open. She did not open her eyes when her name was called. The nurse did not have anything in her hand when she spoke to the resident. The CNA told the nurse she was not swinging anything around. The nurse reported the incident to the oncoming nurse. The clinical record lacked additional information on the resident's allegation that someone had hit her with something. During an interview, on 2/10/26 at 3:44 p.m., QMA 9 indicated if a resident told her that someone had hit them or hit them with something she would report it immediately to her supervisor or charge nurse. She would report it even if the resident was confused because the resident's orientation did not matter if they said someone or something hit them. During an interview, on 2/10/26 at 3:46 p.m., CNA 10 indicated she would contact the Administrator right away if any resident said they were hit or hit with something. During an interview, on 2/10/26 at 3:50 p.m., LPN 11 indicated if a CNA told her a resident had said someone had hit them or something had hit them, she would immediately make sure the resident was safe, then follow up with the resident's story. She would notify the DON, the family, and the physician. During an interview, on 2/10/26 at 4:10 p.m., LPN 12 indicated if a resident had said they were hit by someone or by something she would first make sure they were safe and then report to the manager who handles the complaints like the ADON or the DON. During an interview, on 2/11/26 at 11:11 a.m., LPN 16 indicated if a CNA told her a resident said they were hit, she would talk to that resident and try to figure out who was involved in the situation, make sure the resident was safe, see if there were any witnesses, check for injuries, then notify the Administrator or the DON. Sometimes, residents were care planned for making outlandish accusations, but the allegations still needed to be investigated, and the supervisors needed to be notified. She did not remember Resident 69's situation described above being reported to her. During an interview, on 2/11/26 at 11:27 a.m., the Administrator indicated she did not know anything about the resident's allegations that someone had hit the resident or hit the resident with something. She indicated the nurse who documented the situation should have notified her or the DON immediately. They would have done an investigation immediately if they had known about the situation. During an interview, on 2/11/26 at 3:24 p.m., LPN 13, indicated on the above-mentioned situation, the resident had called and said she woke up with a headache. She did not see anything wrong with the resident. Then, the CNA told her the resident said someone came into the resident's room and was swinging something around and hit the resident's head. She did not consider it abuse. She was not sure it was important. She was not sure if the resident said anything more about it. She thought it was more of an accidental thing. Nothing had been reported to her about something happening to the resident on the prior shift. She indicated, to report abuse, she would tell the person coming on to relieve her or leave a note for the DON or ADON. If she thought someone was being abused, she would notify the supervisors right away. She thought the resident was dreaming. She guessed she should have notified the supervisor if the resident said someone was hitting the resident or hitting the resident with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	something. During an interview, on 2/11/26 at 4:14 p.m., the DON indicated if a resident reported that someone had hit them or hit them with something, she would expect the staff to notify either her or the Administrator immediately. A current policy, dated 11/2025, titled Abuse/Neglect/Exploitation Reporting, provided by the Administrator on 2/11/26 at 2:30 p.m., indicated the following: .It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility. 3.1-28(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents and/or resident representatives received a copy of their baseline care plans on admission for 6 of 10 residents reviewed for care plans. (Residents 7, 11, 13, 50, 55, and 76)Findings include:1.Resident 50's clinical record was reviewed on 2/11/26 at 11 a.m. Census information indicated the resident was admitted on [DATE]. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. During an interview, on 2/11/26 at 11:48 a.m., the Administrator indicated a discussion of Resident 50's baseline care plan summary was not conveyed with Resident 50 ,nor to his representative. 2. Resident 55's clinical record was reviewed on 2/11/26 at 11:45 a.m. Census information indicated the resident was admitted on [DATE]. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. During an interview, on 2/11/26 at 11:48 a.m., the Administrator indicated a discussion of Resident 55's baseline care plan summary was not conveyed with Resident 55, nor to his resident representative. 3. Resident 13's clinical record was reviewed on 2/11/26 at 2:18 p.m. A progress note, dated 11/7/25 at 12:30 p.m., indicated Resident 13 was admitted to the facility. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. An email, dated 2/11/26 at 4:00 p.m., sent by the Administrator, indicated a baseline care plan summary was not provided to Resident 13 nor to her resident representative. 4. Resident 76's clinical record was reviewed on 2/11/26 at 3:00 p.m. A progress note, dated 11/10/25 at 4:08 p.m., indicated Resident 76 was admitted to the facility. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. An email, dated 2/11/26 at 4:00 p.m., sent by the Administrator, indicated a baseline care plan summary was not provided to Resident 76, nor to his resident representative. 5. Resident 7's clinical record was reviewed on 2/9/26 at 10:58 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 2/27/25 at 12:35 p.m., indicated the resident was admitted to the facility. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. During an interview, on 2/10/26 at 4:03 p.m., the MDS (Minimum Data Set) Coordinator indicated she was responsible for the baseline care plans and discussing them with the resident and/or the resident's representative. She had been on leave this past year. When she came back, she realized the person who had filled in for her had not performed the responsibilities the way they should have been done. She was unable to locate in the resident's electronic record where the baseline care plan had been discussed and provided to the family. She had requested medical records to look for the documentation. During an interview, on 2/11/25 at 9:17 a.m., the Administrator indicated she was unable to locate the communication of the resident's baseline care plan with him or his resident representative. 6.Resident 11's clinical record was reviewed on 2/9/26. A progress note, dated 8/25/25 at 5:38 p.m., indicated resident was admitted to the facility. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. During an interview, on 2/11/26 at 11:48 a.m., the Administer indicated the clinical record lacked documentation that the baseline care plan was discussed with Resident 11 and/or their representative. A current policy, undated, titled Baseline Care Plan, provided by the Administrator, on 2/11/26 at 2:30 p.m., indicated the following: .2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
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 observation, interview, and record review, the facility failed to provide adequate supervision for a cognitively impaired resident to prevent repeated falls for 1 of 3 residents reviewed for accidents (Resident 41). Finding includes: During an observation, on 2/6/26 at 9:58 a.m., Resident 41 sat in her recliner with her feet elevated. Nonskid strips were in front of recliner. She wore nonskid slippers and her eyes tracked the television program. Resident 41's record was reviewed on 2/9/26 at 10:10 a.m. Diagnoses included dementia, severe, major depressive disorder, anxiety disorder, fracture of unspecified part of neck of the left femur, and chronic pain syndrome. Current physician orders included the following: sertraline (antidepressant) 50 mg twice a day (2/2/26), tramadol/acetaminophen (pain reliever) 37.5-325 mg twice a day (12/22/25), gabapentin (anticonvulsant) 300 mg twice a day (12/22/25), and non-skid strips in front of recliner, keep walker within reach (1/27/26). An admission Minimum Data Set (MDS) assessment, dated 1/9/26, indicated the resident was severely cognitively impaired. She required substantial/maximal staff assistance with toileting hygiene, showering hygiene, upper body dressing, moving from sitting to lying, lying to sitting, sitting to standing, chair to bed/chair transfers, toilet transfers, and walking 10 feet. She was dependent on staff assistance for lower body dressing, putting on/taking off footwear, and wheelchair mobility for 50 and 150 feet. She was frequently incontinent of bowel and bladder. She received routine and as-needed pain medications and non-medication interventions for pain. She complained of almost constant pain with an intensity of 10/10. The pain frequently affected day-to-day activities and therapy, and occasionally affected sleep. She received physical and occupational therapy. A current care plan, revised on 1/5/26, indicated the resident was at risk for falls due to a recent fall with hip fracture and impaired safety awareness related to diagnosis of severe dementia. Interventions included the following: Call light and personal items within reach (12/22/25), Keep walker within reach (1/27/26), Non-skid strips in front of recliner (12/26/25), PT/OT (physical therapy/occupational therapy) evaluate and treat (1/13/25), Instruct on appropriate safety measures (12/22/25), Maintain safe environment (12/22/25), and Ambulation devices as needed (12/22/25). A progress note, dated 12/22/25 at 11:47 a.m., indicated the resident was alert and oriented to person and family. She required supervision and cueing for all activities of daily living (ADLs). A progress note, dated 12/22/25 at 2:02 p.m., indicated an evaluation was done. The resident required partial/moderate staff assistance with toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking of footwear, and personal hygiene. She required supervision/ touching staff assistance with walking 10, 50, and 150 feet. A progress note, dated 12/24/25 at 1:56 p.m., indicated the resident fell at 9:30 a.m. The fall was witnessed. The resident ambulated unassisted. She wore regular socks. She slid onto the floor directly in front of her recliner. She did not utilize her walker. No injuries were noted. A progress note, dated 12/24/25 at 4:00 p.m., indicated the staff noticed the resident standing in front of her recliner with no walker. The staff educated the resident on call light use and to wait for staff assistance. The staff assisted the resident to sit down in her recliner. The staff left the room and turned around. The resident was standing in front of her recliner again. The staff assisted her to her chair. The resident denied any needs. The staff left the room, turned around, and saw the resident standing in front of her recliner holding her call light. The staff assisted the resident back to her chair and educated the resident on using her call light. A progress note, dated 12/24/25 at 10:26 p.m., indicated the resident was found lying on the floor in her room at 8:12 p.m. The resident was lying on her left side in front of her recliner with her feet facing the bed. She wore one shoe. The call light cord was wrapped around the resident's right foot. The resident was oriented to self and did not know how she fell. The resident denied pain but cried out when the left leg/hip was palpated. The resident was sent to the hospital for a possible fracture. A progress note, dated 12/24/25 at 11:30 p.m., indicated the resident returned (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the hospital. The hospital diagnosed a bladder infection and frequent falls. Imaging was performed at the hospital for the pelvis, cervical spine, chest, and hips. The imaging was negative for acute findings. A progress note, dated 12/25/25 at 7:51 a.m., indicated the resident walked out into the hall. The nurse assisted the resident back to her room. The resident was assisted with bedtime care and changed into pajamas. She was assisted into her recliner, and a movie was tuned on the television. The resident was given something comforting to hold. A progress note, dated 12/25/25 at 9:48 p.m., indicated the resident was found lying on her left side in front of her recliner with her head leaning on the dresser feet facing the bed. The recliner was tipped down with the foot portion elevated. The resident tried to self-transfer without assistance from her recliner with the foot portion elevated and rolled onto the floor into her dresser. She was unable to state what she was trying to do. The resident was assisted to her feet and taken to the bathroom. She was assisted to her recliner and given something comforting to hold. No injuries were noted. A progress note, dated 12/27/25 at 2:11 a.m., indicated the staff heard a noise coming from the resident's room. The staff found the resident lying on the bathroom floor in front of the sink. The resident said she was trying to use the bathroom. The resident was incontinent of stool at the time of her fall. The resident was toileted. Her bed was lowered to the lowest level. Nonskid footwear was applied to her feet, and she was educated on call light use. A progress note, dated 12/27/25 at 10:50 a.m., indicated the resident was pleasantly confused. She was observed several times walking unassisted in her room without her walker. The resident was toileted, then assisted to her recliner with her call light, water, TV remote within reach. Shortly after the resident was assisted to her recliner, she was observed walking in the hallway without her walker, saying she couldn't find her walker. The walker was found sitting next to the resident's recliner. A progress note, dated 12/27/25 at 2:12 p.m., indicated the resident was found up walking in her room. She was toileted by staff. A progress note, dated 12/27/25 at 3:40 p.m., indicated the resident requested a peanut butter and jelly sandwich. The staff returned with the sandwich five minutes later to find the resident walking in her room. The resident was looking for her jacket. The resident was given a sweater, reminded to call for assistance, and given something comforting to hold. A progress note, dated 12/27/25 at 3:47 p.m., indicated the resident walked to the doorway of her room with the TV remote in her hand and asked for help with the television. The resident was assisted back to her recliner and shown how to turn off the television. She was covered with a blanket, shown her call light button, and reminded to use her call light button. A progress note, dated 12/27/25 at 4:04 p.m., indicated the resident fell at 4:01 p.m. The fall was not witnessed. The resident continued to get up without assistance. The resident was using incontinence supplies at the time of the fall. A progress note, dated 12/27/25 at 7:04 p.m., indicated the resident continued to transfer self. The staff had walked by the resident's room a few minutes earlier, and the resident was in her recliner. The staff heard a loud boom and the resident yelling. The resident said she was trying to get the blanket from the end of her bed. The resident was helped to her feet and assisted to the lounge area to sit with a CNA. No injuries were noted. A progress note, dated 12/28/25 at 10:15 a.m., indicated the resident's roommate's visitor pulled the code blue cord because the resident was getting up unassisted. The staff assisted with the resident's needs. The resident denied pain or a need to use the bathroom. A progress note, dated 12/28/25 at 11:00 a.m., the resident's roommate's visitor alerted staff to come to the room because the resident was up unassisted without her walker in the bathroom. The resident was assisted to the recliner by the staff. The resident denied needing to use the bathroom and said she wanted to take a nap. A progress note, dated 12/28/25 at 1:43 p.m., indicated the resident was observed walking in her room without her walker unassisted. The resident was rummaging through things behind her recliner and bending over, reaching for things. The resident was unable to say what she was doing. The resident was assisted to her recliner. She denied pain and the need to go to the bathroom. A progress note, dated 12/28/25 at 3:53 p.m., indicated the staff left the resident's room to get the resident's medication and returned to find the resident standing up with the television remote. The resident indicated she was trying to turn the television off. The staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explained to the resident she could turn the television off and on by pointing it at the television while sitting in her recliner. A progress note, dated 12/28/25 at 7:30 p.m., indicated the resident was up in her room messing with her bed. The staff assisted the resident to sit down and told her they could pull back her bed linens. The staff assisted the resident with bedtime care. A progress note, dated 12/28/25 at 8:45 p.m., indicated the resident stood naked in her room. The staff assisted her with dressing and laying down in bed. As the staff was leaving the room, the resident tried to get up. The staff asked what the resident needed, and she said she needed to get an item. Staff obtained it for her. A progress note, dated 12/29/25 at 2:39 p.m., indicated the resident was seen by the nurse practitioner (NP). A new order was received to refer the resident to the psychiatric provider and to discontinue an antibiotic as the urine culture was negative. A progress note, dated 12/29/25 at 6:06 p.m., indicated the resident was found lying on her back on the floor in her room. The resident was confused and screamed out when her head and left hip were touched. The resident was sent to the hospital for evaluation per the NP's order. A CT (Computed Tomography) report indicated a CT of the lower left extremity without contrast was performed on 12/29/25 at 7:56 p.m. Radiographs performed on 12/29/25 showed irregularity in femoral neck. The finding was an acute subcapital left femoral neck fracture (a break in the upper thighbone, occurring just below the head of the left hip joint). A progress note, dated 1/2/26 at 6:00 p.m., indicated the resident returned to the facility at 5:30 p.m., from the hospital with a diagnosis of left hip fracture. The resident was able to bear weight as tolerated to her left lower extremity. A progress note, dated 1/10/26 at 10:32 a.m., indicated the resident was observed walking unassisted without her walker from the dining room to her room. A progress note, dated 1/26/26 at 1:36 p.m., indicated the resident was heard screaming. The resident was found lying on the floor in her bathroom, lying on her left side. The resident had gotten up from her recliner and walked unassisted, without her walker and without her shoes, to the bathroom. An immediate intervention was frequent checks on the resident and ensuring she wore proper footwear. A progress note, dated 2/2/26 at 12:57 p.m., indicated the resident was observed up walking unassisted without pants on in her room two times during the shift. A progress note, dated 2/3/26 at 1:06 p.m., indicated the resident was walking unassisted in her room without her shoes and her walker. The resident was assisted by staff to her recliner. The resident wanted to talk with her daughter. The daughter came to the resident's room and later told the nurse she thought the mail on the resident's table was making the resident nervous, so she took the mail with her. During an observation, on 2/9/26 at 4:10 p.m., the resident's call light was on. She was sitting up in her recliner with her feet on the floor and was looking around the room. During an observation, on 2/9/26 at 4:15 p.m., the resident was walking unassisted in her room using her walker. The call light remained on. During an observation, on 2/9/26 at 4:18 p.m., the resident's roommate's visitor entered the room and encouraged the resident to sit down in her recliner as she continued to walk about her room. The call light remained on. During an observation, on 2/9/26 at 4:21 p.m., the staff entered the room and answered the call light. During an interview, on 2/10/26 at 11:18 a.m., LPN 7 indicated she checked on the resident every chance she got to prevent her from falling. She often would get the resident comfortable in her recliner and applied a topical analgesic to her legs, then five minutes later the resident got up on her own again. The staff checked on the resident as much as they could. During an interview, on 2/10/26 at 3:26 p.m., CNA 8 indicated, to prevent falls for the resident, she gave her comforting items she had in her room. The staff tried to talk to the resident when she got antsy. They tried to check on her often. During an interview, on 2/10/26 at 3:42 p.m., QMA 9 indicated she tried to watch for the resident to prevent falls. If the resident was up, she would give the resident something comforting to hold and put cowboy programs on the television. She also offered to call the resident's daughter at times. During an interview, on 2/10/26 at 3:43 p.m., CNA 10 indicated some fall interventions for the resident were to offer her something to eat. The resident loved both chocolate and bubble gum. She also distracted the resident from getting up by putting Westerns on the television. During an interview, on 2/11/25 at 9:58 a.m., the ADON indicated the interventions for the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	falls were as follows: for the 12/24/25 9:30 a.m. fall - skid strips were placed in front of the recliner, for the 12/24/25 8:12 p.m., fall - a urinalysis was done indicating a urinary tract infection and an antibiotic was started, for the 12/25/25 9:48 p.m. fall - an evaluation for physical, occupational, and speech therapy was ordered, for the 12/27/25 2:11 a.m., fall - an rug was removed from the resident's bathroom, for the 12/27/25 4:01 p.m. fall - a pharmacy medication review was done, and for the 12/29/25 5:30 p.m. fall - the resident was sent to the hospital and returned to have physical, speech, and occupational therapy. She indicated there was not a fall on 12/27/25 at 7:04 p.m. The nurse had written a post fall evaluation earlier in the day at 4:11 p.m. when it happened then added more details later at 7:04 p.m. She had not included the removal of rug on the care plan as she indicated she did not know how she would do that. The rug removal was listed on the daily huddle sheets - which she provided. She indicated each resident's fall interventions were listed on the inside of their closet doors. These interventions came from the care plan.During an interview, on 2/11/26 at 4:08 p.m., the DON indicated the resident had fallen several times. She was uncertain what had caused the resident to fall multiple times. However, A move from the assisted living to the skilled nursing portion of the building was a huge change. She indicated she had told her staff to peek in the resident's room frequently to make sure if she was up or down and to make sure the resident's needs were met. A current, undated policy, titled Fall Risk Assessment & Prevention Program, provided by the Administrator on 2/11/26 at 2:30 p.m., indicated the following: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 3.1-45(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure physician prescribed diets were followed and resident food preferences were honored for 1 of 3 residents reviewed for nutrition (Resident 9). Finding includes: During an interview, on 2/5/26 at 3:33 p.m., Resident 9 indicated she did not have natural teeth and did not wear dentures. She occasionally received chopped up meat with her meals. She was unsure why sometimes the meat was chopped and other times it was not. She preferred to have her meat chopped at every meal because having no teeth made it difficult to chew. Resident 9's clinical record was reviewed on 2/9/26 at 1:20 p.m. Current physician orders included a regular diet with regular texture, regular consistency, ground meat and no added salt (1/21/26). A current care plan, revised on 8/28/24, indicated Resident 9 was at nutritional risk related to diagnosis of diabetes, hyperlipidemia, anemia, depression, and significant weight gain. She received a therapeutic diet related to her diagnosis of diabetes. Interventions included the following: diet and supplements as ordered (6/26/23), educate resident on healthy intake, lifestyle, and portion sizes (2/29/24), resident typically required independence to supervision with set up assist with eating (6/26/23), and report choking, swallowing, and chewing problems, (6/26/23). A dental note, dated 12/4/25, indicated Resident 9 had no teeth. The resident had a flat lower ridge and minimal bone on the upper arch. She was not a denture candidate. During an observation, on 2/10/26 at 11:43 a.m., Resident 9's tray contained country fried steak. A staff member cut the country fried steak into strips. The staff member then cut a few of the strips into bite size pieces, leaving the remaining cut strips on the plate. Resident 9 finished cutting the remaining country fried steak as she ate. During an interview, on 2/10/26 at 12:03 p.m., the Dietary Manager indicated country fried steak was not considered ground meat. It needed to be run through a food processor if the order was for ground meat. Ground meat terminology was interchangeable with mechanical soft. Resident 9 was not automatically given ground meat unless she asked for it. During an interview, on 2/10/26 at 12:20 p.m., Resident 9 indicated it was difficult to eat the meat served at lunch and wanted any type of meat served with her meals to be ground up. She did not want to ask for ground meat each time, especially after being served regular meat at a meal. She was unsure why sometimes it came out of the kitchen already ground up and other times it was not. The resident reiterated she had no teeth and eating meat was hard to do. During an interview, on 2/10/26 at 12:24 p.m., CNA 14 indicated she usually cut up Resident 9's meat into bite size pieces, but not all the time. Resident 9 only wanted her meat ground up because someone who sat at her table a while back had ground meat and she only requested it because they had it. During an interview, on 2/10/26 at 12:29 p.m., CNA 9 indicated she usually cut up Resident 9's meat for her but sometimes it came from the kitchen already cut up into bite size pieces. Resident 9 occasionally received ground meat, not on regular basis, maybe once a day. During an interview, on 2/11/26 at 9:55 a.m., the ADON indicated Resident 9's diet was changed on 12/24/25 per Resident 9's request to have ground meat. Due to the physician order stating regular, ground meat, that meant ground meat would only be given upon Resident 9's request for ground meat. The order did not indicate ground meat was to automatically be given. A current facility policy, undated, titled Diet Change Orders, provided by the Administrator, on 2/11/26 at 2:30 p.m., indicated the following: Policy: All residents will be provided with the appropriate diet prescribed to meet their nutritional needs. Procedure: 5. Make the necessary revision to the diet order in the resident's electronic medical record under orders as well as in the resident's plan of care to reflect the changed diet order. 6. Assess the resident's meal tray upon delivery to ensure the change in diet was communicated effectively and that proper diet is served to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Pointe of Huntington	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)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) role was filled by a staff member with the appropriate schedule to support the ability to perform IP responsibilities by having the full-time DON assume IP responsibilities.Findings include:During the entrance conference, on 2/5/26 at 9:20 a.m., the Administrator indicated the DON was the Infection Preventionist for the facility.The facility census, provided on 2/5/26 at 10:31 a.m. by the Administrator, indicated the facility census was 75.During an interview, on 2/9/26 at 1:35 p.m., the DON indicated she oversaw the infection prevention and control program with the staff development nurse. The DON was scheduled for 40 hours a week and spent about 10 hours a week performing Infection Prevention duties.During an interview, on 2/10/26 at 3:45 p.m., the Administrator indicated the DON was unable to provide a time sheet to show hours she worked as the DON compared to when she worked as the Infection Preventionist. Depending on what was going on within the facility, the DON could be performing IP duties several times throughout the day.A current facility job description for Infection Preventionist, provided by the Administrator on 2/10/26 at 1:38 p.m., and signed by the DON on 9/28/25, indicated the following: .the Infection Preventionist develops and implements an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infections in order to provide a safe, sanitary, and comfortable environment. Maintain established facility- wide systems for prevention, identification, reporting, investigation and control of infections and communicable diseases of residents, staff, and visitors. Develops and implements written policies and procedures in accordance with current standards or practice and recognized guidelines for infection prevention and control. Oversees resident care activities that increase risk of infection (i.e., use and care of urinary catheters, wound care, incontinence care, skin care, point-of-care blood testing, and medication injections. Oversees the facility's antibiotic stewardship program. Able to occasionally work overtime based on facility or resident's needs.A current facility job description for the Director of Nursing, provided by the Administrator on 2/10/26 at 1:38 p.m., and signed by the DON on 7/21/23, indicated the following: .the DON plans, organizes, develops, and directs the overall operations of the Nursing Service Department in accordance with local, state and federal standards and regulations.The DON works beyond normal working hours and on weekends, holidays when necessary. On call 24 hours per day, 7 days per week.An undated current facility policy, titled Infection Control Policy and Procedure, provided by the Administrator, on 2/11/26 at 2:30 p.m., indicated the following: . The facility will designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program to include the antibiotic stewardship program.