STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/11/2025

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 the Investigation of Complaint IN00458739. Complaint IN00458739 - State deficiencies related to the allegations are cited at R0027. Survey dates: July 10 & 11, 2025 Facility number: 013555 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 7/14/2025	R 0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency	
R 0027	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(b) (b) Residents have the right to a dignified existence, self-determination, and communication with and access to	R 0027	The Facility has the potential to be affected by the alleged deficiency. The deficiency was addressed immediately. Appointment for Resident B made on 7/11/25 with primary Physican for further assessment of self-medication for 7/22/25.The Executive Director and	08/15/2025

	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. Based on observation, interview, and record review, the facility failed to ensure a resident's rights regarding self administration of medications were honored for 1 of 3 residents reviewed for medication self administration, (Resident B). Finding includes: On 7/10/25 at 12:40 P.M., during an observation and interview, Resident B was in his apartment and appeared well-kempt,his apartment was tidy and all of his belongings were stored away appropriately and no items were out of place. During the interview,Resident B indicated he had been a resident of the facility since 12/23/24 and before his admission to the facility, he had been responsible for taking his own medications and had never had any difficulty doing so. The resident indicated he had provided two letters from his physicians that indicated he was capable of self-administrating his medications but the facility had not allowed him to do so. Resident B indicate he wanted to take his medications		Director of Nursing will be in- by OPS Nurse Consultant on 07/13/25. The Executive Director and Director of Nursing are responsible for resident rights being upheld within the community. Residents of community will be reviewed for potential need to address the right to by the 8/6/25 Ongoing monitoring will be of DON/ED or . Results of monitoring will be reported in quarterly quality meeting with recommendations followed immediately. Monitoring will continue for 6 months with quality assurance committee documenting whether monitoring can be stopped or continued after 6 months. Date of Completion 8/16/2025	

independently so he could be sure he received the medications in a timely manor.

During an interview on 7/10/25 at 1:22 P.M., the Director of Nursing indicated she had not personally assessed the resident for his ability to self-administer his medications, but did not feel self-administration was safe because Resident B had frequently refused medications and although the order from Resident B's psychiatric nurse practitioner indicated the resident could self-administer medication, the facility was still responsible to supervise the administrations. The Director of Nursing indicated the facility could not take on the responsibility of supervision when a resident self-administered medication.

During an interview, on 7/10/25 at 1:30 P.M. the Administrator indicated Resident B often refused medications and she felt the facility needed to be aware of what medications and when medications were taken by Resident B. She indicated she considered it a safety issue.

On 7/10/21 at 1:40 P.M., Resident B's clinical record was reviewed. The resident was admitted to the facility on 12/23/24 with diagnoses that included but were not limited to,

anxiety, cellulitis, kidney disease, depression, schizoaffective disorder, bipolar disorder, diabetes with long term use of insulin, and diabetic polyneuropathy.

A Service Plan dated 12/24/24 for an initial Self Medication Assessment, indicated Resident B was capable of self-administering his own medications. The assessment was not signed by the nurse who performed the assessment and a physician's order had not been obtained.

Resident B's psychiatric nurse practitioner had provided a letter to the facility, dated 1/9/25, that indicated the resident had been under her care since 4/24 and while under her care, the resident's thought process was logical and goal directed with adequate insight and judgment. The psychiatric nurse practitioner indicated Resident B was capable of making his own decisions, making appointments and managing his medications with no reported problems. The psychiatric nurse practitioner indicated Resident B was mentally capable of managing his own medication, though he still needed whatever supervision that may have been deemed necessary by others to make sure the resident remained safe.

A Service Plan, dated 1/30/25, indicated the resident did not require any assistance with his medication or treatment procedures.

A Self Medication Assessment, dated 1/22/25, indicated Resident B was able to administer his own medications and treatment and that he had a letter of approval from his psychiatrist.

Resident B's General Practitioner provided a letter, dated 5/6/25, that indicated, "...[Resident B] was seen at our office...5/6/25. Please allow Pt [patient] [to] dispense [his] own medications..."

On 7/10/25 at 11:00 A.M., the Administrator provided the policy, Self Administration dated 10/1/21, and indicated it was the current facility policy. The policy indicated, "...To offer every resident a life full of independence and freedom, resident who have the cognitive and physical ability to take their own medications are encouraged to do so. A resident who takes his or her own medications must be evaluated to determine if the resident is cognitively and physically able to administer their medications and this must be approved by his or her physician to be certain it is an acceptable and safe arrangement...The nurse will

approve each resident who self-administers medication to ensure safe and effective procedures are followed..."

This citation relates to Complaint IN00458739

Based on observation, interview, and record review, the facility failed to ensure a resident's rights regarding self administration of medications were honored for 1 of 3 residents reviewed for medication self administration, (Resident B).

Finding includes:

On 7/10/25 at 12:40 P.M., during an observation and interview, Resident B was in his apartment and appeared well-kempt,his apartment was tidy and all of his belongings were stored away appropriately and no items were out of place. During the interview,Resident B indicated he had been a resident of the facility since 12/23/24 and before his admission to the facility, he had been responsible for taking his own medications and had never had any difficulty doing so. The resident indicated he had provided two letters from his physicians that indicated he was capable of self-administrating his medications but the facility had not allowed him to do so. Resident B indicate he wanted

to take his medications independently so he could be sure he received the medications in a timely manor.

During an interview on 7/10/25 at 1:22 P.M., the Director of Nursing indicated she had not personally assessed the resident for his ability to self-administer his medications, but did not feel self-administration was safe because Resident B had frequently refused medications and although the order from Resident B's psychiatric nurse practitioner indicated the resident could self-administer medication, the facility was still responsible to supervise the administrations. The Director of Nursing indicated the facility could not take on the responsibility of supervision when a resident self-administered medication.

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A Service Plan, dated 1/30/25, indicated the resident did not require any assistance with his medication or treatment procedures.

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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