STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND EMERALD PLACE	4010 S IRONWOOD DR SOUTH BEND, IN 46614

(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 a State Residential Licensure Survey. This visit included the Investigation of Complaint #IN00189043. Complaint #IN00189043 - Substantiated. State deficiencies related to the allegations are cited at R064. Survey dates: December 21 & 22, 2015 Facility number: 013555 Provider number: 013555 AIM number: N/A Residential census: 16 Sample: 10 These State findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed by 14454 on December 28, 2015.	R 0000		
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The			

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 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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	administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure 1 of 5 investigations reviewed regarding allegations of lost or stolen property were reported. (Resident #B) Findings include: On 12-21-15 at 11:00 A.M., the investigation file for Resident #B was reviewed. The investigation included an allegation of 10 towels, an electric blanket and one can of fabreeze air freshener were missing from her apartment. On 12-22-15 at 1:20 P.M., an interview with the ED (Executive Director), indicated he did not report the missing items to the State Agency. The ED indicated he did not know why he did not file a report. On 12-22-15 at 2:00 P.M., the current policy entitled Abuse, Neglect And Exploitation, dated 7-01-14, provided by the ED on 12-21-15, at 11:40 A.M., was reviewed. The policy indicated, "...It is the policy of Enlivant to report to the appropriate authorities, including	R 0064	1. The Executive Director was in-serviced on 1/6/16 by the Regional Director of Care Services on the reporting requirements for Abuse/Neglect/Exploitation. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Current Staff educated on Abuse/Neglect/Exploitation and Resident Rights, on 1/8/16 by Jim May, Executive Director. The Ombudsman spoke to residents on 12/21/15 on how to safeguard their possessions. . 4. The Executive Director is responsible for sustained compliance. Allegations of Abuse/Neglect/Exploitation will be reported to appropriate authorities within 24 hours as required. State reportable events will be discussed in monthly QA meetings. Monitoring will be ongoing. 5. Completion date: 1/22/16.	01/22/2016

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	licensing agencies and law enforcement of the suspicion or allegations of abuse, neglect or exploitation within 24 hours. The report will be made by the Executive Director or designee...." This Residential tag relates to Complaint IN00189043.			
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to maintain complete employee records, related to general	R 0123	1. Employees7 and 8 – completed General Orientation on 12/22/15, which includes training on abuse. 2. Current	01/22/2016

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	orientation, job specific orientation and abuse training, for 2 of 10 employee records reviewed. (Employee #7 and Employee #8) Findings include: On 12-22-15 at 1:50 P.M., review of the employee records for Employee #7 and Employee #8 indicated the "General Orientation Record" form was only partially filled out and lacked completion signatures, by the ED (Executive Director), indicating they were done. Employee #7 and Employee #8's files were also missing documentation of abuse training. During an interview on 12-22-15 at 2:00 P.M., Employee #2 indicated "...general orientation forms are signed by myself or the ED...all employees need to have abuse training...." On 12-22-15 at 2:10 P.M., review of the current policy titled " General Orientation Record," provided by the concierge, who indicated this was the current policy indicated "...Instructions for completing the training record...The trainer and the new employee should initial each item listed...The trainer for each topic and the new employee should sign in the space indicated for each section...Upon		residents have the potential to be affected by the alleged deficient practice. 3. The Executive Director and the Care Services Manager were in-serviced on 1/6/16 by the Director of Care Services on completing general orientation, including required in-services, dates and signatures by employees and trainers. 4. The Executive Director is responsible for sustained compliance. The ED and/or designee will review new hire paperwork within 7 days of beginning orientationto ensure orientation requirements are met. New hire orientation review will be discussed in monthly QA meetings. The QA committee will determine if continued discussion in QA meetings is necessary after 3 consecutive months of full compliance. Monitoring and review of new hire paperwork will be ongoing. 5. Completion date: 1/22/16.	

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	completion of the orientation the staff member should sign the document, acknowledging the completion of training... The Executive Director should also sign the completed form...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to serve food in a sanitary manner, related to properly wearing hairnets. This had the potential to affect 16 of 16 residents that received meals from the kitchen. Findings include: On 12-21-15, between 12:00 P.M. and 12:20 P.M., during the lunch service, in the main dining room, the following was observed: At 12:08 P.M., Employee #6 was observed with her bangs hanging out of her hairnet, she entered the kitchen, retrieved a lunch plate and served it to a resident in the dinning room.	R 0273	1. Employees 4 and 6 – were in-serviced on 12/22/15 by Jim May, Executive Director, on the correct way to wear a hair net. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Staff were in-serviced on 12/22/15 by Jim May, Executive Director, on the proper way to wear hair nets when in foodprep areas. 4. The Chef is responsible for sustained compliance. The Executive Director and/or designee will randomly check for proper hair net wear 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks. The results will be discussed in the monthly QA meetings. The QA Committee will determine if continued random checks will be necessary based on three consecutive months of full	01/22/2016

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	At 12:11 P.M., Employee #4 was observed with her bangs hanging out of her hairnet, she entered the kitchen, retrieved a lunch plate and served it to a resident. At 12:13 P.M., Employee #6 was observed with her bangs hanging out of her hairnet, she entered the kitchen, retrieved a lunch plate and served it to a resident in the dinning room. At 12:15 P.M., Employee #4 was observed with her bangs hanging out of her hairnet, she entered the kitchen, retrieved a lunch plate and served it to a resident. During an interview on 12-22-15 at 2:00 P.M., the Executive Director indicated "... hair nets should be worn covering all hair, including bangs, when in the kitchen..." On 12-22-15 at 2:23 P.M., review of the current policy titled "Infection Control and DNS Dress Code," dated 7/01/2014, provided by the concierge indicated"...Hair nets... that cover all hair must be worn in the food preparation area [kitchen]...."		compliance. 5. Completion date: 1/22/16.	