

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER TANGLEWOOD TRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 530 W TANGLEWOOD LN, MISHAWAKA, , 46545			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00409743. Complaint IN00409743- No deficiencies related to the allegations are cited. Survey dates: August 2 and 3, 2023 Facility number: 009669 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 8/9/2023.	R 0000			

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R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, record review and interview, the facility failed to ensure hot water temperatures were maintained at a safe level on 3 of 3 halls. (Rooms 425, 521, 602 and 622) Finding includes: During an environmental tour of the facility, conducted on 8/2/2023 from 10:40 A.M. -	R 0148	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice. The thermostat temperature control on each of the water heaters and water mixing valves were turned down immediately in affected rooms to correct temperature. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director tested the water temperature in every resident room on 8/10/23.	08/25/2023
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	11:50 A.M., the following hot water temperatures were noted from resident bathroom faucets: Room 425 - 124.3 degrees Fahrenheit Room 521 - 120.4 degrees Fahrenheit Room 602 - 121.6 degrees Fahrenheit Room 622 - 120.4 degrees Fahrenheit During an interview with the Maintenance Supervisor during the environmental tour, he indicated there was a hot water heater for each hallway. Employee 5 was unsure if there were mixing valves on the hot water heaters and thought anywhere around 120 degrees Fahrenheit was acceptable for hot water temperatures. Observation of the hot water heater mixing valve thermostats indicated two of the three were set to 120 degrees Fahrenheit and the third mixing valve thermostat for the 600 hall was set between 123 - 124 degrees Fahrenheit.		3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Director of Maintenance was in-serviced on hot water policy on 8/16/23. He will monitor water heaters and mixing valves weekly. 4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The Director of Maintenance will complete a weekly water temperature check, identified areas of concern will be corrected immediately. Four rooms per hallway will be checked weekly for 3 months until all temperatures are consistently in the acceptable temperature range. The Administrator or his/her designee will report quarterly to the Quality Assurance (QA) committee	
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the ongoing results of audits.

5 What date the systematic changes will be completed.

8/25/23

Review of the maintenance temperature log record for July 2023 indicated there were two occasions where the routine temperature hot water assessments were over 120 degrees.

The facility policy and procedure, regarding hot water temperatures, titled, "Tels Master" included the following instructions: "...Ensure patient room water temperature are between 105 % - 115 % Fahrenheit (or as specified by state requirements) " The policy indicated Indiana's requirements were 100 - 120 degrees Fahrenheit.

Based on observation, record review and interview, the facility failed to ensure hot water temperatures were maintained at a safe level on 3 of 3 halls. (Rooms 425, 521, 602 and 622)

Finding includes:

During an environmental tour of the facility, conducted on 8/2/2023 from 10:40 A.M. - 11:50 A.M., the following hot water temperatures were noted from resident bathroom faucets:

Room 425 - 124.3 degrees Fahrenheit

Room 521 - 120.4 degrees Fahrenheit

Room 602 - 121.6 degrees

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Fahrenheit

Room 622 - 120.4 degrees
Fahrenheit

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Maintenance Supervisor during
the environmental tour, he
indicated there was a hot water
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Employee 5 was unsure if there
were mixing valves on the hot
water heaters and thought
anywhere around 120 degrees
Fahrenheit was acceptable for
hot water temperatures.

Observation of the hot water
heater mixing valve thermostats
indicated two of the three were
set to 120 degrees Fahrenheit
and the third mixing valve
thermostat for the 600 hall was
set between 123 - 124 degrees
Fahrenheit.

Review of the maintenance
temperature log record for July
2023 indicated there were two
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The facility policy and
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	were 100 - 120 degrees Fahrenheit.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation	R 0217	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice. Care plan was updated for affected resident on 8/3/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. Director of Nursing will review assessments and care plans for all residents to ensure compliance. 3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not	08/25/2023

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indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on interview and record review, the facility failed to ensure a service plan was completed for 1 out of 7 clinical records reviewed. (Resident D)

Finding includes:

The record for Resident D was reviewed on 8/2/2023 at 11:00 A.M. The diagnoses included, but were not limited to: type 2 diabetes mellitus, hypertension, major depressive disorder, and Alzheimer's.

During an interview on 8/3/2023 at 9:33 A.M., the Director of Nursing indicated that Resident D did not have a service plan and she should have had one completed.

On 8/3/2023 at 10:48 A.M., the Administrator provided a policy titled, "Assistance/Service Plan", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...2. The Resident Services Coordinator and Resident Assistant will visit with resident and family to complete

recur.

The Director of Nursing was in-service on assessment and care plans policy on 8/16/23. She will be monitoring due date for the next assessments and care plans for all residents in Point Click Care.

4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.

The Director of Nursing will complete a weekly audit of assessments and care plans. Identified areas of concern will be corrected immediately. Audits will be completed weekly for 4 weeks, then monthly for 3 months to ensure compliance.

The Administrator or his/her designee will report quarterly to the Quality Assurance (QA) committee the ongoing results of audits.

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the plan...."

Based on interview and record review, the facility failed to ensure a service plan was completed for 1 out of 7 clinical records reviewed. (Resident D)

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On 8/3/2023 at 10:48 A.M., the Administrator provided a policy titled, "Assistance/Service Plan", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...2. The Resident Services Coordinator and Resident Assistant will visit with resident and family to complete the plan...."

5 What date the systematic changes will be completed.

All alleged deficiencies will be corrected by 8/25/ 2023.

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FORM APPROVED

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OMB NO. 0938-0391

R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (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, record review and interview, the facility failed to ensure 1 of 1 kitchens was maintained in a sanitary manner and failed to ensure there was an adequate air gap between the ice machine drainage pipe and the floor drain. This deficient practice potentially affected 67 of 67 residents in the facility. Findings include: During the kitchen sanitation tour, conducted on 8/2/2023 between 9:30 A.M. - 10:15 A.M., the following was observed: The top of the double stacked convection ovens had a dark gray layer of dust and grime . An open shelf, beside the grill, utilized to store large rectangular shaped pans was splattered with food particles and dust. The paint on the floor between the baking storage closet and the baking prep area was	R 0273	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice. The air gap for the ice machine tubing was corrected immediately on 8/2/23. The top convection ovens and wall behind and underneath the spice rack was cleaned immediately on 8/2/23. The paint floor crack was repaired on 8/14/23. The floor drain grate will be replaced and open shelving will be repaired by the Maintenance on 8/25/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. The entire kitchen was inspected for cleanliness and repairs. The affected areas were cleaned and repairs scheduled to complete by the Maintenance	08/25/2023
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cracked and chipped with missing paint.

The drainage pipe underneath the ice machine was resting on the floor drain. The floor drain grate was coated with a heavy accumulation of rusty brown colored build up.

The wall behind and underneath the spice rack was noted to have a heavy accumulation of a greasy orange substance.

The open shelving underneath the food prep counter, across from the stove, had peeling shelf paper and an accumulation of grime and black build up around the edges of the surface. The shelving was utilized to store clean food preparatory items and dishes.

During an interview with the Food Service Supervisor, on 8/2/2023 at 10:00 A.M., she indicated the maintenance staff had repaired the ice machine drainage pipe immediately. She also confirmed the facility utilized the large pans on the open shelf beside the grill area.

Review of the facility policy and procedure, titled, "Cleaning" included the following procedures: "...3. All food surfaces will be cleaned at the end of each food preparation session...8. Wall surfaces that become splattered during the food preparation process must

Director.

3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

The Director of Food Services and kitchen staff was in-serviced on kitchen sanitation policy and cleaning on 8/14/23. Employees cleaning check list will be reviewed weekly by The Director of Food Service.

4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.

The Food Services Director will complete a weekly audit of kitchen areas utilizing the dietary checklist. Identified areas of concern will be corrected immediately. Audits will be completed weekly for 4 weeks, then monthly for 3 months to ensure compliance.

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be cleaned daily...."

Based on observation, record review and interview, the facility failed to ensure 1 of 1 kitchens was maintained in a sanitary manner and failed to ensure there was an adequate air gap between the ice machine drainage pipe and the floor drain. This deficient practice potentially affected 67 of 67 residents in the facility.

Findings include:

During the kitchen sanitation tour, conducted on 8/2/2023 between 9:30 A.M. - 10:15 A.M., the following was observed:

The top of the double stacked convection ovens had a dark gray layer of dust and grime .

An open shelf, beside the grill, utilized to store large rectangular shaped pans was splattered with food particles and dust.

The paint on the floor between the baking storage closet and the baking prep area was cracked and chipped with missing paint.

The drainage pipe underneath the ice machine was resting on the floor drain. The floor drain grate was coated with a heavy accumulation of rusty brown colored build up.

The Administrator or his/her designee will report quarterly to the Quality Assurance (QA) committee the ongoing results of audits.

5 What date the systematic changes will be completed.

All alleged deficiencies will be corrected by 8/25/23.

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The wall behind and underneath the spice rack was noted to have a heavy accumulation of a greasy orange substance.

The open shelving underneath the food prep counter, across from the stove, had peeling shelf paper and an accumulation of grime and black build up around the edges of the surface. The shelving was utilized to store clean food preparatory items and dishes.

During an interview with the Food Service Supervisor, on 8/2/2023 at 10:00 A.M., she indicated the maintenance staff had repaired the ice machine drainage pipe immediately. She also confirmed the facility utilized the large pans on the open shelf beside the grill area.

Review of the facility policy and procedure, titled, "Cleaning" included the following procedures: "...3. All food surfaces will be cleaned at the end of each food preparation session...8. Wall surfaces that become splattered during the food preparation process must be cleaned daily...."

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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