

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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	<p>This visit was for the Investigation of Complaint IN00431968.</p> <p>Complaint IN00431968 -- State Residential Findings related to the allegations are cited at R0090, R0116, R0118 and R0241.</p> <p>Survey date: June 21, 2024</p> <p>Facility number: 004444</p> <p>Residential Census: 30</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on June 25, 2024.</p>	R 0000	<p>what corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Reeducation will be provided to the nursing staff regarding all policies and procedures that reflect this tag. Licensures will be checked by two members of management prior to orientation.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficiency practice and what corrective action will be taken?</p> <p>Continuous education as needed for current and new staff. Licensures will be checked by two members of management prior to orientation.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?</p> <p>The facility will reeducate the nursing staff regarding the policies and procedures of medication administration.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Shawn M Steele

Executive Director

08/01/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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 0090 Bldg. 00	<p>410 IAC 16.2-5-1.3(g)(1-6)</p> <p>Administration and Management - Deficiency</p> <p>(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:</p> <p>(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. 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:</p> <p>(A) epidemic outbreaks;</p> <p>(B) poisonings;</p> <p>(C) fires; or</p> <p>(D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(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.</p> <p>(3) Obtaining director approval prior to the</p>		<p>The Executive Director and Director of Nursing, or other member of management, will routinely check licensures and continue to reeducate the staff regarding medication management.</p> <p>By what date the systemic changes will be completed.</p> <p>7/31/2024</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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
	<p>admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(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.</p> <p>(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</p> <p>Based on interview and record review, the facility failed to provide a detailed reportable incident to the Indiana Department of Health's (IDOH) Long Term Care (LTC) Division, involving a Qualified Medication Aide (QMA) and Certified Nurse's Aide (CNA) in the facility and inappropriate medication administration. (QMA 3 and CNA 4)</p> <p>Findings include:</p> <p>An IDOH-LTC Division incident reportable, dated 2-14-24 and completed by the Administrator, indicated Resident B, identified as alert and oriented, requested a pain medication on/around 2-13-24 at 11:30 a.m., for an unknown malady from CNA 4, who in turn, notified QMA 3 of this.</p> <p>QMA 3 obtained and readied the medication when CNA 4 "offered to take pain medication to resident and took medication to resident and</p>	R 0090	The Executive Director and Director of Nursing, or other member of management, will routinely check licensures and continue to reeducate the staff regarding medication management.	07/31/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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
	<p>placed it on the table by resident's chair. Resident did take medication. Both CNA and QMA acted outside of their scope of practice."</p> <p>The report identified only the CNA by name and license/certification number; the QMA was not identified by name or license/certification number. It indicated the actions taken after this event were notification to the doctor, family, Director of Nursing and Administrator and the re-education of both staff members.</p> <p>In an interview on 6-21-24 at 1:50 p.m., with the Administrator regarding this event, she indicated the report should have identified the date of the incident as 2-12-24; 2-13-24 is the date the issue was discovered. The Administrator indicated from a review of the medication administration records, it appeared QMA 3 documented as administered by herself was not a narcotic, but her scheduled aspirin. She indicated a written statement by CNA 4, she stated she was the person who actually administered the medication. She added in her investigation, there were no narcotics signed out by QMA 3 and she had not signed the facility's Master Signature log. The Administrator included in CNA 4's statement, the resident and her family had asked for something for her headache multiple times, and they were upset about the resident not receiving a pain-reliever. The CNA brought this to QMA 3's attention and the CNA (4) offered to take the medication to the resident and QMA 3 allowed this.</p> <p>Of note in this investigation, it was learned less than 2 weeks later, QMA 3 did not have a valid QMA license in this state.</p> <p>In an interview on 6-21-24 at 12:25 p.m., with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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 0116 Bldg. 00	<p>Administrator she indicated, "Now that I look at the incident, obviously I should have included the QMA's name and license number. The CNA ended up being termed [terminated] shortly after this. The QMA told me that in Florida it was okay for the QMA to pull medicines and have a CNA take the medication to the resident. I have no idea if this is, in fact, correct or not."</p> <p>On 6-21-24 at 2:10 p.m., the Administrator provided a copy of a policy entitled, "Incident Reporting Guidelines," with a revision date of 12/2023. This document indicated, "An incident is defined as any unusual occurrence that results in actual or potential injury to a resident, visitor, staff member or property. Unless otherwise indicated, the Universal Incident Report should be completed as soon as possible after the incident occurs...The Executive Director or designee will notify the state licensing agency as required by state specific regulations.</p> <p>This Residential tag relates to Complaint IN00431968.</p> <p>2.5-1.3(g)(1)</p> <p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>Based on interview and record review, the facility failed to provide written documentation of the facility's screening process for prospective</p>	R 0116	The Executive Director and Director of Nursing, or other member of management, will	07/12/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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
	<p>employees, to include verification of an employee's current licensure and/or certification status in this state. (QMA 3)</p> <p>Findings include:</p> <p>In an interview with the Administrator on 6-21-24 at 9:50 a.m., she indicated at the time of Qualified Medication Aide (QMA) 3's hiring, the former Director of Nursing (DON) was not aware the State of Indiana does not allow a QMA to work without a current Indiana certification as a QMA and QMA 3 was hired by the former DON and worked for nearly a month prior to the Administrator becoming aware of the lack of licensure/certification. The Administrator indicated QMA 3 repeatedly told the DON she would bring in a copy of her Florida QMA license and never brought in the QMA license. "I got involved after the DON told me she (QMA 3) still had not brought her license in. I told her that if we did not have a copy of the license, I was taking her off the schedule and I did." The Administrator added she has since discovered, via the Indiana Professional Licensing Agency (PLA), that QMA 3 she has a current Certified Nurse's Aide (CNA) license in Indiana, which was issued after QMA 3's employment at the facility.</p> <p>In another interview with the Administrator on 6-21-24 at 10:24 a.m., she further explained at the time of hire, she [the Administrator] was under the impression the former DON at the time had already received the Florida license and the DON was told by QMA 3 that she was actively working on gaining her Indiana licensure.</p> <p>A review of QMA 3's employment record indicated the following information:</p> <p>-QMA 3 was hired on 1-23-24.</p>		<p>routinely check licensures and continue to reeducate the staff regarding medication management.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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
	<p>-No type of health-related licensure or certification was located in her record.</p> <p>-A copy of QMA 3's job description as a "Care/Medication Technician," indicated under, "Qualifications," this position a "Certified Nurse's Aide certification preferred." This job description was signed by the Administrator on 2-1-24, but QMA 3 did not sign this document.</p> <p>-An undated resume for QMA 3, indicated she held a CNA license, but did not include an expiration date, and a "Certified Medication Aide [effective] January 2020 to May 2025."</p> <p>-A "Counseling Documentation Form," dated 2-26-24 for QMA 3, indicated, "Employee lied to employer. Worked as a QMA, unlicensed, practicing outside her scope of practice. Failed Introductory Period." A handwritten note, signed by the Administrator, added, "Termed [terminated] via voice mail and letter." An associated document, entitled, "Reportable Work Sheet," undated, indicated QMA 3, "Staff member practiced under a non-Indiana QMA license...Termed employee."</p> <p>-Payroll information indicated QMA 3, had 10, hours of training over two days, then had 109.99 hours of working with residents over 10, days, prior to her termination on 2-26-24.</p> <p>In a phone interview with the Indiana Department of Health's Nurse Aide Investigation on 6-21-24 at 10:52 a.m., she indicated she was currently investigating the circumstances of an unlicensed personnel, QMA 3, at this facility. She indicated her department has been able to locate a possible CNA license, but no QMA/QMAP license in Florida at this time, but the investigation remains active.</p> <p>On 6-21-24 at 2:10 p.m., the Administrator provided a copy of an undated document entitled,</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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 0118 Bldg. 00	<p>"Hiring and Orientation Policies." This document indicated, "Personnel File Policy. The company will keep an accurate, complete and confidential employment record for each Team Member. Employment records shall be kept for at least five years from the date of the Team Member's termination." This policy did not address the issue of current licensure or certification requirements for employment for any position.</p> <p>In an interview on 6-21-24 at 3:01 p.m., with the Administrator, she clarified if there is not a specific policy to address a concern or issue, the facility is to follow State Regulations.</p> <p>This Residential tag relates to Complaint IN00431968.</p> <p>2.5-1.4(a)</p> <p>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.</p> <p>Based on interview and record review, the facility failed to verify the licensure/certification of a prospective employee for the position of a QMA, prior to beginning employment. (QMA 3)</p> <p>Findings include:</p>	R 0118	Continuous education as needed for current and new staff. Licensures will be checked by two members of management prior to orientation. The Executive Director and Director of Nursing, or other member of management, will routinely check licensures and	07/12/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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
	<p>In an interview with the Administrator on 6-21-24 at 9:50 a.m., she indicated at the time of Qualified Medication Aide (QMA) 3's hiring, the former Director of Nursing (DON) was not aware the State of Indiana does not allow a QMA to work without a current Indiana certification as a QMA and QMA 3 was hired by the former DON and worked for nearly a month prior to the Administrator becoming aware of the lack of licensure/certification. The Administrator indicated QMA 3 repeatedly told the DON she would bring in a copy of her Florida QMA license and never brought in the QMA license. "I got involved after the DON told me she (QMA 3) still had not brought her license in. I told her that if we did not have a copy of the license, I was taking her off the schedule and I did." The Administrator added she has since discovered, via the Indiana Professional Licensing Agency (PLA), that QMA 3 had a current Certified Nurse's Aide (CNA) license in Indiana, which was issued after QMA 3's employment at the facility.</p> <p>In another interview with the Administrator on 6-21-24 at 10:24 a.m., she further explained at the time of hire, she [the Administrator] was under the impression the former DON at the time had already received the Florida license and the DON was told by QMA 3 that she was actively working on gaining her Indiana licensure.</p> <p>A review of QMA 3's employment record indicated the following information:</p> <ul style="list-style-type: none"> -QMA 3 was hired on 1-23-24. -No type of health-related licensure or certification was located in her record. -A copy of QMA 3's job description as a "Care/Medication Technician," indicated under, "Qualifications," this position a "Certified Nurse's Aide certification preferred." This job description 		continue to reeducate the staff regarding medication management.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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
	<p>was signed by the Administrator on 2-1-24, but QMA 3 did not sign this document.</p> <p>-An undated resume for QMA 3, indicated she held a CNA license, but did not include an expiration date, and a "Certified Medication Aide [effective] January 2020 to May 2025."</p> <p>-A "Counseling Documentation Form," dated 2-26-24 for QMA 3, indicated, "Employee lied to employer. Worked as a QMA, unlicensed, practicing outside her scope of practice. Failed Introductory Period." A handwritten note, signed by the Administrator, added, "Termed [terminated] via voice mail and letter." An associated document, entitled, "Reportable Work Sheet," undated, indicated QMA 3, "Staff member practiced under a non-Indiana QMA license...Termed employee."</p> <p>-Payroll information indicated QMA 3, had 10, hours of training over two days, then had 109.99 hours of working with residents over 10, days, prior to her termination on 2-26-24.</p> <p>In a phone interview with the Indiana Department of Health's Nurse Aide Investigation on 6-21-24 at 10:52 a.m., she indicated she was currently investigating the circumstances of an unlicensed personnel, QMA 3, at this facility. She indicated her department has been able to locate a possible CNA license, but no QMA/QMAP license in Florida at this time, but the investigation remains active.</p> <p>On 6-21-24 at 2:10 p.m., the Administrator provided a copy of an undated document entitled, "Hiring and Orientation Policies." This document indicated, "Personnel File Policy. The company will keep an accurate, complete and confidential employment record for each Team Member. Employment records shall be kept for at least five years from the date of the Team Member's</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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 0241 Bldg. 00	<p>termination." This policy did not address the issue of current licensure or certification requirements for any position.</p> <p>In an interview on 6-21-24 at 3:01 p.m., with the Administrator, she clarified if there is not a specific policy to address a concern or issue, the facility is to follow State Regulations.</p> <p>This Residential tag relates to Complaint IN00431968.</p> <p>2.5-1.4(c)</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(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:</p> <p>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on interview and record review, the facility failed to ensure medication administration was only provided by state-licensed QMA's. (QMA 3)</p> <p>Findings include:</p> <p>In an interview with the Administrator on 6-21-24 at 9:50 a.m., she indicated at the time of Qualified Medication Aide (QMA) 3's hiring, the former Director of Nursing (DON) was not aware the State of Indiana does not allow a QMA to work without a current Indiana certification as a QMA and QMA 3 was hired by the former DON and worked for nearly a month prior to the Administrator becoming aware of the lack of</p>	R 0241	<p>what corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Reeducation will be provided to the nursing staff regarding all policies and procedures that reflect this tag. Licensures will be checked by two members of management prior to orientation.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficiency practice and what corrective action will be</p>	07/31/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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
	<p>licensure/certification. The Administrator indicated QMA 3 repeatedly told the DON she would bring in a copy of her Florida QMA license and never brought in the QMA license. "I got involved after the DON told me she (QMA 3) still had not brought her license in. I told her that if we did not have a copy of the license, I was taking her off the schedule and I did." The Administrator added she has since discovered, via the Indiana Professional Licensing Agency (PLA), that QMA 3 had a current CNA license in Indiana, which was issued after QMA 3's employment at the facility.</p> <p>In another interview with the Administrator on 6-21-24 at 10:24 a.m., she further explained at the time of hire, she [the Administrator] was under the impression the former DON at the time had already received the Florida license and the DON was told by QMA 3 that she was actively working on gaining her Indiana licensure.</p> <p>A review of QMA 3's employment record indicated the following information:</p> <ul style="list-style-type: none"> -QMA 3 was hired on 1-23-24. -No type of health-related licensure or certification was located in her record. -A copy of QMA 3's job description as a "Care/Medication Technician," indicated under, "Qualifications," this position a "Certified Nurse's Aide certification preferred." This job description was signed by the Administrator on 2-1-24, but QMA 3 did not sign this document. -An undated resume for QMA 3, indicated she held a CNA license, but did not include an expiration date, and a "Certified Medication Aide [effective] January 2020 to May 2025." -A "Counseling Documentation Form," dated 2-26-24 for QMA 3, indicated, "Employee lied to employer. Worked as a QMA, unlicensed, 		<p>taken? Continuous education as needed for current and new staff. Licensures will be checked by two members of management prior to orientation.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The facility will reeducate the nursing staff regarding the policies and procedures of medication administration.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Executive Director and Director of Nursing, or other member of management, will routinely check licensures and continue to reeducate the staff regarding medication management.</p> <p>By what date the systemic changes will be completed. 7/31/2024</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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
	<p>practicing outside her scope of practice. Failed Introductory Period." A handwritten note, signed by the Administrator, added, "Termed [terminated] via voice mail and letter." An associated document, entitled, "Reportable Work Sheet," undated, indicated QMA 3, "Staff member practiced under a non-Indiana QMA license...Termed employee."</p> <p>-Payroll information indicated QMA 3, had 10 hours of training over two days, then had 109.99 hours of working with residents over 10 days, prior to her termination on 2-26-24.</p> <p>In a phone interview with the Indiana Department of Health's Nurse Aide Investigation on 6-21-24 at 10:52 a.m., she indicated she was currently investigating the circumstances of an unlicensed personnel, QMA 3, at this facility. She indicated her department has been able to locate a possible CNA license, but no QMA/QMAP license in Florida at this time, but the investigation remains active.</p> <p>On 6-21-24 at 2:10 p.m., the Administrator provided a copy of an undated document entitled, "Hiring and Orientation Policies." This document indicated, "Personnel File Policy. The company will keep an accurate, complete and confidential employment record for each Team Member. Employment records shall be kept for at least five years from the date of the Team Member's termination." This policy did not address the issue of current licensure or certification requirements for employment for any position.</p> <p>On 6-21-24 at 2:10 p.m., the Administrator provided a copy of a policy entitled, "Medication Administration Policy," with an effective date of 7-1-23. This indicated, "Medication and treatments are administered to residents as</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER WALKER PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 2216 N RILEY HWY SHELBYVILLE, IN 46176		
(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
	<p>determined by review of their medication status, and in accordance with physician order, state laws. and assisted living regulations...Medications and treatments are only administered by personnel who are legally authorized to do so, such as: Licensed nurses; Employees who have received appropriate state training; Employees who have completed LakeHouse medication training and delegation...Prohibition on Passing Medication. LakeHouse employees who have not been trained or competency tested may not pass medication. Medication administration competencies will be reviewed quarterly by the Care Services Manager or Delegating RN."</p> <p>In an interview on 6-21-24 at 3:01 p.m., with the Administrator, she clarified if there is not a specific policy to address a concern or issue, the facility is to follow State Regulations.</p> <p>This Residential tag relates to Complaint IN00431968.</p> <p>2.5-4(e)(1)</p>			