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	05/09/2022

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

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00379278, IN00378382 and IN00377537 Complaint IN00379278 - Substantiated. State Residential Findings related to the allegations are cited at R0027, R0117, R0241 and R0248. Complaint IN00378382 -Substantiated. State Residential Findings related to the allegations are cited at R0027, R0117, R0241 and R0248. Complaint IN00377537 -Substantiated. No State Residential Findings related to the allegations were cited. Unrelated deficincies are cited. Survey date: May 4, 5, 6, 7 & 9, 2022 Facility number: 013330 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 5/19/22	R 0000		
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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Based on interview and record review, the facility failed to ensure the resident's right to have access to nursing services; such as a nurse who would administer medications and/or treatments, on a weekend. This failure effected all 44 residents who resided at the facility and required assistance with medications. Findings include: The facility had three shifts. The day shift hours were 6:00 A.M. - 2:00 P.M. The evening shift hours were 2:00 P.M. - 10:00 P.M. and the night shift hours were 10:00 P.M. - 6:00 A.M. A staffing schedule, for 4/16/22, provided by the Administrator, on 5/4/22, indicated LPN 2, was scheduled to work the day shift, QMA 3 (Qualified Medication Aide) and RN 4 were to work the evening shift. LPN 5 was to work the night shift. A form titled, "Detailed Hours", dated 4/16/22, provided by the Administrator on 5/4/21, indicated there was no hours worked by a RN, LPN or QMA for the day shift. A form titled, "EMAR [Electronic Medication Administration Record] Dashboard Report", dated 4/16/22, indicated on the day shift 32 residents did not receive their medications and/or treatments. The evening shift and the night shift all medications/treatments were administered. A staffing schedule, for 4/17/22, provided by the Administrator, on 5/4/22, indicated LPN 2 was to work the day and evening shift, QMA 3 was to work the evening and night shift.	R 0027	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. 3. All staff educated on Resident Rights. Full time scheduler in place to ensure accuracy of schedule. Staff educated on appropriate notifications regarding crisis staffing. 4. Staffing meeting to occur every day with ED and Scheduler to discuss open positions, open shifts, current staffing, and upcoming schedule(s). Findings to be taken to QAPI for monitoring for 6 months and as needed thereafter	06/06/2022

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	A form titled, "Detailed Hours", dated 4/17/22, provided by the Administrator, on 5/4/21, indicated there was no hours worked by a RN, LPN or QMA for the day shift, evening shift nor the night shift. LPN 5 clocked out on 4/17/22 at 10:00 A.M. and the next nurse to arrived to the facility was at 6:02 A.M. on the morning of 4/18/22. A form titled, "EMAR Dashboard Report, dated 4/17/22, indicated on the day shift 20 residents did not receive their medications and/or treatments. On the evening shift 44 residents did not receive their medication and/or treatments. On the night shift, 18 residents did not receive their medications and there were no treatments needed on this shift. On 5/6/22 at 2:20 P.M., a Resident Handbook was provided by the Administrator. The Handbook indicated "...As a resident of [name of the facility], you have certain rights and protections under Federal law that help ensure you get the care and services you need...Generally - All residents have the right to equal access to quality care...." This State tag relates to complaints IN00378382 and IN00379278.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident.			

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	Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			

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	Based on record review and interview, the facility's Administrator failed to ensure staffing included the following: nursing staff qualified to pass medications, a CNA (Certified Nursing Assistant) was not working with expired license and the Administrator failed to report these unusual occurrences to the Department of Health. This deficiency had the potential to effect all 44 Residents who resided at the facility. Finding includes: A staffing Schedule for 4/16/22 and 4/17/22 was received from the Administrator on 5/4/22. The 4/16/22 schedule indicated the day shift had the following staff members working: LPN 2, with CNA 7, 9, 10 & 6. The evening shift had the following staff members: LPN 2 with CNAs 9, 6 & 10. The night shift had CNA 7 & 11. The schedule for 4/17/22, day shift had the following staff members working: LPN 2 and CNAs 7, 9, 6 & 10. The evening shift had the following staff member working: LPN 2 with CNAs 9, 6, 10 & 11. The night shift had QMA 3 with CNAs 7 & 11. On 5/5/22 at 10:50 A.M. the Administrator indicated she had noted, when gathering CNA's license information for the surveyor, CNA 7's license expired on 7/20/21 and had not been renewed. She informed CNA 7 she was taken off the schedule, as of today. Her hire date was 10/23/19. The time sheets for CNA 7 indicated in the month of April 2022 she work at the facility on the following dates: 4/1, 4/2, 4/3,4/5, 4/8, 4/9, 4/10, 4/22, 4/23, 4/24, 4/29 and 4/30. Her last day she worked was 5/1/22. She called off 4/15, 4/16 and 4/17/22.	R 0090	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. 3. Administrator educated by RVPO on unusual occurrences and reporting timely. All files audited for verification of licenses. 4. Employee files to be audited weekly x4, x2 monthly thereafter, findings to be taken to QAPI to identify need for ongoing monitoring. Unusual occurrences to be audited weekly x4, x2 monthly thereafter, findings to be taken to QAPI for 6 months as needed thereafter.	06/06/2022

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	On 5/5/22 at 12:35 P.M., the Administrator confirmed, on 4/16/22, there was no licensed staff member who was qualified to pass medications from 6 A.M. until the 2nd shift nurses arrived in the building. Then LPN 5 worked the night shift, on 4/16 from 10:00 P.M. until 10:00 A.M. The Administrator indicated there were no licensed nurses available on 4/17/22 from 10:00 A.M. until the next day, 4/18/22 at 6:02 A.M. She indicated all resident (44) were to have medications administered to them and probably all 44 residents missed getting their medications on 4/17/22. On 5/6/22 at 1:48 P.M., the Administrator indicated she was aware an Agency LPN 2 worked on 5/1/22 for 24 hours, due to QMA called off for her night shift duty On 5/6/22 at 1:56 P.M., the Administrator indicated she should of self-reported when the facility had no nurse in the facility on April 16th and 17th. Incident Report #224 indicated dated 5/6/22, during a complaint survey, the surveyor identified the community did not have a nurse nor a QMA on 4/17/22 from 10:00 A.M. until 4/18/22 at 6:02 A.M. The report indicated 44 residents who were to receive medications administered by a nurse, did not receive them. On 5/6/22 at 10:11 A.M., the Administrator indicated there were no policy's regarding staffing, however she provided a "Job Description", dated 8/2020, for the Executive Director/Administrator. The Job Description indicated "...Provide leadership, supervision, training, guidance, and communication while overseeing all aspects of Community			

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	management, including special attention to the following areas:...Human Resources - Develop and maintain staff that provides quality service and ensures resident satisfaction. This includes direct responsibility for hiring; training; supervising; scheduling of hours, breaks, and meal periods; performance management, discipline, and discharge...Compliance - Ensure that the Community is following company policy, state and federal regulations, and other applicable rules and regulations. This includes but is not limited to safety, training, and staffing...." On 5/6/22 at 12:03 P.M., the Administrator provided a policy titled, "Reporting Unusual Occurrences to Community Support Office", dated 1/15/20 and indicated the policy was the one currently used by the facility. The policy indicated "...Community staff will report unusual occurrences which could have a negative outcome in the areas of public relations, regulatory, legal, Resident safety, staff injuries and property damage or loss to the designated Regional or Community Support Office personnel and to any state or local government agencies as required by regulation...."			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current			

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	CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there were sufficient number of staff, working at the facility, to provide services to 44 residents who resided at the facility. Finding includes: During an interview, on 5/4/22 at 10:05 A.M., LPN 8 indicated she was scheduled to work today from 10:00 A.M. to 10:00 P.M. She indicated she has had to work long days and had resigned from the facility due to being expected to cover multiple shifts. She indicated she knew of an agency nurse who once worked 24 hours. She indicated she did not have access to the Corporate Nurse prior to today. During an interview, on 5/4/22 at 11:25 A.M., Resident G's family member indicated he had visited the weekend of April 16-17 and the resident told him he did not receive his evening medications. The family member indicated the resident fixates on getting his meletonin before	R 0117	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. 3. Full time scheduler in place to ensure accuracy of schedule. Staff educated on appropriate notifications regarding crisis staffing. HSD in place. All appropriate contacts given to staff for off-hour concerns. All appropriate contacts posted at the nurses' station for staff to utilize, should the need arise. Manager on Duty program put in place for weekend coverage. Manager on duty will report any call-offs to HSD and ED. Full time Evening Shift Supervisor hired. In addition to, ad placed on Indeed for weekend supervisor. 4. Staffing meeting to occur	06/06/2022

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	bed, as resident believes he can not sleep if he doesn't get it. When the family member visited, that weekend, there was a change in the pattern for that day-no medication carts out or in hallway. No nurses passing medications and usually there is at least medication carts out. Also an employee who quit working at the facility, told him there was no nurse to pass medication those days. He did not talk to the Administrator about the situation. During an interview, on 5/4/22 at 2:22 P.M., LPN 2 indicated even though the schedule for 4/16/22 & 4/17/22 indicated she worked from 6:00 A.M. until 10:00 P.M., both days. LPN indicated she did not work at the facility and confirmed with her agency she did not work those days. During an interview, on 5/4/22 at 3:05 P.M., a previous employee indicated he was the Weekend Manager on 4/16/22 and 4/17/22. On 4/16/22 when he arrived at the facility, at approximately 8:00 A.M., there were only 3 CNA's working, with no nurse-RN, LPN or QMA. He indicated he had texted and called the Administrator about the situation but she never returned his call or texts. He left the facility, between 2:30-3:00 P.M., and still no nurse had arrived. When he returned the next day a LPN 5 named indicated she was upset. She had worked all night and no one was there to relieve her. LPN 5 told the Weekend Manager she would pass the morning medications, then she was leaving, as her family was in the lobby waiting on her. He indicated no nurse ever showed and again he contacted the Administrator via text and phone calls, but she never returned his attempts to contact her. He left the building between 2:30-3:00 PM and still there was no nurse. He		every day with ED and Scheduler to discuss open positions, open shifts, current staffing, and upcoming schedule(s). Findings to be discussed at QAPI for 6 months and as needed thereafter,	

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	doesn't think there was a nurse who worked the evening nor night shift that day, so no medications were passed. He indicated there was no DON (Director of Nursing) to contact only the Administrator to contact to obtain staff to work. He had no access to staff names and phone numbers nor the Corporate Nurse's contact number. On 5/5/22 at 12:35 P.M., the Administrator confirmed on 4/16/22 there was no licensed staff members who were qualified to pass medications from 6 A.M. until 2nd shift nurses arrived in the building. Then LPN 5 worked the night shift on 4/16 at 10:07 P.M. until 10:00 A.M. No licensed nurses were available on 4/17/22 from 10:00 A.M. until the next day, 4/18/22 at 6:02 A.M. She indicated all resident (44) were to have medications administered to them and probably all 44 residents missed getting their medications on 4/17/22. During an interview, on 5/6/22 at 11:00 A.M., LPN 2, from an agency, indicated on 5/1/22 she worked a 24 hour shift. LPN 2 indicated she was scheduled to work 6:00 A.M. to 10:00 P.M., however, another nurse did not show to work, the night shift, so she stayed until the next day and was relieved of her duties when the day shift nurse arrived at 6:00 A.M. on 5/2/22. On 5/6/22 at 10:11 A.M., the Administrator indicated there were no policy's regarding staffing, however she provided a "Job Description", dated 8/2020, for the Executive Director/Administrator. The Job Description indicated "...Provide leadership, supervision, training, guidance, and communication while overseeing all aspects of Community management, including special attention to the			

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	following areas:...Human Resources - Develop and maintain staff that provides quality service and ensures resident satisfaction. This includes direct responsibility for hiring; training; supervising; scheduling of hours, breaks, and meal periods; performance management, discipline, and discharge...Compliance - Ensure that the Community is following company policy, state and federal regulations, and other applicable rules and regulations. This includes but is not limited to safety, training, and staffing...." This State tag relates to complaint IN00379278 and IN00378382.			
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review, the facility failed to ensure a CNA (Certified Nurse Aide) had the required license to provide care, at the facility. Finding includes: The staffing schedules indicated CNA 7 was scheduled to work on 4/16/22 and 4/17/22 from 6:00 A.M. until 2:00 P.M. and was scheduled to work from 10:00 P.M. until 6:00 A.M.	R 0118	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. 3. All employee files audited to ensure any necessary license is active. ED and HSD or designee to be responsible for ensuring licenses are current. 4. Appropriate licenses to be	06/06/2022

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	On 5/5/22 at 10:50 A.M. the Administrator indicated she had noted, when gathering CNA's license information for the surveyor, CNA 7's license expired on 7/20/21 and had not been renewed. She informed CNA she was taken off the schedule, as of today. Her hire date was 10/23/19. The time sheets for CNA indicated in April 2022 she work at the facility on 4/1, 4/2, 4/3,4/5, 4/8, 4/9, 4/10, 4/22, 4/23, 4/24, 4/29 and 4/30. Her last day she worked was 5/1/22. She called off 4/15, 4/16 and 4/17/22. On 5/6/22 at 10:11 A.M., the Administrator indicated there was no policy regarding the procedure of verifying and keeping the facility's staff current on staff's license up to date. The Administrator provided a form titled, "Job Description", dated 0/2021. The form indicated a Caregiver/CNA's minimum job qualifications and requirements were "...Appropriate certification, as required by state...Meet state related requirements...."		audited and verified by ED, HSD or designee upon hire and monthly thereafter. Findings to be discussed at QAPI for 6 months and monitored thereafter, as needed. Any employee with an expired or inappropriate licensure to be removed from the schedule until proper licensure is in place.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure a licensed nurse was working in the facility to administer medications to 4 of 4 residents reviewed, nor to administer PRN (as needed/requested). The failure effected all 44 residents who resided at the facility and required administration of their medications, by	R 0241	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. 3. Full time scheduler in place	06/06/2022

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		A. BUILDING 00 B. WING	05/09/2022

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

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	a licensed nurse. (Resident D, Resident E, Resident F, Resident G and Resident H) Findings include: 1. On 5/5/22 at 11:33 A.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but were not limited to: cerebrovascular disorder, renal failure, benign prostatic hyperplasia, depression and osteoarthritis. The Physician Order Sheet indicated the resident was to be administered the following medication: Aspirin 81 milligrams (mg) daily at 8:00 A.M., Atorvastatin Calcium (lowers bad cholesterol) 40 mg daily at 8:00 P.M., Calcium-Vitamin D 600/400 units every Mon, Wed, Fri at 8:00 A.M., Lexapro (antidepressant) 5 mg at 8:00 P.M., Latanoprost 0.0005% solution (treats increased pressure inside the eye) instill into left eye at 8:00 P.M., Metoprolol Tartrate (treats chest pain-effects blood flow) 25 mg at 8:00 A.M. and 8:00 P.M., Prednisone 7.5 mg at 8:00 P.M., Muti-vitamin at 8:00 A.M. and 8:00 P.M., Tamsulosin (relaxes muscles in prostate-making it easier to urinate) 0.4 mg at 8:00 A.M., Timolol Maleate 0.5% solution instill in left eye at 8:00 A.M. and 8:00 P.M., Tramadol (pain medication) 50 mg at 8:00 A.M. and 8:00 P.M. and Vitamin D 1000 units-give 3 tabs daily for 30 days at 8:00 A.M. A form titled, " EMAR (Electronic Medication Administration Record) Dashboard Report, dated 4/16/22 indicated the resident "missed" receiving the following 8:00 A.M. and/or 8:00 P.M. medications: Aspirin, Calcium/Vitamin D, Metoprolol Tartrate, Prednisone, Multi-vitamin, Tamsulosin, Timolol Maleaate, Tramadol and		to ensure accuracy of schedule. Staff educated on appropriate notifications regarding crisis staffing. HSD in place. All appropriate contacts given to staff for off-hour concerns. All appropriate contacts posted at the nurses' station for staff to utilize, should the need arise. Manager on Duty program put in place for weekend coverage. Manager on duty will report any call-offs to HSD and ED. Full time Evening Shift Supervisor hired. In addition to, ad placed on Indeed for weekend supervisor. 4. Staffing meeting to occur every day with ED and Scheduler to discuss open positions, open shifts, current staffing, and upcoming schedule(s). Findings to be discussed at QAPI. Electronic Medication Administration Record Dashboard Report to be audited daily by HSD, HSC or designee daily to ensure compliance. Findings to be discussed at QAPI for 6 months and as needed thereafter.	

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	Vitamin D. A form titled, " EMAR (Electronic Medication Administration Record) Dashboard Report, dated 4/17/22 indicated the resident "missed" receiving the following 8:00 A.M., and/or 8:00 P.M. medications: Aspirin, Atorvastatin Calcium, Lexapro, Latanoprost, Calcium/Vitamin D, Metoprolol Tartrate, Prednisone, Multi-vitamin, Tamsulosin, Timolol Maleaate, Tramadol and Vitamin D. 2. On 5/6/22 at 10:33 P.M., a review of the clinical record for Resident E was conducted. The resident's diagnoses included, but were not limited to: vascular dementia with behavioral disturbance, convulsions and restless legs syndrome. A Pre Move-In Assessment, dated 6/9/21, indicated the resident would require "Medication Management". The Physician Order Sheet indicated the resident was to be administered the following medication: Atorvastatin Calcium 10 mg at 8:00 P.M., Cholecalciferol 1000 Units at 8:00 A.M., Eliquis 2.5 mg at 8:00 A.M. & 5:00 P.M., and Zoloft (anti-depressant) 50 mg at 8:00 A.M. A form titled, " EMAR (Electronic Medication Administration Record) Dashboard Report, dated 4/17/22 indicated the resident "missed" receiving the following 8:00 A.M., and/or 8:00 P.M. medications: Atorvastatin, and Eliquis. 3. On 5/4/22 at 2:03 P.M., a review of the clinical record for Resident F was conducted. The resident's diagnoses included, but were not limited to: alcohol-induced dementia and TIA			

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	(Transient Ischemic Attack) The Physician Order Sheet indicated the resident was to be administered the following medication: Eliquis 5 mg at 8:00 A.M. & 5 P.M., Melatonin 5 mg at 8:00 P.M., Remeron 7.5 mg at 8:00 P.M., Zyprexa (anti-psychotic) 5 mg at 12:00 P.M. & 8:00 P.M., Zoloft 50 mg 8:00 A.M. & 8:00 P.M., Vitamin B-12 2000 micrograms at 8:00 A.M., and Vitamin D3 5000 units at 8:00 A.M. A form titled, " EMAR (Electronic Medication Administration Record) Dashboard Report, dated 4/17/22 indicated the resident "missed" receiving the following 8:00 A.M., and/or 8:00 P.M. medications: Eliquis, Melatonin, Remeron and Zyprexa. 4. On 5/4/22 at 2:03 P.M., a review of the clinical record for Resident G was conducted. The resident's diagnoses included, but were not limited to: dementia, gastro-esophageal reflux disease, insomnia, hypertension and glaucoma. A Pre Move-In Assessment, dated 11/14/19, indicated the resident would require "Medication Management". The Physician Order Sheet indicated the resident was to be administered the following medication: Amlodipine (decreases blood pressure) 5 mg at 8:00 A.M., Latanoprost 0.0005% solution instill 2 drops in both eyes at 5:00 P.M., Lexapro 10 mg at 5:00 P.M., Remeron 7.5 mg at 5:00 P.M. for decreased appetite, Protonix 20 mg at 8:00 A.M. and Vitamin D 2000 units at 8:00 A.M. A form titled, " EMAR (Electronic Medication Administration Record) Dashboard Report, dated 4/17/22 indicated the resident "missed" receiving			

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	the following 8:00 P.M., medications: Lananoprost eye drops, Lexapro and Remeron. 5. On 5/7/22 at 2:15 P.M., a review of the clinical record for Resident H was conducted. The resident's diagnoses included, but were not limited to: dementia, mood disorder, anxiety and osteoarthritis. The Physician Order Sheet indicated the resident could have, as needed, either a Tylenol or Norco for pain every 4-6 hours. On 5/5/22 at 12:35 P.M., the Administrator confirmed on 4/16/22 there was no licensed staff member who was qualified to pass medications from 6 A.M. until the 2nd shift nurses arrived in the building. Then a LPN worked the night shift on 4/16 at 10:00 P.M. until 10:00 A.M. The Administrator indicated there were no licensed nurses available on 4/17/22 from 10:00 A.M. until the next day, 4/18/22 at 6:02 A.M. She indicated all resident (44) were to have medications administered to them and probably all 44 residents missed getting their medications on 4/17/22. During an interview, on 5/6/22 at 11:05 A.M., CNA 6 indicated there was no nurse or QMA (Qualified Medication Aide) in the building, on 4/17/22 after 10:00 A.M., and no one showed up for the second or third shift either. CNA 6 indicated she left after doing 2 shifts around 10:00 P.M. and there was only one (1) CNA who showed up to work the night shift. CNA 6 indicated there were two (2) residents who asked for a PRN (as needed) medication-Tylenol, Resident G and Resident H, however, there was no one to administer the medications.			

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	On 5/6/22 a request for Resident D, E, F and G's current "Service Plan" was made to the Administrator, however none were provided. The Administrator provided "Residency Agreement" forms which indicated administration of medications are not included in the resident's monthly service charge and would be billed monthly for that service. On 5/6/22 at 10:15 A.M., the Administrator provided a policy titled, "Medication Administration", dated 1/15/22, and indicated the policy was the one currently used by the facility. The policy indicated "... The administration of medication shall be ordered by the Resident's physician and shall be supervised by a person licensed under their respective state law to administer on the premises...1. The licensed nurse and the qualified medication aide will administer medications... This State tag relates to complaints IN00379278 and IN00378382.			
R 0248 Bldg. 00	410 IAC 16.2-5-4(f) Health Services - Deficiency (f) The facility shall have available on the premises or on call the services of a licensed nurse at all times. Based on observation, interview and record review, the facility failed to ensure a licensed nurse was on the premises or on call at all times. Finding includes: During an interview, on 5/4/22 at 10:13 A.M., QMA 3 indicated she works the night shift without a RN or LPN in the building. If she has any PRN (as needed medications) she has no one to contact to obtain approval prior to	R 0248	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. 3. Full time scheduler in place to ensure accuracy of schedule. Staff educated on appropriate notifications regarding crisis staffing. HSD in place. All	06/06/2022

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	administering these medications. She has asked for the phone number of the Corporate Nurse, as that was who she was informed, by the Administrator, to contact for PRN medications. This phone number has never been given to her or made available to any of the staff. She had another conversation with the Administrator yesterday, for that person's phone number and she indicated she would text her with the number, currently still does not have it. On 5/4/22 at 10:04 A.M., the Administrator was observed posting a sheet of paper at the nurse's station. The note indicated the name and phone number of the Corporate Nurse. During an interview, on 5/4/22 at 10:05 A.M., LPN 8 indicated she was scheduled to work today from 10:00 A.M. to 10:00 P.M. She indicated she has had to work long days and had resigned from the facility, due to being expected to cover multiple shifts. She indicated she knew of an agency nurse who once worked 24 hours. She indicated she did not have access to the Corporate Nurse's information prior to today. During an interview, on 5/4/22 at 10:48 A.M., the Administrator indicated she had posted the Corporate Nurse's name and phone, at the nurse's station, just this morning. During an interview, on 5/4/22 at 11:25 A.M., Resident G's family member indicated he had visited the weekend of Aril 16-17 and the resident told him he did not receive his evening medications. The family member indicated the resident fixates on getting his meletonin before bed, as resident believes he can not sleep if he doesn't get it. When he visited that weekend there was a change in the pattern for that day-no		appropriate contacts given to staff for off-hour concerns. All appropriate contacts posted at the nurses' station for staff to utilize, should the need arise. Manager on Duty program put in place for weekend coverage. Manager on duty will report any call-offs to HSD and ED. Full time Evening Shift Supervisor hired. In addition to, ad placed on Indeed for weekend supervisor. 4. Staffing meeting to occur every day with ED and Scheduler to discuss open positions, open shifts, current staffing, and upcoming schedule(s). Findings to be taken to QAPI for 6 months and monitored as needed.	

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	medication carts out or in hallway. No nurses passing medications and usually there is at least medication carts out. Also an employee who quit working at the facility, told him there was no nurse to pass medication those days. He did not talk to the Administrator about the situation as he didn't want to get the nurse in trouble. He also indicated the DON (Director of Nursing) left in March and the facility has no one in charge. On 5/5/22 at 12:35 P.M., the Administrator confirmed on 4/16/22 there was no licensed staff members who were qualified to pass medications from 6 A.M. until 2nd shift nurses arrived in the building. Then LPN 5 worked the night shift on 4/16 at 10:07 P.M. until 10:00 A.M. No licensed nurses were available on 4/17/22 from 10:00 A.M. until the next day, 4/18/22 at 6:02 A.M. Se indicated all resident (44) were to have medications administered to them and probably all 44 residents missed getting their medications on 4/17/22. On 5/6/22 at 10:11 A.M., the Administrator indicated there were no policy's regarding staffing, however she provided a "Job Description", dated 8/2020, for the Executive Director/Administrator. The Job Description indicated "...Provide leadership, supervision, training, guidance, and communication while overseeing all aspects of Community management, including special attention to the following areas:...Human Resources - Develop and maintain staff that provides quality service and ensures resident satisfaction. This includes direct responsibility for hiring; training; supervising; scheduling of hours, breaks, and meal periods; performance management, discipline, and discharge...Compliance - Ensure that the Community is following company			

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	policy, state and federal regulations, and other applicable rules and regulations. This includes but is not limited to safety, training, and staffing...." This State tag relates to complaints IN00379278 and IN00378382.			