

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155828	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Heritage Pointe of Fort Wayne		STREET ADDRESS, CITY, STATE, ZIP CODE 5250 Heritage Parkway Fort Wayne, IN 46835	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>37147</p> <p>Based on interview and record review, the facility failed to ensure an allegation of physical abuse was reported for 1 of 3 residents reviewed for abuse (Resident B).</p> <p>Findings include:</p> <p>An anonymous complaint reported to the Indiana Department of Health, dated 11/15/24, alleged on 11/12/24, Resident B had reported to her family, a Certified Nurse Aide (CNA 3) had been rough while providing incontinent care. The resident alleged she slapped CNA 3 to stop hurting her and the CNA slapped her back. Resident B slapped the CNA a second time and CNA 3 slapped the resident back a second time. The incident had been reported to the Director of Nursing (DON) but the complainant alleged there had been no follow up to the reported altercation.</p> <p>On 12/12/24 at 11:15 A.M., Resident B's record was reviewed. Diagnoses included recurrent urinary tract infections (UTI), dementia, and cerebral atherosclerosis (Arteries in the brain become hard, thick, and narrow due to buildup of plaque inside the artery walls).</p> <p>A significant change in condition Minimum Data Set (MDS) assessment, dated 10/12/24, indicated the resident had moderately impaired cognition with no behaviors. She required moderate assistance to being dependent with all activities of daily living (ADL).</p> <p>A nurse progress note, dated 11/11/24 at 8:06 a.m., indicated the resident had complained of discomfort while urinating and had increased incontinence. She was observed with a functional decline and had voiced some intermittent confusion.</p> <p>A nurse progress note, dated 11/12/24 at 11:20 p.m., indicated a urinalysis had been sent out to the hospital on 11/11/24 and facility was waiting on results.</p> <p>There was no documentation or follow-up completed in the resident's record regarding the resident's allegation of being slapped by CNA 3 the morning of 11/12/24.</p> <p>On 12/12/24 at 1:25 P.M., the DON was interviewed. She indicated she had spoken with both family members on the phone on 11/12/24, and had initiated an investigation but had not reported the incident as required for an allegation of abuse.</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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/12/24 at 3:09 P.M., Resident B's family member was interviewed. The family member indicated, the morning of 11/12/24, she had been in to visit the resident, who reported to her, CNA 3 had been rough with her and slapped her twice. The family member indicated she was told of this and told another family member who immediately reported to the DON. At the time of the allegation, the family member believed the resident was cognitively aware, able to accurately describe what had occurred and who the CNA was, however, the resident would not be able to describe the incident at this time due to overall decline in condition.</p> <p>A current facility policy, titled Abuse, Neglect and Exploitation, was provided on 12/12/24 at 11:00 A.M. by the DON, which stated the following: .Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking .Identification of Abuse, Neglect and Exploitation .possible indicators of abuse include, but are not limited to: Resident, staff or family report of abuse .Reporting/Response: The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframe's</p> <p>This Citation relates to Complaint IN00447537.</p> <p>3.1-28(c)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>37147</p> <p>Based on interview and record review, the facility failed to ensure a thorough investigation of alleged physical abuse was conducted for 1 of 3 residents reviewed for abuse (Resident B).</p> <p>Findings include:</p> <p>An anonymous complaint, reported to the Indiana Department of Health, dated 11/15/24, alleged on 11/12/24, Resident B had reported to her family, a Certified Nurse Aide (CNA 3) had been rough while providing incontinent care. The resident alleged she slapped CNA 3 to stop hurting her and the CNA slapped her back. Resident B slapped the CNA a second time and CNA 3 slapped her back a second time. The incident had been reported to the Director of Nursing (DON) but the complainant alleged there had been no follow up to the reported altercation.</p> <p>On 12/12/24 at 11:15 A.M., Resident B's record was reviewed. Diagnoses included recurrent urinary tract infections (UTI), dementia, and cerebral atherosclerosis (Arteries in the brain become hard, thick, and narrow due to buildup of plaque inside the artery walls).</p> <p>A significant change in condition Minimum Data Set (MDS) assessment, dated 10/12/24, indicated the resident had moderately impaired cognition with no behaviors. She required moderate assistance to being dependent with all activities of daily living (ADL).</p> <p>A care plan, revised 11/25/24, indicated the resident had anxiety with episodes of agitation and yelling at staff during care. Interventions included: If agitated and yelling at others, offer 1:1 conversation and reassurance, explain the behavior wasn't appropriate and ask to stop-initiated 11/25/24.</p> <p>A care plan, revised on 12/3/23, indicated the resident had bladder and bowel incontinence. Interventions included: Offer care in pairs-initiated 11/15/24.</p> <p>A nurse progress note, dated 11/11/24 at 8:06 a.m., indicated the resident had complained of discomfort while urinating and had increased incontinence. She was observed with a functional decline and had voiced some intermittent confusion.</p> <p>A nurse progress note, dated 11/12/24 at 11:20 p.m., indicated a urinalysis had been sent out to the hospital on 11/11/24 and facility was waiting on results.</p> <p>There was no documentation or follow-up completed in the Resident B's record regarding the resident's allegation of being slapped by CNA 3 the morning of 11/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/12/24 at 1:25 P.M., the DON was interviewed. She indicated, on 11/12/24, she had spoken with family members on the phone. They reported an alleged altercation between Resident B and CNA 3 had occurred that morning. After speaking with family, she called and spoke with staff who had worked on night shift and the morning of 11/12/24. On 11/12/24, she spoke with CNA 3 by phone. CNA 3 indicated when she went to get Resident B up for the morning, she noticed the resident was more agitated by the tone of her voice. CNA 3 had trouble rolling the resident in bed and tried to get her to put her hand on the side rail to help with rolling. Resident B would not keep her hand on the side rail where placed but denied slapping the resident or being hit by the resident. CNA 3 indicated the resident was tearful at breakfast but had calmed down after talking with her. The resident was unable to say why she had been crying. The DON indicated, after speaking with CNA 3 by phone, she had not suspended the CNA because she had determined there was no abuse that occurred. There were no interviews conducted with other residents who were cared for by CNA 3 nor skin assessments completed on non-interviewable residents to check for injuries of unknown source. CNA 3 came back into work her next scheduled day (11/13/24) and provided care to Resident B. The DON indicated the family had requested CNA 3 not provide care to the resident and was no longer assigned to care for her. When asked, the DON indicated CNA 3 should have been suspended and not allowed to return to duty until a thorough investigation had been completed.</p> <p>A current facility policy, titled Abuse, Neglect and Exploitation, was provided on 12/12/24 at 11:00 A.M. by the DON, which stated the following: .Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking .Identification of Abuse, Neglect and Exploitation .possible indicators of abuse include, but are not limited to: Resident, staff or family report of abuse .Investigation of Alleged Abuse, Neglect and Exploitation: An immediate investigation is warranted when suspicion of abuse .are reported . Written procedures for investigations include: Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . Providing complete and thorough documentation of the investigation .Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm as well as additional abuse, during and after the investigation. Examples include by are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation; examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and residents; room or staffing changes to protect the resident from the alleged perpetrator; protection from retaliation; providing emotional support and counseling to the resident; and revision of resident's care plan .as a result of an incident of abuse</p> <p>This Citation relates to Complaint IN00447537.</p> <p>3.1-28(d)</p>		