

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155705</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE POINTE OF WARREN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N HUNTINGTON AVE</b> <b>WARREN, IN 46792</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00433530, IN00433434, IN00434125, IN00436004, IN00436049, IN00437152 and IN00438363.</p> <p>Complaint IN00433530 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00433434 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00434125 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00436004 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00436049 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00437152 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00438363 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: July 8 and 9, 2024.</p> <p>Facility number: 000542 Provider number: 155705 AIM number: 100267380</p> <p>Census Bed Type: SNF/NF: 74 Total: 74</p> <p>Census Payor Type:</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 000	Continued From page 1 Medicare: 3 Medicaid: 58 Other: 13 Total: 74  Heritage Pointe of Warren was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00433530, IN00433434, IN00434125, IN00436004, IN00436049, IN00437152 and IN00438363.  Quality review completed July 15, 2024.	F 000			