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	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	1215 TRINITY PLACE MISHAWAKA, IN 46545

(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 a State Residential Licensure Survey. Survey dates: 4/4 and 4/5/2024 Facility number: 013330 Residential Census: 16 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/15/24.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alison Lynch	Health Services Director	06/05/2024

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.

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	in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure the fire department was invited to participate in a fire and evacuation drill every 6 months. This deficient practice had the potential to affect 16 of 16 residents who resided in the facility. Finding includes: During a record review of fire and disaster drills held over the past 12 months, no documentation could be found indicating participation by the fire department. During an interview, on 4/5/2024 at 10:20 A.M., the Maintenance Director indicated he had not included the fire department and had not contacted them to participate as required. On 4/5/2024 at 11:33 A.M., the Administrator provided a current policy titled, "Disaster Drills", revised October 2021. The policy indicated, "...Disaster drills will be conducted in accordance with the state and local regulations, but at the minimum frequencies listed below. Local emergency services agencies will be asked to participated in disaster planning and drills, if required. FULL-SCALE EVACUATION DRILLS - EVERY 6 MONTHS...."	R 0092	R 092 Problem: During a record review of fire and disaster drills held over the past 12 months, no documentation could be found indicating participation by the fire department. During an interview, on 4/5/2024 at 10:20 A.M., the Maintenance Director indicated he had not included the fire department and had not contacted them to participate as required. Action Plan: 1 Fire drills shall be completed quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. 2 At least 12 drills will be conducted each year by the Maintenance Director and to be performed to include all shifts. 3 At least every 6 months the facility shall attempt to hold fire drills in conjunction with the local fire department. A record of all training and drills shall be documented and signed by all participants involved including the local Fire Marshall. 4 The Maintenance Director will contact the local Fire Marshall to plan for him to be present for our next fire drill. 5 The Fire Marshall will be on	05/31/2024

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			site May 2, 2024 at 1:00pm to participate in our scheduled fire drill. A signature will be obtained by the Maintenance Director that the Fire Marshall was present and placed in the Fire Safety Binder. 6. The Maintenance Director will hold a quarterly fire drill and all staff present will sign the drill and the record of the drill will be placed in a Fire Safety Binder. Fire Drills will be performed on various shifts to ensure all staff are properly trained. 7. The Maintenance Director will contact the local Fire Marshall to ensure their presence at least 2 of these drills. The Fire Marshall will sign off on these drills and they will be placed in the Fire Safety Binder 8. ED and Regional Maintenance Director will perform monthly audits to ensure that fire drills are performed quarterly and on all shifts.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility	R 0246	R 246	05/31/2024

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	failed to ensure an as needed (PRN) medication administered by a Qualified Medication Aide (QMA) was approved by a licensed nurse, for 1 of 7 residents reviewed for medications. (Resident 3) Finding includes:A record review was completed on 4/4/2024 at 10:44 A.M. Resident 3's diagnoses included, but were not limited to: Alzheimer's disease and amnesia. A MAR (Medication Administration Record), dated February 2024, indicated a PRN Acetaminophen had been administered on 2/12/2024 at 11:56 A.M. and on 2/26/2024 at 1:44 P.M. by QMA 4, and on 2/13/2024 at 1:49 P.M. by QMA 2, without documentation of a licensed nurse approving the administration of the medication. During an interview on 4/4/2024 at 3:49 P.M., the Director of Nursing indicated the QMAs should have documented in the record the nurses' approval was received. On 4/5/2024 at 11:24 A.M.. the Director of Nursing provided the policy titled, "Medication Management", dated 2/12/2024, and indicated the policy was the one currently used by the facility. The policy indicated"...If an alert and oriented Resident requests a medication ordered "PRN", or a Resident with dementia-related diagnosis shows symptoms of temperature elevation, pain, extreme anxiety, or agitation for which a "PRN" medication has been ordered, the qualified medication aide will notify the licensed nurse and obtain authorization to implement the "PRN" order prior to administering the medication. The "PRN" medication will be documented according to Medication Records and Logs Policy...."		Problem: Based on record review and interview, the facility failed to ensure an as needed (PRN) medication administered by a Qualified Medication Aide (QMA) was approved by a licensed nurse, for 1 of 7 residents reviewed for medications. (Resident 3) Action Plan: 1 Care staff educated on proper procedure involving the administration of PRN medications by QMA's. 2 The QMA will receive appropriate authorization for each administration of a PRN medication from a licensed nurse or physician. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. 3 QMA's will document in nursing notes when approval has been obtained and when medication has been given, including the reason medication has been administered. 4 Licensed nurse will sign PRN medication administration report daily. 5 In-service education will be provided to all care staff upon hire date and quarterly by HSD. 6 HSD will do daily monitoring of PRN medications to ensure proper documentation and authorization	

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			has been completed. 7 HSD will obtain PRN medication reports daily, sign off on them and place them in a PRN medication binder. 8 ED will perform weekly audits for 6 months to ensure proper documentation has been obtained. After 6 months with 100% documentation, ED will continue with quarterly PRN audits.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was labeled and stored in a sanitary manner, in 1 of 1 kitchen reviewed. (Main Kitchen) This had the potential to affect the 16 residents who received food from the kitchen. Findings include: 1. During the kitchen tour, conducted on 4/4/2024 at 9:48 A.M., the following was observed: a. In the walk-in fridge there was a pan of green bean casserole with a use by date of 4/5/2024 and a bag of hashbrowns that were not sealed appropriately. An opened container of heavy cream was missing the open date. b. The walk-in freezer had a large build up of ice on the ceiling and the floor. During an interview on 4/4/2024 at 9:50 A.M. with	R 0273	R 273 Problem: Based on observation and interview, the facility failed to ensure food was labeled and stored in a sanitary manner, in 1 of 1 kitchen reviewed. (Main Kitchen) This had the potential to affect the 16 residents who received food from the kitchen. Action Plan: 1 Executive chef to conduct weekly inspections of food products both prepared and ingredients to ensure they are properly sealed and stored in food-safe and closed containers. Open dates of products to be labeled appropriately. 2 Executive Chef to conduct daily inspections of expiration	05/31/2024

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	the Kitchen Manager, he indicated the hashbrowns and green beans should have been sealed appropriately. 2. During an observation on 4/4/2024 at 11:49 A.M., there were three knives with dried on food stored in a knife rack covered in dust, and a kitchenaide mixer had dried food on the front of the bowl and the stand. 3. During an observation of the dry storage area on 4/5/2024 at 9:23 A.M., there was an open bag of Raisin Bran, an opened bag of powdered sugar, and an opened bag of rotini noodles without open dates, an opened box of biscuit mix not sealed appropriately, and a dented can of mandarin oranges. There was a spice rack covered in dust and loose spices and a container of expired Cajun seasoning, dated 4/2/2024. There were three skillets missing the Teflon coating and two skillets with a build-up of black grease around the inside edge. During an interview on 4/5/2024 at 9:44 A.M., the Kitchen Manager indicated the food should have been sealed appropriately and the skillets and spices should have been discarded. On 4/5/2024 at 11:22 A.M., the Director of Nursing provided the policy titled, "Safety and Health", dated 8/2023 and indicated the policy was the one currently used by the facility. The policy indicated, " ...Food Handling: Chipped, cracked, or rusted containers and utensils must be discarded and replaced. Food Storage: Store all food off the floor in food-safe, closed containers ...."		dates of food and ingredients. Executive Chef to remove any food past their expiration dates 3 Vendor contacted regarding ice buildup on ceiling and floor of walk-in freezer. A new thermostat was installed. Executive Chef to monitor for buildup and contact vendor if buildup returns. Maintenance Director to do daily checks of freezer checking for any build up. 4 Executive Chef to conduct weekly inspections of kitchen utensils and equipment to ensure they are clean and in proper working condition. Executive Chef to remove any chipped, cracked, or rusted containers and utensils. Teflon skillets have been removed from kitchen. 5 In-service education will be provided to all kitchen staff upon hire date and quarterly by Executive Chef and/or ED. 6 Executive Chef to perform weekly checks on all kitchen utensils and supplies. The Executive chef will remove any worn or defective equipment. Weekly deep cleaning of kitchen and equipment to be performed by Executive Chef or Chef in charge. 7 Executive Chef or Chef in charge to perform daily checks to ensure proper storage and labeling of prepared food and ingredients. Formal action will take place if food not to be found in proper containers labeled, dated and	

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			sealed. 8 ED will perform bi-weekly kitchen audits for 6 months to ensure proper working conditions of kitchen. After 6 months of 100% success, ED will perform quarterly kitchen audits.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on record review and interview, the facility failed to ensure the 8 Hour Controlled Drugs - Count Record sheets were signed by the on-coming and off-going nursing staff, for 2 of 2 Count Record sheets reviewed. (QMA & Nursing medication carts) Finding includes: During an observation, on 4/4/2024 at 10:30 A.M., the 8 Hour Controlled Drugs-Count Record sheet for the QMA cart was missing 23 signatures from both on-coming and off-going nursing staff and the Nursing cart was missing 16 signatures from both on-coming and off-going nursing staff for March and April 2024. During an interview on 4/4/2024 at 10:31 A.M., the Administrator indicated nurses should have been signing to verify counts in the narcotic logbooks before coming on to shift and when off-going. On 4/4/2024 at 2:50 P.M., the Director of Nursing provided the policy titled, "Narcotics, Controlled Substances, and Preventing Drug Diversion",	R 0296	R 296 Problem: Based on record review and interview, the facility failed to ensure the 8 Hour Controlled Drugs - Count Record sheets were signed by the on-coming and off-going nursing staff, for 2 of 2 Count Record sheets reviewed. (QMA & Nursing medication carts) Action Plan: 1 A Narcotic Count sheet will be maintained for all narcotic medications. At the end of each shift, the staff member responsible for medication completing his/her shift, and the staff member responsible for medications who is starting his/her shift will count all narcotic medications and confirms that the amount on hand matches the count on the Narcotic Count sheet for each medication. Both care staff members will sign the Narcotic Count sheet to confirm	05/31/2024

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	dated 1/1/2021, and indicated the policy was the one currently used by the facility. The policy indicated, " ...Procedure: 2. A Narcotic Count Sheet will be maintained for all narcotic medications. C. At the end of each shift, the staff member responsible for medication completing his/her shift, and the staff member responsible for medications who is starting his/her shift, count all narcotic medications and confirm that the amount on hand matches the count on the Narcotic Count Sheet for each medication. Both staff members will sign a Narcotic Reconciliation Sheet to confirm the accurate account of narcotics on hand ...."		the accurate account of Narcotic medications in the cart. 2 In-service education will be provided to all care staff members regarding Narcotic Count sheet and 2 person sign off upon hire date and annually. 3 HSD to check narcotic control sheets daily to ensure proper documentation. 4 HSD to perform daily checks on narcotic control sheets. Formal action will take place if signatures are not obtained every shift.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the emergency binder was complete and accurate with all required resident	R 0356	R 356 Problem: Based on record review and	04/29/2024

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	information, for 4 of 5 residents whose emergency information was reviewed. (Residents 2, 3, 6, & 4) Findings include: 1. On 4/4/2024, the Director of Nursing provided the Emergency binder for the facility. Resident 2's clinical information sheet lacked a hospital preference.2. A review of the Emergency binder was completed on 4/4/2024 at 10:44 A.M. Resident 3's emergency information lacked the residents hospital preference. 3. A review of the Emergency binder was completed on 4/4/2024 at 11:13 A.M. Resident 6's emergency information lacked the resident's hospital preference. During an interview on 4/5/2024 at 11:17 A.M., the Administrator indicated the Emergency Medical Service staff would take the resident to the nearest hospital if there was an emergency, and some of the families may not have made a decision about the hospital preference.4. During a review of the Emergency binder, conducted on 4/4/2024 at 10:15 A.M., Resident 4's face sheet did not identify a hospital preference. During an interview on 4/5/2024 at 11:17 A.M., the Administrator indicated the Emergency Medical Service staff would take the resident to the nearest hospital if there was an emergency, and some of the families may not have made a decision about the hospital preference. On 4/5/2024 at 11:30 A.M., the Administrator indicated there was no policy regarding the		interview, the facility failed to ensure the emergency binder was complete and accurate with all required resident information, for 4 of 5 residents whose emergency information was reviewed. (Residents 2, 3, 6, & 4) Action Plan: 1 The emergency binder has been updated with current hospital preferences for all current residents. Emergency Binder was updated with preferences before inspectors left the building. 2 HSD to ensure emergency binder is kept current with resident hospital preference and all new residents will have hospital preference listed upon admission by POA. HSD will perform monthly checks to ensure emergency information is up to date. 3 ED to perform quarterly chart audits to ensure that the proper emergency information is listed.	

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	emergency file binder and information it should contain.			