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	03/05/2024

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 the Investigation of Complaint IN00426243. Complaint IN00426243 - State deficiencies related to the allegations are cited at R0027, R0217, R0306, and R0349. Survey date: February 29, March 1, 4 & 5, 2023 Facility number: 013330 Residential Census: 20 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/11/24.	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), was immediately accessible, for 1 of 3 residents reviewed for medication administration. (Resident B) Action Plan: 1. Previous EMAR system, Eldermark, was unavailable due to server issues. EMAR system is now available, and facility is able to access records. 2. Heritage Point ED and DON educated on process to access Eldermark and previous medical records.	
R 0027 Bldg. 00	410 IAC 16.2-5-1.2(b) Residents' Rights - Deficiency (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on interview and record review, the facility failed to honor a resident's rights when the resident's responsible party was not notified of a	R 0027	Plan of Correction: Complaint IN00426243.	03/29/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alison Lynch	Health Services Director	05/28/2024

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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	psychiatric evaluation until after the evaluation was completed, and did not notify the resident's responsible party of new medication orders until 3 days after the medications were ordered to begin, for 1 of 3 residents reviewed for Resident Rights. (Resident B) Finding includes: On 2/29/23 at 2:04 P.M., Resident B's clinical records were reviewed. Resident B was admitted to the facility on 9/12/23. Diagnoses included, but were not limited to, dementia, hypertension, congestive heart failure, unsteadiness on feet, and stroke. The resident was discharged from the facility on 11/14/23. A Psychiatry Initial Consult, dated 10/25/23, indicated Resident B had been referred for a psychiatric evaluation and management due to chronic psych diagnosis and concerns about mood, anxiety, and behavior. The assessment and plan indicated the resident would start Mirtazapine 7.5 mg every night and Melatonin 5 mg every evening at dinner. Physician's Orders, dated 10/25/23, indicated the resident was to begin receiving Melatonin 5 mg every evening with dinner and Mirtazapine 7.5 mg every night at bedtime, both related to vascular dementia. Notification to the resident's POA of the psychiatry initial consult and the addition of the medications Melatonin and Mirtazapine were not documented in the resident's clinical record. A Resident Rights form, provided to Resident B/ Responsible Party and signed on admission,		Problem: Based on interview and record review, the facility failed to honor a resident's rights when the resident's responsible party was not notified of a psychiatric evaluation until after the evaluation was completed and did not notify the resident's responsible party of new medication orders until 3 days after the medications were ordered to begin, for 1 of 3 residents reviewed for Resident Rights. (Resident B) Action Plan: 1. Consent for psych services was signed by the resident's wife, who was his POA upon move in date. Consent was given to state surveyor. 2. Care staff educated on procedure to notify POA for any changes, new medication orders, or incidents. 3. In-service education regarding proper communication between care staff and POA, will be provided to all new care staff employees and on a quarterly basis. 4. HSD to perform weekly chart audits for any new orders or changes in resident's care. HSD to ensure that the POA is notified of any changes to resident care or services provided. POA to be notified of any change in resident condition. 5. ED to audit charts monthly for	

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	indicated, "...The facility must immediately consult...the resident's legal representative when the facility has noticed:...a need to alter treatment significantly...or to commence a new form of treatment..." During an interview, on 3/4/24 at 12:30 P.M., the Director of Nursing (DON) indicated she could not say if Resident B's responsible party was notified of the psychiatric evaluation or the addition of Melatonin and Mirtazapine, but notification was not documented in the resident's clinical records. On 3/4/23 at 2:04 P.M., a policy titled, Change in Condition, dated 2/12/24, was provided as current by the Administrator. The policy indicated, "Any change in a Resident's condition...will be communicated to the family/responsible party...The outcome of notification to the family/responsible party is documented in the Resident care note..." This citation relates to Complaint IN00426243.		6 months to ensure proper communication between facility and POA. After 6 months if found to be effective communication, charts will be audited quarterly.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and			

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	revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review, the facility failed to ensure a Service Plan was in place to identify the services to be provided by the facility, for 1 of 3 residents reviewed for Service Plans, (Resident B). Finding includes: On 2/29/23 at 2:04 P.M., Resident B's clinical records were reviewed. Resident B was admitted to the facility on 9/12/23. Diagnoses included, but were not limited to, dementia, hypertension, congestive heart failure, unsteadiness on feet, and stroke. Resident B was discharged on 11/14/23. Resident B's Pre Move-In Assessment, dated 9/8/23, indicated Resident B required verbal cueing and standby assistance for bathing, grooming, and dressing. The resident required setup assistance for meals, needed to be reminded to come to meals and daily events, was a potential	R 0217	Plan of Correction: Complaint IN00426243. Problem: Based on interview and record review, the facility failed to ensure a Service Plan was in place to identify the services to be provided by the facility, for 1 of 3 residents reviewed for Service Plans, (Resident B). Action Plan: 1. Care staff educated on ensuring all residents have care plan in place on admission, 30 days after admission, and quarterly. 2.All care plans are to be reviewed with POA, signed, and dated. 3.Nurse will review care plans and make corrections at above times and for any significant changes and events. POA will be notified	04/19/2024

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	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. The DON indicated Resident B should have had a Service Plan while 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 review...A 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.		of any changes. 4. Care plans are reviewed, updated and signed quarterly or if any significant change occurs with the resident by the POA and HSD. POA will be notified every time the care plan is reviewed. 5. Education will be provided quarterly to all care staff by HSD in regard to care plans and when they need to be reviewed and updated. 6. ED to review care plans monthly for 6 months to ensure that they are updated properly and signed by family. After 6 months, ED to audit charts quarterly.	
R 0306 Bldg. 00	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. (5) The amount disposed of.			

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	(6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interview, the facility failed to ensure medications were disposed of appropriately and as directed by the facility policy, for 1 of 3 residents reviewed for medication administration. (Resident B). Finding includes: On 2/29/23 at 2:04 P.M., Resident B's clinical records were reviewed. Resident B was admitted to the facility on 9/12/23. Diagnoses included, but were not limited to, dementia, hypertension, congestive heart failure, unsteadiness on feet, and stroke. The resident was discharged from the facility on 11/14/23. Physician's Orders indicated the resident was to receive the following: Atorvastin 40 mg every night at bedtime, dated 9/12/23, with no end date, Aspirin 81 mg every day, dated 9/12/23, with no end date, Levothyroxine 25 mcg every day, dated 9/12/23, with no end date, Carvedilol 12.2 mg 2 times daily, dated 9/12/23, with no end date, Amlodipine 5 mg daily, dated 9/12/23, with no end date, Furosemide 20 mg daily, dated 9/12/23, with no end date, Mirtazapine 7.5 mg every night at bedtime, dated 10/25/24, with no end date,	R 0306	Plan of Correction: Complaint IN00426243. Problem: Based on record review and interview, the facility failed to ensure medications were disposed of appropriately and as directed by the facility policy, for 1 of 3 residents reviewed for medication administration. (Resident B). Action Plan: 1. Care staff educated on proper procedure and disposal of medications upon discharge of a resident. 2. Quarterly in-service education will be provided to all care staff employees. 3. All controlled substances will have destroyed count log with two nurses signing off. 4. HSD will provide quarterly education on proper procedure and disposal of medications upon discharge of resident. HSD will sign off as a witness to destroyed medications. 5. ED will witness any waste of medications and sign off on them. 6. ED to perform monthly medication checks for 6 months to ensure that medications are	04/19/2024

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	Melatonin 5 mg every evening with dinner, dated 10/25/23, with no end date. On 3/4/23 at 3:00 P.M., the Director of Nursing (DON) provided a list of medications received by the facility from the facility's pharmaceutical supplier. The medication list indicated Resident B had most recently received the following as of 11/9/23: 7 tablets of Atorvastin 40 mg, 7 tablets of Levothyroxine 25 mcg, 14 tablets of Carvedilol 12.2 mg, 7 tablets of Furosemide 20 mg, 7 tablets of Mirtazapine 7.5 mg, 7 tablets of Melatonin 5 mg. During an interview, on 3/4/24 at 12:30 P.M., the DON indicated it was the practice of the facility to destroy medications when a resident expired at the facility, and in Resident B's case, all medications that remained at the facility should have been counted, documented, destroyed and signed off by the nurse who destroyed the medications. The previous Director of Nursing did not document the count or destruction of Resident B's remaining medications, so the current DON could not say what happened to the remaining medications. On 3/4/23 at 2:04 P.M., a policy titled Medication Records and Logs, dated 2/12/24, was provided as current by the Administrator. The policy indicated, "...LOGS...A log for each medication received by the Community for use by a Resident of the Community must be kept. the log is in the EHR [Electronic Health Record], and must include: They type and quantity of medication received by the Community...The date on which any unused medications are removed from the Community or destroyed."		disposed of properly. After 6 months if disposed of properly, ED to perform quarterly medication reviews with HSD for proper disposal.	

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	This citation relates to Complaint IN00426243.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure the clinical record, specifically the Medication Administration Record (MAR), was immediately accessible, for 1 of 3 resident's reviewed for medication administration. (Resident B) Finding includes: On 2/29/23 at 2:04 P.M., Resident B's clinical records were reviewed. Resident B was admitted to the facility on 9/12/23. Diagnoses included, but were not limited to, dementia, hypertension, congestive heart failure, unsteadiness on feet, and stroke. The resident was discharged from the facility on 11/14/23. Physician's Orders indicated the resident was to receive the following: Atorvastin 40 mg every night at bedtime, dated 9/12/23, with no end date, Aspirin 81 mg every day, dated 9/12/23, with no end date, Levothyroxine 25 mcg every day, dated 9/12/23,	R 0349	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), was immediately accessible, for 1 of 3 residents reviewed for medication administration. (Resident B) Action Plan: 1. Previous EMAR system, Eldermark, was unavailable due to server issues. EMAR system is now available, and facility is able to access records. 2. Heritage Point ED and DON educated on process to access Eldermark and previous medical records. 3. HSD and ED will continue to monitor Eldermark to ensure	04/19/2024

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	with no end date, Carvedilol 12.2 mg 2 times daily, dated 9/12/23, with no end date, Amlodipine 5 mg daily, dated 9/12/23, with no end date, Furosemide 20 mg daily, dated 9/12/23, with no end date, Mirtazapine 7.5 mg every night at bedtime, dated 10/25/24, with no end date, Melatonin 5 mg every evening with dinner, dated 10/25/23, with no end date. During an interview, on 2/29/24 at 2:24 P.M., the Director of Nursing (DON) indicated she could not say whether Resident B received any of the prescribed medications. The facility did not have access to the complete Electronic Medical Records (EMR) and Medication Administration Record (MAR) that may have documentation of the medication administration. During an interview, on 2/29/24 at 2:24 P.M., the Administrator indicated some of Resident B's clinical records were in the old EMR system that the facility no longer used. The facility should have access to the Medication Administration Record (MAR) in the previous system, but they did not have access to the MAR at that time. During an interview, on 3/1/24 at 10:41 A.M., the Administrator indicated the facility still did not have access to Resident B's MAR, and the facility did not have a hard copy of the MAR in the resident's records at the facility. During an interview, on 3/4/24 at 12:30 P.M., the Administrator indicated the facility still did not have access to Resident B's MAR. On 3/4/23 at 2:04 P.M., a policy titled Medication		accessibility. 4. ED to perform monthly Eldermark checks for 6 months to ensure proper accessibility. After 6 months if access is available, quarterly checks will be provided.	

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	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.			