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	06/02/2022

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00380669 and IN00379748. Complaint IN00380669- Substantiated. State Residential Findings related to the allegations are cited at R0052. Complaint IN00379748- Substantiated. No State Residential Findings related to the allegations were cited. Survey dates: May 31, June 1 & 2, 2022 Facility number: 013330 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 6/6/22.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observations, interview and record review, the facility failed to ensure a resident's safety in 1 of 4 residents reviewed for accidents. In addition, the facility failed to ensure a resident with aggressive behaviors was monitored, after having previous acts of aggression, which	R 0052	1. All residents have the potential to be affected by deficient practice. 2. All residents interviewed. No residents displaying any s/sx of physiological distress.	06/20/2022

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.

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	resulted in an injury to another resident. (Resident B and F) Findings include: 1. On 6/2/22 at 10:10 A.M., a review of the clinical record for Resident B was conducted. The resident's diagnoses included, but were not limited to: vascular dementia and neuropathy. A self reported incident #222 which occurred on 5/5/22 at 7:01 P.M., indicated Resident F" ...struck [name of Resident B] with the use of a telephone. Staff separated immediately ...." Resident B received small cuts to facial area. Both residents were sent to the local Emergency Room (ER) for an evaluation and returned to the facility. Resident F was place on 1:1 monitoring. Resident B and her family requested her door to be locked. The follow up report indicated neither resident had been displaying signs or symptoms of distress. Continue to follow up as needed. A statement, dated 5/5/22, from the Administrator, indicated she had came to the building to see Resident B. The statement indicated the following: "...When I visited with pt [patient] she was resting in bed with a small abrasion on the bridge of her nose, blood on her shirt & phone. Also noticed blood in both nostrils. She seem terrified and did not want staff to leave her alone. Staff promised her to lock her door & check on her frequently. Pt [patient] remained in bed, watching TV by end of visit, door locked as promised...." A Progress Note, dated 5/5/22 at 10:24 P.M., indicated Resident B was transported via an ambulance to a local Emergency Room for an evaluation.		3. All staff educated on Abuse and Neglect Policy. Resident received medication regime. No resident displaying any s/sx of physiological distress. 4. Any resident behaviors to be documented and monitored by HSD or designee on daily basis and brought forth to daily clinical meeting to discuss managing change of condition/behavior(s). Findings to be discussed in QAPI for 6 months and monitored as needed thereafter.	

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	A Progress Note, dated 5/6/22 at. 12:31 A.M., indicated the resident returned to the facility with her daughter with no new orders. Resident was in her room resting, with door locked. A Progress Notes, dated 5/10, 5/11 and 5/12/22, indicated the Resident B continued to be on 15 minute safety checks. On 5/31/22 at 12:54 P.M., Resident B was observed in her room, lying in hospital bed. She was alert to self and place. The resident indicated she requested her door be kept locked, as she had a man come into her room and he hit her with her own phone. It was not a cell phone but a phone, which required a plug into the wall. She didn't remember if if used the phone as a weapon or had picked it up and dropped it on her. She indicated she had been in bed since her return from the hospital (this was prior to the incident with Resident F) and keeps her phone in the bed with her at all times. She indicated she was not fearful or worried about it happening again as she believed the resident who did this to her left the facility. 2. On 5/31/22 at 10:10 A.M., Resident F was observed sitting in a chair near the nurses station. He was pleasant and smiled and said hello when spoken to. On 6/1/22 at 9:33 A.M., Resident F was observed walking in hallway, near his room, towards the nursing desk. He came up to desk, talked to staff then walked away and sat in a chair. Later, he was observed to be in the TV area watching TV with 2 other female residents, with no staff in the area. On 6/1/22 at 10:56 A.M., a review of the clinical record for Resident F was conducted. The			

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	resident's diagnoses included, but were not limited to: alcohol-induced dementia and TIA (Transient Ischemic Attack) A Hospital History & Physician Examination, dated 12/21/22, indicated the resident presented to the ER, with a significant history of dementia with aggression and was recently at the hospital for the same diagnosis. He was reported to have had an increase in agitation and aggression. While in the emergency department, patient was pushing staff and acting aggressive, refusing testing and care. Resident F was admitted to a Medical Behavioral Hospital for further evaluation. The resident completed his stay at the Behavioral Hospital and was admitted to the facility on 3/21/22. Progress Note, dated 3/21/22, indicated resident admitted from Medical Behavior Hospital. A Progress Note, dated 3/28/22 at 4:16 A.M., indicated the resident was resistant towards staff, with multiple attempts to provide incontinence care for the resident. Need to utilize 2 staff members when providing care as resident was swatting at staff. A form titled," Heritage Point Procedure for falls", dated 4/6/22, indicated the resident fell at 7:04 P.M. The form indicated the resident lost his balance and fell to ground level. The resident had been re-directed several times to go to his room to get changed and he became combative. A Progress Note, dated 4/15/22 at 9:19 A.M., indicated resident's daughter called and demanded the resident be taken off his Depakote. The daughter was informed the resident had been			

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	in an altercation with another resident causing a skin tear (Note did not specify if the skin tear was on Resident F or another resident.) And the Note indicated the resident had gone into another resident's room, pouring coffee on her and trying to hit her with the coffee cup, but staff were able to intervene. The Note indicated the daughter was advised, the resident went to the ER this morning due to picking at a scab on his face, which was bleeding profusely due to the resident not allowing staff to provide appropriate interventions, such as pressure and ice. The Progress Note went on to say the resident was combative and beat up on three staff members who were trying to provide care. The daughter was advised to have a family member or hire someone else, to provide 1:1 care, to ensure the safety of other residents as well as the staff. A Progress Note, dated 4/20/22 at 1:04 P.M., indicated the nurse received a call from the resident's family physician. The physician's requested the facility to stop the administration of Depakote, per the family request. The medication was discontinued. A Progress Note, dated 5/5/22 at 10:34 P.M., indicated the resident had assaulted another resident in her room. Resident B had visible injuries to bridge of her nose and was sent to the Emergency Room. Resident F was sent to the Emergency Room for psychological evaluation. A form titled "After Visit Summary" from the ER, dated 5/5/22, indicated the resident was seen for "aggressive behavior" and was diagnosed with pneumonia of the right lung. A Physician's Medical Office Visit Note, dated 5/6/22 indicated the resident was seen for			

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	"medication overuse" and hip pain. Notes indicated the following: " ...Patient's ex wife and son-in-law were present during today's visit. They are concerned that the nursing home is giving him too much medication. Patient's ex wife brought in a list of medications from [name of facility] that was printed out on 05/05/22 ...[name of physician] called [name of facility] on 05/05/22 and instructed that tramadol be administered as needed and only when patient is in severe pain. The patient's ex wife and son in law are worried about patient overdosing. Blood work was ordered ...in order to assess patient's condition further. Advised the patient's ex-wife and son-in-law that [name of resident] is to discontinue tramadol [pain medication], doxycycline (antibiotic), melatonin, Mirtazapine [anti-depressant], zoloft [anti-depressant] and olanzapine [anti-psychotic]...." The Office Note indicated physician called the facility to discontinue medications and change his pain medication tramadol to an as needed status. A Progress Notes: On 5/6/22 at 7:51 A.M., indicated the resident was placed on 1:1 until a medication review was conducted or referral to a psych unit for an evaluation. Resident went out to doctor appointment and returned with new orders to discontinue some of his medications. During an interview on 6/1/22 at 1:20 P.M., the Administrator indicated the nurse who wrote the Progress Note, on 4/15/22, no longer worked at the facility and she was not aware of the incidents and had no record of it, only the Progress Note, which she read today. On 6/1/22 at 12:04 P.M., the Administrator provide a current policy titled, "Reporting Abuse, Neglect and Exploitation and Reasonable Suspicion of a			

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	Crime", dated 1/15/20. The policy indicated "...Abuse, neglect and exploitation include, but are not limited to: 1. Any intentional or reckless act or failure to act that causes or may have caused physical injury to an individual...." On 6/1/22 at 1:39 P.M., the Administrator provided a form titled, "Resident Rights", dated 4/8/14, and indicated this form was given to each resident on day of admission. The form indicated "...Residents have the right to be free from: (1) sexual abuse; (2) physical abuse...." This State complaint relates to complaint IN00380669.			