PRINTED: 05/29/2024 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/05/2024	
NAME OF PROVIDER OR SUPPLIER HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER			1215 TI	ADDRESS, CITY, STATE, ZIP COD RINITY PLACE WAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
R 0000						
Bldg. 00	IN00426243. Complaint IN00426 to the allegations are and R0349. Survey date: Februar Facility number: 01 Residential Census:	20 attial Findings are cited in 0 IAC 16.2-5.	R 0000	Plan of Correction: Complaint IN00426243. Problem: Based on record review and interview, the facility failed to ensure the clinical record, specifically the Medication Administration Record (MAR), immediately accessible, for 1 residents reviewed for medica administration. (Resident B) Action Plan: 1. Previous EMAR system, Eldermark, was unavailable diserver issues. EMAR system now available, and facility is a to access records. 2. Heritage Point ED and DON educated on process to acces Eldermark and previous medic records.	of 3 tion ue to is ble	
R 0027 Bldg. 00	existence, self-det communication wi and services insid Residents have th rights as a residen citizen or resident Based on interview failed to honor a res	- Deficiency e the right to a dignified	R 0027	Plan of Correction: Complaint IN00426243.	03/29/2024	
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE	

Alison Lynch Health Services Director 05/28/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/05/2024	
	ROVIDER OR SUPPLIER	MER'S SPECIAL CARE CENTER	1215 T	ADDRESS, CITY, STATE, ZIP COD RINITY PLACE WAKA, IN 46545	•
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
1710		on until after the evaluation	ING	Problem:	DATE
		did not notify the resident's		Based on interview and recor	rd.
	-	f new medication orders until 3		review, the facility failed to ho	
		cations were ordered to begin,		resident's rights when the	лю а
		reviewed for Resident Rights.		resident's responsible party w	100
	(Resident B)	reviewed for Resident Rights.		not notified of a psychiatric	ias
	(Resident D)			evaluation until after the evaluation	uction
	Finding includes:			was completed and did not no	
	Finding includes.			•	•
	On 2/20/23 at 2:04	P.M., Resident B's clinical		the resident's responsible par new medication orders until 3	-
	records were review	· · · · · · · · · · · · · · · · · · ·			
	records were review	veu.		days after the medications we	ele
	Resident B was admitted to the facility on 9/12/23. Diagnoses included, but were not limited to, dementia, hypertension, congestive heart failure,			ordered to begin, for 1 of 3	ont
				residents reviewed for Reside	ent
				Rights. (Resident B)	
		t, and stroke. The resident		Action Plans	
				Action Plan:	
	was discharged from	m the facility on 11/14/23.		1. Consent for psych services	
	A Darrahiatur Initial	Consult, dated 10/25/23,		signed by the resident's wife,	I
		B had been referred for a		was his POA upon move in d	ale.
				Consent was given to state	
		on and management due to nosis and concerns about		surveyor.	
		behavior. The assessment and		2. Care staff educated on	
	plan indicated the re			procedure to notify POA for a	-
	*	esident would start every night and Melatonin 5		changes, new medication ord	iers,
	mg every evening a			or incidents.	dia a
	ing every evening a	t diffier.		3. In-service education regard	=
	Physician's Ordans	dated 10/25/23, indicated the		proper communication between	en
	-	in receiving Melatonin 5 mg		care staff and POA, will be provided to all new care staff	
	_	dinner and Mirtazapine 7.5 mg		•	
		· -		employees and on a quarterly	/
	every night at bedtime, both related to vascular dementia.			basis.	ort
				4. HSD to perform weekly cha	art
	Notification to the	resident's POA of the		audits for any new orders or changes in resident's care.	ieu
		onsult and the addition of the		to ensure that the POA is not	
		onin and Mirtazapine were not		of any changes to resident ca	
		resident's clinical record.			
	documented in the i	esident's chinear record.		services provided. POA to be	
	A Resident Diahta f	form provided to Resident R/		notified of any change in resid	ueni.
		form, provided to Resident B/		condition.	, for
	Responsible Party a	and signed on admission,	1	5. ED to audit charts monthly	/ IOF

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ í	UILDING	onstruction 00	(X3) DATE : COMPL 03/05/	ETED	
NAME OF PROVIDER OR SUPPLIER HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER				1215 TF	ADDRESS, CITY, STATE, ZIP COD RINITY PLACE WAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated, "The facility must immediately consultthe resident's legal representative when the facility has noticed:a need to alter treatment significantlyor to commence a new form of treatment"				6 months to ensure proper communication between facilit and POA. After 6 months if for to be effective communication charts will be audited quarterly	und ,	
	Director of Nursing not say if Resident I notified of the psycl addition of Melaton	y, on 3/4/24 at 12:30 P.M., the (DON) indicated she could B's responsible party was hiatric evaluation or the in and Mirtazapine, but documented in the resident's					
	Condition, dated 2/1 by the Administrato change in a Residen communicated to th partyThe outcome	M., a policy titled, Change in 12/24, was provided as current or. The policy indicated, "Any at's conditionwill be e family/responsible to of notification to the party is documented in the"					
D 0047		to Complaint IN00426243.					
R 0217 Bldg. 00	facility, using appr members, shall ide services to be pro- follows: (1) The services or resident shall be a (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.	pletion of an evaluation, the operately trained staff entify and document the vided by the facility, as					

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STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPLETED	
		B. WIN	/2024				
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			RINITY PLACE		
	GE POINT ALZHEIN	MER'S SPECIAL CARE CENTER		MISHA	NAKA, IN 46545		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		oriate and discussed by the					
		ty as needs or desires e facility or the resident may					
	request a service	-					
	-	oon service plan shall be					
	1 ' '	by the resident, and a copy					
	I -	n shall be given to the					
	resident upon req	<u> </u>					
		on and documentation of					
	services provided	is needed if evaluations					
		initial evaluation indicate					
	no need for a cha	-					
	l ` '	on of medications or the					
	1 '	ential nursing services, or					
		a licensed nurse shall be					
		ication and documentation of					
	the services to be	and record review, the facility	D 02	17	Plan of Correction:		04/10/2024
		ervice Plan was in place to	R 02	1 /	Complaint IN00426243.		04/19/2024
		s to be provided by the facility,			Complaint invo420243.		
	1	reviewed for Service Plans,			Problem:		
	(Resident B).	To viewed for Service Flants,			Based on interview and record	4	
	()				review, the facility failed to en		
	Finding includes:				a Service Plan was in place to		
					identify the services to be prov		
	On 2/29/23 at 2:04	P.M., Resident B's clinical			by the facility, for 1 of 3 reside		
	records were review	ved.			reviewed for Service Plans,		
					(Resident B).		
		mitted to the facility on 9/12/23.					
	_	l, but were not limited to,			Action Plan:	_	
		sion, congestive heart failure,			Care staff educated on ensity	-	
		et, and stroke. Resident B was			all residents have care plan in		
	discharged on 11/14	4/23.			place on admission, 30 days a	aπer	
	Resident R's Dra M	ove-In Assessment, dated			admission, and quarterly.	awad	
		esident B required verbal			2.All care plans are to be reviewith POA, signed, and dated.	-weu	
		assistance for bathing,			3.Nurse will review care plans	and	
		sing. The resident required			make corrections at above tim		
	-	meals, needed to be reminded			and for any significant change		
		nd daily events, was a potential			and events. POA will be notifi		

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NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COMPLI	ETED
		1215 T	TRINITY PLACE	OD .	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
for falls, and required Resident B had a sh required frequent re wandered within the During an interview Director of Nursing did not have a Service records at the facility or confirm a Service Electronic Medical used while the reside DON indicated Resident Service Plan while a A policy titled, "Servith a revision date Health Services Director for each Resident put the Service Plan is a reviewA current of by the Resident and retained in the Resident Falls of the Service Plan is a reviewA current of the Service Plan is a reviewA current of the Service Plan is a reviewA current of the Resident and retained in the Resident and retained in the Resident Plans of the Service Plans is a reviewA current of the Service Plans i	ed reminders for safe transfers. For attention span which edirection, and occasionally to common areas of the facility. For on 3/4/24 at 12:30 P.M., the (DON) indicated Resident B ice Plan in his closed medical try, and was unable to retrieve the Plan from the previous Record (EMR) system that was lent was at the facility. The ident B should have had a seat the facility. Frevice Plans - Memory Care," 2/12/24, indicated, "The rector develops a Service Plan rior to admissionA copy of available to all staff for copy of the Service Plan signed for responsible party is dent's record" To Complaint IN00426243.	IAU	of any changes. 4. Care plans are review updated and signed quarted any significant change of the resident by the POA HSD. POA will be notified time the care plan is reviewed any significant change of the resident by the POA will be notified time the care plan is reviewed updated. 5. Education will be proquarterly to all care staff in regard to care plans at they need to be reviewed updated. 6. ED to review care plan monthly for 6 months to that they are updated p signed by family. After	wed, arterly or if occurs with A and fied every viewed. ovided ff by HSD and when ed and lans o ensure roperly and 6 months,	DATE
,	-, -,				
(g) Medications ac shall be disposed appropriate federa disposition of any destroyed medica the resident 's clir include the followi (1) The name of th (2) The name and (3) The prescription (4) The reason for	dministered by the facility in compliance with al, state, and local laws, and released, returned, or tion shall be documented in nical record and shall ng information: ne resident. strength of the drug. on number.				
	PROVIDER OR SUPPLIER SUMMARY: (EACH DEFICIEN REGULATORY OR for falls, and require Resident B had a sh required frequent re wandered within the During an interview Director of Nursing did not have a Service records at the facilit or confirm a Service Electronic Medical used while the resid DON indicated Res Service Plan while: A policy titled, "Ser with a revision date Health Services Dir for each Resident pr the Service Plan is a reviewA current of by the Resident and retained in the Resid This citation relates 410 IAC 16.2-5-6(Pharmaceutical So (g) Medications ac shall be disposed appropriate federa disposition of any destroyed medica the resident's clir include the followi (1) The name and (3) The prescriptic (4) The reason for	OF CORRECTION IDENTIFICATION NUMBER PROVIDER OR SUPPLIER	DENTIFICATION NUMBER A BUILDING B. WING PROVIDER OR SUPPLIER SE POINT ALZHEIMER'S SPECIAL CARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION for falls, and required reminders for safe transfers. Resident B had a short attention span which required frequent redirection, and occasionally wandered within the common areas of the facility. During an interview, on 3/4/24 at 12:30 P.M., the Director of Nursing (DON) indicated Resident B did not have a Service Plan in his closed medical records at the facility, and was unable to retrieve or confirm a Service Plan from the previous Electronic Medical Record (EMR) system that was used while the resident was at the facility. A policy titled, "Service Plans - Memory Care," with a revision date 2/12/24, indicated, "The Health Services Director develops a Service Plan for each Resident prior to admission A copy of the Service Plan is available to all staff for reviewA current copy of the Service Plan signed by the Resident and/or responsible party is retained in the Resident's record" This citation relates to Complaint IN00426243. 410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident's clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal.	OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CO. 1215 TRINITY PLACE MISHAWAKA, IN 46545 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION For falls, and required reminders for safe transfers. Resident B had a short attention span which required frequent redirection, and occasionally wandered within the common areas of the facility. During an interview, on 3/4/24 at 12:30 P.M., the Director of Nursing (DON) indicated Resident B did not have a Service Plan in his closed medical records at the facility, and was unable to retrieve or confirm a Service Plan from the previous Electronic Medical Record (EMR) system that was used while the resident was at the facility. A policy titled, "Service Plans - Memory Care," with a revision date 2/12/24, indicated, "The Health Services Director develops a Service Plan for each Resident prior to admissionA copy of the Service Plan is available to all staff for reviewA current copy of the Service Plan signed by the Resident and/or responsible party is retained in the Resident's record" This citation relates to Complaint IN00426243. 410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident's clinical record and shall include the following information: (1) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal.	OF CORRECTION IDENTIFICATION NUMBER A BUILDING 00 COMPLICATION OF BUILDING BUILDIN

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/05/2024	
NAME OF PROVIDER OR SUPPLIER HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER				1215 TI	ADDRESS, CITY, STATE, ZIP COD RINITY PLACE WAKA, IN 46545		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΛTE	(X5) COMPLETION
TAG	REGULATORY OF (6) The method of (7) The date of the (8) The signature the disposal of the (9) The signature disposal of the dre Based on record reversed failed to ensure metappropriately and a policy, for 1 of 3 readministration. (Referred failed for the signature disposal of the dre Finding includes: On 2/29/23 at 2:04 records were review Resident B was addressed from the signature dementia, hypertentors unsteadiness on feet was discharged from the signature of the signat	R LSC IDENTIFYING INFORMATION If disposition. It disposal. If disposal. If the person conducting of the person conducting of drug. If a witness, if any, to the larg. If the person conducting of a witness, if any, to the larg. If the person conducting of a witness, if any, to the larg. If the person conducting of a witness, if any, to the large. If the person conducting of a witness, if any, to the large. If the person conducting of a witness, if any, to the large. If the person conducting of a witness, if any, to the large of a witness, if any, to the large. If the person conducting of a witness, if any, to the large of a witn	RO	TAG	Plan of Correction: Complaint IN00426243. Problem: Based on record review and interview, the facility failed to ensure medications were disp of appropriately and as directe the facility policy, for 1 of 3 residents reviewed for medica administration. (Resident B). Action Plan: 1. Care staff educated on proprocedure and disposal of medications upon discharge or resident. 2. Quarterly in-service educat will be provided to all care statemployees. 3. All controlled substances whave destroyed count log with nurses signing off. 4. HSD will provide quarterly education on proper procedur disposal of medications upon discharge of resident. HSD will provide quarterly education on proper procedur disposal of medications upon discharge of resident. HSD will provide quarterly educations and sign off on the ED will witness any waste medications and sign off on the ED to perform monthly	osed ed by ation oer of a of two e and of	DATE 04/19/2024
	Mirtazapine 7.5 mg 10/25/24, with no e	every night at bedtime, dated nd date,			medication checks for 6 month ensure that medications are	hs to	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	COMP	E SURVEY LETED 5/2024
NAME OF PROVIDER OR SUPPLIER HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER			1215 T	ADDRESS, CITY, STATE, ZIP C RINITY PLACE WAKA, IN 46545	COD	
(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
	On 3/4/23 at 3:00 P (DON) provided a lathe facility from the supplier. The medihad most recently relatively 11/9/23: 7 tablets of Atorvas 7 tablets of Levothy 14 tablets of Carvet 7 tablets of Furoser 7 tablets of Mirtaza 7 tablets of Mirtaza 7 tablets of Melator During an interview DON indicated it we destroy medications that relatively and in I medications that relative been counted, signed off by the numedications. The proof document the consideration of the Community in the Consideration of the Community in EHR [Electronic He They type and quarthe CommunityTill	ist of medications received by a facility's pharmaceutical cation list indicated Resident B eceived the following as of tin 40 mg, proxime 25 mcg, fillol 12.2 mg, fillol 12.2 mg, fillol 15.2 mg, fillol 15.2 mg, fillol 15.2 mg, fillol 16.2 mg, fillol 16.2 mg, fillol 16.2 mg, fillol 17.3 mg, fillol 18.3 mg. 18.4 on 3/4/24 at 12:30 P.M., the first the practice of the facility to so when a resident expired at Resident B's case, all mained at the facility should documented, destroyed and first who destroyed the revious Director of Nursing did bunt or destruction of fining medications, so the current what happened to the		disposed of properly. months if disposed of to perform quarterly m reviews with HSD for p disposal.	properly, ED nedication	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/05/2024	
	PROVIDER OR SUPPLIER GE POINT ALZHEIN	MER'S SPECIAL CARE CENTER	1215 T	ADDRESS, CITY, STATE, ZIP COD RINITY PLACE AWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	This citation relates 410 IAC 16.2-5-8. Clinical Records - (a) The facility muston each resident. maintained under employee of the faresponsibility. The follows: (1) Complete. (2) Accurately doc. (3) Readily access (4) Systematically Based on record revisited to ensure the Medication Adminisimmediately accessive reviewed for medicals. Finding includes: On 2/29/23 at 2:04 I records were reviewed Resident B was adminisimgeness included dementia, hypertens	to Complaint IN00426243. 1(a)(1-4) Noncompliance st maintain clinical records These records must be the supervision of an acility designated with that e records must be as sumented. sible. organized. riew and interview, the facility clinical record, specifically the stration Record (MAR), was ible, for 1 of 3 resident's ation administration. (Resident P.M., Resident B's clinical red. nitted to the facility on 9/12/23. , but were not limited to, sion, congestive heart failure,		Plan of Correction: Complaint IN00426243. Problem: Based on record review and interview, the facility failed to ensure the clinical record, specifically the Medication Administration Record (MAR) immediately accessible, for 1 residents reviewed for medica administration. (Resident B) Action Plan: 1. Previous EMAR system,	04/19/2024 0, was of 3 ation	
	was discharged from Physician's Orders it receive the followin Atorvastin 40 mg ev 9/12/23, with no end Aspirin 81 mg every end date,	very night at bedtime, dated		Eldermark, was unavailable d server issues. EMAR system now available, and facility is a to access records. 2. Heritage Point ED and DOI educated on process to acces Eldermark and previous medi records. 3. HSD and ED will continue monitor Eldermark to ensure	is able N ss cal	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/05/2024	
NAME OF PROVIDER OR SUPPLIER HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER				•	1215 TF	ADDRESS, CITY, STATE, ZIP COD RINITY PLACE WAKA, IN 46545		
	(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	(X5) COMPLETION
	TAG	with no end date, Carvedilol 12.2 mg with no end date, Amlodipine 5 mg d date, Furosemide 20 mg end date, Mirtazapine 7.5 mg 10/25/24, with no e Melatonin 5 mg eve 10/25/23, with no e During an interview Director of Nursing not say whether Re- prescribed medicati access to the compl Records (EMR) and Record (MAR) that the medication adm During an interview Administrator indic clinical records wer the facility no longe have access to the M Record (MAR) in the did not have access During an interview Administrator indic have access to Resi did not have a hard resident's records at During an interview Administrator indic have access to Resi did not have a hard resident's records at	ery evening with dinner, dated and date. W, on 2/29/24 at 2:24 P.M., the g (DON) indicated she could sident B received any of the cons. The facility did not have ete Electronic Medical did Medication Administration of amy have documentation of anistration. W, on 2/29/24 at 2:24 P.M., the cated some of Resident B's are in the old EMR system that her used. The facility should Medication Administration he previous system, but they to the MAR at that time. W, on 3/1/24 at 10:41 A.M., the cated the facility still did not dent B's MAR, and the facility copy of the MAR in the the facility. W, on 3/4/24 at 12:30 P.M., the cated the facility still did not		TAG	accessibility. 4. ED to perform monthly Eldermark checks for 6 month ensure proper accessibility. A 6 months if access is available quarterly checks will be provide	s to .fter	DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/05/2024		
NAME OF PROVIDER OR SUPPLIER HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER				1215 TF	ADDRESS, CITY, STATE, ZIP COD RINITY PLACE WAKA, IN 46545		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Records and Logs, dated 2/12/24, was provided as current by the Administrator. The policy indicated, "A record of the medication administration to each Resident must be kept, to include: The type of medication administered. The date and time that the medications was administered. the date and time that a Resident refuse, or otherwise misses, and administration of medication; and Instructions for administering the medication to the Resident that reflect each current order or prescription of the Resident's physician" This citation relates to Complaint IN00426243.						

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