STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00410444, IN00410384, IN00410462, and IN00410466. Complaint IN00410444: No deficiencies related to the allegations are cited. Complaint IN00410384: State deficiencies related to the allegations are cited at R0006. Complaint IN00410462: State deficiencies related to the allegations are cited at R0006. Complaint IN00410466: State deficiencies related to the allegations are cited at R0006. Survey dates: June 13 & 14, 2023 Facility number: 014377 Residential Census: 116 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on June 19, 2023.	R 0000	This Plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report.	
R 0006 Bldg. 00	410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on observation, interview, and record review, the facility failed to discharge a resident who had been determined to require a level of care beyond the scope of services the facility could provide. Resident C remained in the facility and had not received a discharge notice following an assessment that indicated the resident was inappropriate for return to the facility. (Resident C) Finding includes: During an observation and interview on 6/13/23 at 9:50 A.M., Resident C was sitting in a reclining chair in their apartment. Resident C and a family member indicated the resident had been hospitalized in April 2023. Following a return to the facility after hospitalization, the resident was unable to walk and had been discharged from the hospital too soon. The resident was then sent back to the hospital and then to another facility for rehabilitation. Following rehabilitation, the resident returned to facility. At that time, administrative staff indicated the resident would not be able to stay, and told the family member they would have to stay at the facility with the	R 0006	1. Resident C was issued a 30 day notice upon the recommendation of the ISDH surveyor and according to 410 IAC 16.2-5-0.5(f)(1-5). 2. Facility leadership will continue to perform assessments on residents prior to admission to the facility, when residents have been out of the facility receiving medical treatment at a higher level of care, and when resident's present a change in condition or have disease progressions that may render them outside the scope of residential care in accordance with 410 IAC 16.2-5-0.5(f)(1-5). If assessment indicates the resident is outside of the scope of residential care, the facility will issue a notice of discharge in accordance with 410 IAC 16.2-5-1.2 3. Facility will ensure timely	06/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident until they find another facility to go to. The facility had not given them a discharge notice, but continues to ask if they have found a facility to move to. During record review on 6/13/23 at 12:30 P.M., Resident C's diagnoses included, but were not limited to; type II diabetes, dementia with other behavioral disturbance, unsteadiness on feet, muscle weakness, lack of coordination, chronic pain syndrome, history of cardiovascular accident (cerebral infarction), hypertension, tremors, and repeated falls. Resident C's nurses notes included: 4/17/23 - Resident transferred to hospital on 4/17/23 at 5:00 P.M. 4/20/23 - Resident returned to facility from hospital at 5:00 P.M. 4/23/23 - Resident complains of body aches and arthritic type pain especially in feet and wrists. Resident continues to be 2 person assist. Resident can not get herself up or walk to use the bathroom. 4/23/23 - Resident requesting transfer to hospital. 4/23/23 - Resident transferred to nursing and rehab facility for new/worsening pain. 6/2/23 at 3:24 P.M. - Resident was assessed at rehab facility by LPN 4 for return to residential facility. Resident states that she had a fall early that day. When level of assistance needed assessed, resident states that staff "does everything for her." Nurse reports that resident very unsteady on feet. Call placed to daughter to explain that upon assessment, resident is not deemed safe to return to facility, as she requires assistance with transfers and toileting safely... 6/7/23 at 5:30 P.M. - Resident returned to facility from SNF (Skilled Nursing Facility). 6/7/23 at 7:00 P.M. - Notified of resident's return to		issuance of notices of discharge as opposed to taking the word of resident's representative that they are seeking a higher level of care, to ensure the highest level of safety for the resident. 4. Facility will ensure adherance to bed hold policy for all residents that are outside the facility receiving treatment at a higher level of care. Also, review facility acuity list weekly to evaluate the need for further assessment on in house residents that exhibit disease progressions and may be outside the scope of residential care in accordance with 410 IAC 16.2-5-0.5(f)(1-5). Reason for IDR request: Resident C was only back in the facility because after a 45 day SNF stay, she was assessed and deemed inappropriate to return. The SNF where Resident C was staying had discharge plans in place for LTC placement. Resident C was told to return to the facility by the local Ombudsman. There was no communication from the SNF, Ombudsman, or Resident C that she would be returning. There was no report called, no medications sent with Resident C, home health therapy orders were later discovered in her transfer packet and the facility reached out to the home health company to assess the resident for home health	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility by administrator who was on site at the time of her arrival. Nurse Practitioner made aware of the unexpected return. 6/8/23 at 9:26 A.M. - "Nurse was contacted 06/07/23 around [5:30 P.M.] by reception [sic] that a nurse was needed in resident's room as her daughter had brought her back from SNF [Skilled Nursing Facility] this nurse ask reception [sic] if management is aware due to this nurse being told resident was going to stay at SNF due to recent assessment nurse told reception i [sic] was in with another resident but would follow up as soon as i [sic] was finished Nurse left residents room and called and text DON [Director of Nursing] was unable to get response nurse then called and text Admin [Administrator] with no response nurse then contacted nurse that did assessment on resident to verify that resident should not have been back and was told she was not supposed to be back Nurse then called the marketing director who reported she was with admin and they were aware resident was not supposed to return to facility and would call me back before leaving Nurse did not hear back by phone but when nurse was leaving at the end of shift i [sic] met admin on elevator and was asked to check residents medications before going residents daughter did bring back paperwork but did not bring any medications back with her so nurse was unable to verify med list with medication residents daughter reports she was aware resident was not supposed to come back to this facility due to higher level of care being needed but stated she only had one day notice from (Skilled Nursing Facility) that resident had to leave or it would cost over seven hundred dollars a day so residents daughter reported ombudsman told her to just bring her back to [facility] residents daughter reports ombudsman aware of recent assessments nurse was told i [sic] could go by admin as he stayed in		services. Facility was attempting to work with Resident C's family and local ombudsman on LTC placement upon the survey date. Facility has provided the highest level of care possible throughout, despite poor situation. Notice of discharge has been provided to Resident C and an appeal hearing is upcoming.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents room speaking with resident and residents daughter" 6/8/23 3:30 P.M. - DON "Went to resident room to check on well-being. Daughter in apartment at this time. Acknowledges that she was told about the outcome of the assessment on 6/2. Discharge papers[from SNF] given to myself. When reviewing, discharge order states that she is ok [sic] to discharge from [SNF] to [name of other facility and name of home health service] for PT, OT, ST [physical therapy, occupational therapy, speech therapy] and nursing services. When mentioned, daughter states that the order must've been before she was told to bring resident back to our facility by Ombudsman. Also states that they were not aware of any orders for home health or continued therapy. I assessed resident having her get up from recliner and go to bathroom. Resident took 10 attempts before being able to stand. Once up, resident very unsteady walking to bathroom. Once in bathroom, resident only able to get her brief partially down, but could pull up while stumbling side to side. Returned to recliner. Daughter stated that she must be having such difficulty because she is upset..." 6/10/23 at 9:50 P.M. - CNA reported that resident had fallen in her room. Resident indicated she had lost her balance. 6/11/23 at 10:53 P.M. - CNA reported to QMA that resident was on the floor this evening by the bathroom door. Resident indicated the walker had gotten away from her while coming out of the bathroom. During an interview on 6/14/23 at 8:40 A.M., the DON indicated Resident C had fallen at a previous facility during a rehabilitation stay and was requiring 24 hour care. Resident C did not pass the return assessment by their nurse and had discharge orders to be transferred to another			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility but the resident unexpectedly returned to this facility. Resident C required full assistance with toileting and was not getting out to eat. The facility asked family to stay with the resident due to being unable to provide the required nursing care as per their current staffing levels. The resident had fallen twice since returning to the facility, and required assistance with transfers. An "Initial Service Plan" and "Standardized Interview/Initial Assessment" dated 6/1/23, completed by LPN 4 included that Resident C required moderate/max assistance with bathing, moderate/max assistance with dressing, was incontinent of bladder, needed escorted to meals, required supervision with locomotion, needed help standing, and needed help with transfers. The assessment included that the resident had fallen that day (6/1/23). On 6/14/23 at 10:45 A.M., the DON provided a facility policy titled, Discharge Policy, and dated 4/2023. The policy included, "It is the policy of this community to discharge a resident that does not meet the terms for occupancy as stated in the resident contract... Substantiated reasons for discharge include: A. When a transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility... C. The safety of the individuals in the facility is endangered; D. The health of individuals in the facility would otherwise be endangered... This Residential tag relates to Complaints IN00410384, IN00410462, and IN00410466.			