STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/07/2026

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

(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 Intake 468927. Intake 468927 - State deficiencies related to the allegations are cited at R0149. Survey dates: 7/2-7/7/2026 Facility number: 013555 Residential Census: 42 These State Residential Findings are cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-5. Quality Review completed on 7/16/2026	R 0000		
R 0149	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(f) (f) The facility shall have a pest	R 0149	**1. Corrective Action for Resident Affected** Facility wide inspection of	08/15/2026

	control program in operation in compliance with 410 IAC 7-24. Based on interview and record review, the facility failed to maintain an effect pest control program related to treating an identified pest problem for 1 of 4 residents who were reviewed. (Resident B) Finding includes: During an interview, on 7/6/2026 at 1:25 P.M., Resident B indicated she had been having issues with bed bugs since March 23, 2026, and that the facility had had a pest control company treat her old room (room 215). Resident B indicated the facility had moved her to a new room (Room 221) so Room 215 could be treated. However, the new room the facility provided, Room 221, had bed bugs as well and the resident was moved to Room 218. Resident B indicated she had seen live bed bugs in her current room (room 218) as recently as 7/6/2026. A review of Resident B's record was completed, on 7/6/2026 at 2:10 P.M. Resident B originally resided in room 215 and was moved to 221 and then to 218 related to bed bugs and bed bug treatments. A review of the facility's pest		apartments for current signs of bed bug activity were completed and Licensed Vendor was notified promptly of need for treatment in affected room/s. **2. Identification of Other Residents with Potential to Be Affected** The Executive Director and Maintenance Director reviewed reports of suspected bed bug activity to verify that residents with reported concerns had been referred to the contracted pest control provider. Any additional concerns identified were addressed according to the facility's existing pest control process. * The Maintenance Director will tour any apartment wih suspected activity promptly and start the treatment plan as agreed upon with ecolab and notify ecolab to schedule visit. **3. Measures Implemented to Prevent Recurrence** The Executive Director, Maintenance Director, nursing staff, and housekeeping staff	

	control invoices was completed, on 7/6/2026 at 2:30 P.M. A local pest control company treated room 215 on the following dates: -On 4/13/2026, chemical sprays were used and low bed bud activity was observed. -On 5/11/2026, chemical sprays were used and low bed bud activity was observed. -On 5/22/2026, chemical sprays were used and no bed bud activity was observed. -On 6/24/2026, chemical sprays were used and no bed bud activity was observed. A local pest control company treated room 221 on the following dates: -On 4/2/2026, chemical insecticide sprays were used to treat two chairs, wheelchair, mattress, box spring, bedframe and baseboards. The pest control company recommended another treatment in two weeks. -On 4/13/2026, no live bed bug activity observed and the room had been treated with chemical insecticides.		will be re-educated on 7/29/2026 by Corporate RN on the facility's existing bed bug response process, emphasizing: • Prompt reporting of suspected bed bug activity. • Timely notification of the contracted licensed pest control provider. • Documentation of identified concerns, vendor notification, and treatment. • Coordination with the pest control provider until treatment is completed. • Resident education will be provided by the Maint. Director and Executive Director (Town Hall) on 7/31;we will review the policy and educate the residents on our plan going forward. 4. The Executive Director and/or Maintenance Director will monitor 10 random apartments weekly for 6 weeks and monthly thereafter for signs of bed bug activity. If activity is noted Licensed Pest Control will be notified for treatment promptly. Quarter in QA meeting the bed	

	-On 5/11/2026, low bed bug activity was observed and the room had been treated with chemical insecticides. -On 5/22/2026, no bed bud activity was located the room had been treated with chemical insecticides. -On 5/26/2026, no bed bud activity was located the room had been treated with chemical insecticides. A local pest control company treated room 218 on the following dates: -On 4/13/2026, inspected with no bed bug activity observed and no treatments had been used. -On 5/22/2026, inspected with no bed bug activity observed and no treatments had been used. The local pest control company's invoices lacked the documentation that Resident B's original room, Room 215 had been treated prior to 4/13/2026. During an interview, on 7/6/2026 at 2:30 P.M., the Executive Director (ED) indicated the facility had used a local pest control company to treat for bed bugs. The ED indicated the the facility had not been heat treating rooms or resident's		bug activity report will be reviewed and suggestions will be implemented promptly by maintenance director or designee. Date Certain: 8/15/2026	

	belongings after bed bugs were observed. The ED indicated the facility had invested in a heat box to treat resident's personal items and furniture but the heat box damaged almost all of the resident's furniture and the facility decided to stop using the heat box. A policy, dated 8/2025 was provided by the ED, on 7/6/2026 at 4:32 P.M. The policy titled,"Bed Bug Policy". The ED identified the policy as the one currently used by the facility. The policy indicated, "...4. The ED is responsible for notifying the Maintenance director as soon as possible for direction so professional pest control vendor resources can be accessed to direct, manage, and treat the infestation...7. And should follow the steps below when suspecting a bed bug infestation... b. Follow the professional pest control vendor instruction, community's Bed Bug Protocol. c. Monitor for bed bugs daily or as otherwise directed...." This citation relates to intake IN00468927.			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all	R 0154	1. Corrective Action for the Area Affected (Facility-Wide, 42 of 42 Residents) Conventional oven, convection	08/15/2026

	kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to keep kitchen equipment clean, stored dishware appropriately and sanitize dishware and surfaces with appropriate concentration of sanitation solution for 42 of 42 residents residing at the facility. Finding includes: During an initial tour of the kitchen, on 7/2/2026 from 8:30 A.M. through 9:05 A.M., the following was observed: -There was a brown substance adhered to the side and front of the conventional oven, the doors of the convection oven, the hood ventilator and the flattop/range top. -Dinnerware that included plates and bowls next to the serving table were not inverted. Bowls stored on a shelf were not inverted. -A bucket for surface sanitation was on a stainless-steel prep counter. A test strip to determine sanitation concentration was dipped into the bucket by the Interim Dietary		oven doors, hood ventilator, and flattop/range top were degreased and cleaned same day. All dinnerware (plates, bowls) was re-stored inverted per proper practice. Sanitizer bucket and three-bin sink solution were re-tested and refilled to the correct concentration (minimum 200 ppm). The high-temperature dishwasher's temperature booster will be repaired/serviced; the three-bin sink is being used correctly (60-second submersion) as a validated interim method while the dishwasher is confirmed operational. A sanitizer line was attached to the dishwasher by ino-serve on July 7, 2026 to ensure that the dishwasher is sanitized with or without a temperature booster in place. 2. Identification of Other Areas/Residents with Potential to Be Affected Because this deficiency is facility-wide (kitchen serves all 42 residents), the corrective actions above apply to the entire kitchen operation rather than an individual resident population. Dietary Manager conducted a	

	Manager. The test strip did not change color indicating the sanitation concentration was zero. During an observation, on 7/2/2026 at 9:42 A.M., the three-bin sink was in use for washing, rinsing and sanitation dishes and kitchen equipment because the temperature booster for the high temperature dishwasher was not working. A test strip to determine sanitation concentration was dipped into the third sink bin with plates and cups in the bin. The test strip did not change color indicating the sanitation concentration was zero. The Interim Dietary Manager checked the automated sanitation solution jug attached to the third sink bin and the jug was empty. During an interview, on 7/2/2026 at 8:57 A.M., the Interim Dietary Manager indicated the kitchen had a cleaning schedule and the equipment should not have had grease splatter or build-up on them. She indicated the dinnerware should have been stored inverted and the sanitation strip should have changed colors to indicate a concentration of at least 200 (the strips test for concentration between 0 to 500 parts per million) for the buckets of water used for hard surface sanitation.		full walk-through of sanitizing stations (dishwasher and three-bin sink) the same day to confirm no other equipment had a sanitation-concentration failure. 3. Systemic Measures The Kitchen staff was re-educated on the use of the cleaning schedule and on use and reading of sanitation by the interim Dietary Manager on 7/8/2026. Retrained dietary staff on three-bin sink procedure, minimum 200 ppm sanitizer concentration, and use of test strips at the required minimum frequency (every 4 hours or between food items) on 7/8/2026 by Interim Dietary manager. 4. Monitoring Process Dietary Manager will test and log sanitizer concentration at each meal service (3x daily) for 30 days, then daily ongoing.	

	A policy was provided by the Executive Director, on 7/6/2026 at 4:32 P.M. The policy titled, "Cleaning", indicated, " ...All equipment, food contact surfaces, and utensils shall be cleaned:..d. Whenever contamination may have occurred ...4. Grid panels in the fire suppression hood over the stove will be removed and run through the dish machine once a month ...." A policy for proper storage of dinnerware was requested on 7/6/2026 at 3:32 P.M., but a policy was not provided. A policy was provided by the Executive Director, on 7/6/2026 at 4:32 P.M. The policy titled, "Cleaning and Sanitation", indicated, " ...To provide information needed to practice good cleaning and sanitizing methods in the workplace to help prevent foodborne illness outbreaks ...Cleaning & Sanitizing In a Three-Compartment Sink ...Submerge items in the third sink with sanitizer for a minimum of 60 seconds ...When to Clean/Sanitize Anything that comes in contact with food must be washed, rinsed, and sanitized -After each use -Between different food items -Often! Minimum of every 4 hours if in constant use. Important Considerations When		Executive Director or designee will conduct random kitchen equipment cleanliness audits twice weekly for 4 weeks, then weekly for 8 weeks.Results reported to the QA quarterly and suggestions will be implemented by Dietary manager promptly. Daily santitizer concentration checks will be ongoing. Date Certain: August 15, 2026	

	Sanitizing -Is the solution at the proper concentration [Use a test kit or test strips to determine concentration.] ...."			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to follow a physician order with parameters for 1 of 7 residents reviewed for medication administration. (Resident 7) Finding includes: A record review was completed for Resident 7, on 7/6/2026 at 9:48 A.M. Diagnoses included, but were not limited to: dialysis dependent, end stage renal disease and peripheral vascular disease.	R 0243	1. Corrective Action for Resident(s) Affected Resident 7's physician will be notified 7/21/2026 of the administration despite hold parameters being met, for review and any new orders or clarification. Resident 7 will be clinically assessed for any adverse effects related to Midodrine administration at elevated blood pressure. Resident 7's MAR/care plan updated to display the hold parameters clearly at the point of administration. 2. Identification of Other Residents with Potential to Be Affected DON/designee will audit current residents with parameter-based ("hold for") medication orders — e.g., blood pressure, heart rate, or blood glucose parameters — to confirm each MAR accurately reflects the physician's hold criteria and that recent administrations were compliant.	08/15/2026

	A Service Plan, dated 3/11/2026 and 4/15/2026, indicated Resident 7 required medication assistance with administration. A Physician's Order, dated 3/11/2026, indicated Midodrine (a medicaiton to treat low blood pressure) 5 milligrams three times daily and hold for a systolic blood pressure greater than 130-140 mmHg (millimeters of mercury) or a diastolic blood pressure greater than 90-100 mmHg. The May 2026 Medication Administration Record indicated the Midodrine had been administered with the following blood pressure readings: -5/21/2026 5:00 P.M. 142/84 mmHg -5/22/2026 5:00 P.M. 138/68mmHg -5/23/2026 5:00 P.M. 137/80 mmHg -5/25/2026 12:00 P.M. 145/67 mmHg -5/27/2026 5:00 P.M. 139/83 -5/28/2026 5:00 P.M. 142/82 mmHg -5/30/2026 8:00 A.M. 132/69 mmHg The June 2026 Medication		Any additional discrepancies identified will be reported to the attending physician and addressed individually. 3. Systemic Measures Educate licensed nursing staff (RNs/LPNs) and QMAs on parameter-based medication administration, hold criteria, and the requirement to document the decision and notify the physician when a dose is held. Education will be provided by the DON by date certain. 4. Monitoring Process DON/designee will audit MARs for residents with hold-parameter orders weekly for 4 weeks, then monthly for 6 months, verifying vital signs were obtained and parameters followed prior to administration. Results reported to the QA committee quarterly and suggestions will be implemented promptly. Date Certain: August 15, 2026	

	Administration Record indicated the Midodrine had been administered with the following blood pressure readings: -6/3/2026 5:00 P.M. 138/64 mmHg -6/8/2026 5:00 P.M. 143/67 mmHg -6/10/2026 5:00 P.M. 132/82 mmHg -6/11/2026 5:00 P.M. 145/74 mmHg -6/12/2026 8:00 A.M. 140/80 mmHg -6/12/2026 5:00 P.M. 138/83 mmHg -6/15/2026 5:00 P.M. 142/78 mmHg -6/17/2026 5:00 P.M. 132/78 mmHg -6/18/2026 5:00 P.M. 145/78 mmHg 6/20/2026 5:00 P.M. 132/78 mmHg During an interview, on 7/6/2026 at 1:39 P.M., LPN 2 indicated that the Midodrine should have been held according to the physician's order for a systolic blood pressure greater than 130 mmHg or a diastolic blood pressure greater than 90			

	mmHg. A policy for following physician orders was requested on 7/6/2026 at 3:32 P.M. The policy provided and titled, "Physician Orders for Medications", did not address the administration of medication per physician order.			
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 and interview, the facility failed to store food in a sanitary manner related to properly labeling food with opened on dates and disposing outdated food in the kitchen. This had the possibility to affect 42 of 42 residents who received their meals from the facility's kitchen. Finding includes: During an initial tour of the kitchen, on 7/2/2026 from 8:30 A.M. through 9:05 A.M., the following was observed: -A spice shelf had the following	R 0273	1. Corrective Action for the Area Affected (Facility-Wide, 42 of 42 Residents) Identified unlabeled spices were dated/labeled the same day the deficiency was identified. All identified outdated items (leaf basil, cilantro, ground basil, ground nutmeg, ground white pepper, nacho cheese sauce, granola, and cereal containers) were discarded immediately. Walk-in refrigerator, dry storage, and kitchen shelving were inspected facility-wide the same day for any additional undated or expired items, which were corrected on the spot. 2. Identification of Other Areas with Potential to Be Affected	08/15/2026

	spices without open dates on the bottles, kosher salt 3 pounds, parsley flakes 11 ounces, granulated garlic 1.5 pounds, rainbow sprinkles 24 ounces, ground rosemary 9 ounces, all purpose herb seasoning 13 ounces, ground ginger 16 ounces, Spanish paprika 16 ounces, crushed red pepper 12 ounces, Lawery's seasoning salt 2.5 pounds, granulated garlic 1.25 pounds, leaf oregano, black pepper 16 ounces, Old Bay seasoning 1 pound, corn starch 1 pound, classic BBQ rub 19 ounces, baking soda 36 ounces and powdered sugar 32 ounces. - A spice shelf had the following spices with an open date and out of date use by date label, leaf basil use by 4/23/2026, cilantro use by 5/11/2026, ground basil use by 6/11/2026, ground nutmeg use by 6/11/2026, ground white pepper use by 5/9/2026 -The walk-in refrigerator had an unidentified container of an orange substance with a use by date of 6/25/2026. The Interim Dietary Manager identified the substance as nacho cheese sauce. -The dry storage had an opened bag of granola with a use by date of 6/17/2026. -A shelf in the kitchen had three		A full kitchen audit was conducted the same day across all food storage areas (walk-in refrigerator, freezer, dry storage, spice shelf, and cereal/dry-good containers) and documented on an audit log by the Interim Dietary Manager. 3. Systemic Measures / Policy Revision The Dietary staff was re-educated by the dietary manager reinforcing the existing "Labeling and Dating for Safe Storage" policy on 7/7/202 4. Monitoring Process Dietary Manager will conduct a daily date-check audit of the spice shelf, walk-in refrigerator, dry storage, and cereal containers for 30 days, then three times weekly for 60 days, documented on a log. Audits will continue monthly ongoing. Executive Director or designee will conduct random audits weekly for 8 weeks. Results reported to the QA quarterly with any suggestions being promptly followed. Audits will continue by Dietary Manager monthly ongoing. Date Certain: August 15, 2026	

	plastic cereal containers. A container of frosted flakes, Cheerios and raisin bran had a use by date of 6/15/2026. During an interview, on 7/2/2026 at 8:57 A.M., the Interim Dietary Manager indicated the spices should have been labeled with use by dates and the labeled outdated foods should have been discarded.. A policy was provided by the Executive Director, on 7/6/2026 at 4:32 P.M. The policy titled, "Labeling and Dating for Safe Storage", indicated, " ...Labeling and Dating are critical in order to promote food safety. All products should be dated upon receipt. Use "use-by-dates" on all food once opened and stored under refrigeration ...3. All food should be labeled with a received date and use-by date ...6. When food is taken out of an original container write the name of the food being stored on the container and the use by date ...9. When to throw food away a. Refrigerators do not stop the spoiling process. Leftover food can be kept for a few days ...."			
R 0382	Mental Health Screening - Noncompliance 410 IAC 16.2-5-11.1(f) (f) Each resident with a major	R 0382	1. Corrective Action for Resident(s) Affected Individualized, comprehensive care plans will be updated for	08/15/2026

	mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on record review and interview, the facility failed to develop a comprehensive care plan to address mental illness for 3 of 7 records reviewed for mental illness. (Residents 2, 4, and C) Findings include: 1. A record review was completed on 7/6/2026 at 8:26 A.M. for Resident 2. Diagnoses included, but were not limited to, major depressive disorder. A comprehensive care plan that addressed Resident 2's depression could not be found in the record. During an interview on 7/7/2026 at 10:15 A.M. the DON indicated there was not a care plan for depression but there should have been. 2. A record review was completed on 7/6/2026 at 11:10 A.M. for Resident 4. Diagnoses included, but were not limited to, schizophrenia.		Resident 2 (major depressive disorder), Resident 4 (schizophrenia), and Resident C (paranoid schizophrenia), to reflect care plan for mental health diagnosis. 2. Identification of Other Residents with Potential to Be Affected DON/designee will audit current residents with a major mental illness diagnosis or receiving mental health services to confirm each has an individualized comprehensive care plan addressing their specific diagnosis. Any resident found without an adequate plan will have one developed within the same corrective timeframe. 3. Systemic Measures Training on this requirement provided to DON by Corporate RN on 7/29/2026. 4. Monitoring Process DON/designee will audit care plans for all new admissions with a major mental illness diagnosis for completion within the required 30-day window, monthly for 3 months, then quarterly thereafter. Results reported to the QA committee with suggestions	

	A comprehensive care plan that addressed Resident 4's schizophrenia could not be found in the record. During an interview on 7/7/2026 at 11:10 A.M. indicated there was not a care plan for schizophrenia but here should have been. 3. A record review was completed, on 7/6/2026 at 8:26 A.M. for Resident C. Diagnoses included, but were not limited to: paranoid schizophrenia. Resident C's record lacked the documentation to indicate the resident had had a comprehensive care plan that addressed the resident's paranoid schizophrenia. During an interview, on 7/7/2026 at 9:05 A.M., the Director of Nursing (DON) indicated the program the facility used for their Electronic Medical Records had not allowed for care plans to be customized or altered, and all care plans were generic. The DON indicated residents who received mental health services should have had comprehensive care plans created with the assistance of the mental health provider. On 7/7/2026 at 9:00 A.M., the Executive Director provided a policy titled, "Coordination-Individualization		being implemented promptly Date Certain: August 15, 2026	

	of Service Plan". The policy provided did not address the creation of a comprehensive care plan for residents who receive mental health services.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview the facility failed to obtain an Annual Health Statement that indicated the residents were free of communicable disease for 3 of 7 residents reviewed for Annual Health Statements. (Residents 6, 8 and 2) Finding includes: 1. Resident 6's record review was completed, on 7/2/2026 at 11:00 A.M. Diagnoses included but were not limited to: hypertension, osteoporosis, depression and anxiety. Resident 6 moved into the facility on 7/23/2021.	R 0409	1. Corrective Action for Resident(s) Affected Updated Annual Health Statements will be obtained from each resident's physician for Residents 6, 8, and 2. 2. Identification of Other Residents with Potential to Be Affected DON/designee will audit current resident records to identify other Annual Health Statements that are due or overdue, and schedule physician visits/statements accordingly. 3. Systemic Measures The Director of Nursing will be educated on 7/29/2026 by the Corporate Nurse on the regulation requiring annual health statements. Newly admitted residents will have the annual health statement on their orders. Residents will have the ancillary order -I have examined and certify that the above resident is free of any communicable disease including Tuberculosis and is appropriate to reside in	08/15/2026

	The most recent Annual Health statement for Resident 6 was dated 6/3/2023. 2. Resident 8's record review was completed, on 7/2/2026 at 11:30 A.M. Diagnoses included, but were not limited to: anxiety, osteoporosis, arthritis and dementia. Resident 8 moved into the facility on 9/29/2022. The most recent Annual Health statement for Resident 8 was dated 4/25/2025. 3. A record review was completed on 7/6/2026 at 9:36 A.M. for Resident 2. An Annual Health Statement signed by the physician could not be found in the record. The most recent signed Health Statement was dated 6/3/2023. During an interview on 7/7/2026 at 10:35 A.M. the DON indicated it was the most recent Health Statement she could find and the Health Statement should have been completed yearly. On 7/7/2026 at 10:00 A.M. a policy regarding Annual Health Statements was requested from the DON but one was not provided before exiting on 7/7/2026 at 11:10 A.M.		Assisted Living." These orders will be noted by physicians every 90 days when they sign resident orders. Any new recommendations by Physician will be followed for resident. 4. Monitoring Process DON/designee will run audit Annual Health Statement status of residents and audit for compliance for 6 months, then quarterly thereafter. Results reported to the QA Committee quarterly with any suggestions being followed promptly. Date Certain: August 15, 2026	

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 SIGNATURELeigh Keirn	TITLERN Corporate Nurse	(X6) DATE07/29/2026