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

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155635	B. W	ING		05/24/	2024
	ROVIDER OR SUPPLIER			337 GR	ADDRESS, CITY, STATE, ZIP COD ACE VILLAGE DR A LAKE, IN 46590		
					7 (2 (1 (2)) (1 () () () () () () ()		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 21, 22, 23, and 24, 2024 Facility number: 000501 Provider number: 155635 AIM number: 100266260		F 00	000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be	e s.	
					construed as an admission of by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction	fault o nis	
	Census Bed Type:				This plan of correction is		
	SNF/NF: 46				submitted as the facility's cred	ible	
	Residential: 46				allegation of compliance.		
	Total: 92				Grace Village request		
	Census Payor Type: Medicare: 4 Medicaid: 26 Other: 62 Total: 92				consideration for desk review of all citations.	on	
	This deficiency refleaccordance with 410	ects State Findings cited in IAC 16.2-3.1.					
	Quality Review con	npleted on 6/4/2024					
F 0812 SS=E Bldg. 00	§483.60(i) Food sa The facility must - §483.60(i)(1) - Pro	e/Prepare/Serve-Sanitary afety requirements. cure food from sources dered satisfactory by					
LABORATOR	federal, state or lo (i) This may includ directly from local		GNATURI		TITLE		(X6) DATE

Jerod Williams **HFA** 06/19/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1ISQ11 Facility ID: 000501 If continuation sheet Page 1 of 19

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155635	B. WI	NG		05/24	/2024
	PROVIDER OR SUPPLIER			337 GR	ADDRESS, CITY, STATE, ZIP COD PACE VILLAGE DR IA LAKE, IN 46590		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NAME CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facilities from usin gardens, subject to applicable safe grapractices. (iii) This provision from consuming for facility. §483.60(i)(2) - Store serve food in account standards for food Based on observation review, the facility stored appropriately ensure dishes and engood working cond 1 kitchenette observation the potential to affer receive meals from from the kitchenette Findings include: 1. During an observe 5/21/2024 at 9:50 At the following was occupant of drinks 5/19/2024. 2. During a revisit of 10:02 A.M., with the following was observed in the following was ob	does not prohibit or prevent g produce grown in facility o compliance with owing and food-handling does not preclude residents bods not procured by the ore, prepare, distribute and ordance with professional a service safety. In, interview and record failed to ensure foods were or and not expired and failed to equipment was clean and in ition in 1 of 1 kitchens and 1 of orded. This deficient practice had cet 46 of 46 residents who the kitchen and/or were served experienced by the distribution of the kitchen on a.M., with the Dietary Manager, observed: in the refrigerator: 3 is with a used by date of of the kitchen, on 5/22/2024 at the Dietary Manager, the	F 08	12	F812 Preparation and/or execution this plan do not constitute admission or agreement by the provider that a deficiency exist This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's creat allegation of compliance. Grace Village request consideration for desk review all citations. §483.60(i) Food safety requirements. The facility must §483.60(i)(2) - Store, prepared distribute and serve food in accordance with professional standards for food service saft This REQUIREMENT is not mas evidenced by: Rased on observation interviews.	e ts. e fault o his on. lible on	06/20/2024

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155635	B. W	ING		05/24/	
				CTREET	ADDRESS SITV STATE ZIR SOR		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
CDACE		CARE EACH ITY			RACE VILLAGE DR		
GRACE '	VILLAGE HEALTH	CARE FACILITY		WINON	IA LAKE, IN 46590		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	s with cracked seals along the			and record review, the facility		
	bottom of the 2 top	doors.			failed to ensure foods were st		
					appropriately and not expired	and	
	_	w, on 5/22/2024 at 10:04 A.M.,			failed to ensure dishes and		
		er indicated the dishes should			equipment was clean and in $\mathfrak g$	good	
	not be dirty, the microwave should be cleaned and				working condition in 1 of 1		
	the seals to the refr	igerators should be repaired.			kitchens and 1 of 1 kitchenett		
	3. During an observation of the kitchenette on				observed. This deficient pract		
	3. During an observation of the kitchenette on				had the potential to affect 46		
	5/23/2024 at 10:02 A.M., with Dietary Staff 4, the				residents who receive meals		
	following was observed:				the kitchen and/or were serve	ed	
	a. Refrigerator:				from the kitchenette.		
	_	dated package of lunch meat			Findings include:		
		a clear liquid coming from the			1. During an observation of th	ie	
	package.				kitchen on 5/21/2024 at 9:50		
		ed cheese not sealed.			A.M., with the Dietary Manage		
		of cheese slices not dated with			the following was observed: ii		
	a liquid substance				refrigerator: 3 containers of d		
	_	f butter, with no date and not			with a used by date of 5/19/20		
	sealed tightly.				2. During a revisit of the kitch		
		ad a broken door on the left			on 5/22/2024 at 10:02 A.M.,w		
	side with a hanging				the Dietary Manager, the follo	-	
		eapple chunks with no date.			was observed: 3 mini bowls w		
		mesan cheese with no date			dried foods substances on the		
	b. Pantry:				dirty scoop a microwave with		
		bag that was not sealed tightly			food on the sides and the ceil	ıng	
	in the cabinet.				of it 2 of 2 refrigerators with		
	<u> </u>	5/00/0004 - 10 10 10 17			cracked seals along the botto	m of	
	_	w, on 5/22/2024 at 10:10 A.M.,			the 2 top doors.	2004	
	1	icated the meat should have be			During an interview, on 5/22/2	2024	
		ds should have a date on			at 10:04 A.M., the Dietary		
		uld not be stored in that			Manager indicated the dishes		
	manner.				should not be dirty, the micro		
	0 5/00/0004 : 0	51 D.M. (L. D.)			should be cleaned and the se	als	
	On 5/23/2024 at 2:51 P.M., the Dietary Manager				to the refrigerators should be		
		titled." Production,			repaired.	_	
	Purchasing, Storage, Food and Supply Storage",				3. During an observation of th		
		indicated the policy was the one			kitchenette on 5/23/2024 at 1		
	1 -	he facility. The policy			A.M., with Dietary Staff 4, the		
	ındıcated" Foods	past the "used by", "sell-by",			following was observed: a.		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155635	B. W	ING		05/24/	2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			RACE VILLAGE DR		
GRACE \	VILLAGE HEALTH	CARE FACILITY			IA LAKE, IN 46590		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	DROVIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	"best-by", or "enjoy	by" date should be			Refrigerator: -An opened and		
	discarded. Cover, as	nd label and date unused			undated package of lunch me	at	
	portions and open packagesUnused portions of				not sealed and with a clear liq	uid	
	canned fruits and vegetables must be transferred				coming from the packageA		
	to clean, approved s	storage containersLabel the			package of sliced cheese not		
	container"				sealedAnother package of		
					cheese slices not dated with a	ı	
	On 5/23/2024 at 2:5	53 P.M., the Dietary Manager			liquid substance on itAn ope	ened	
	provided the policy titled, "Safety and Equipment				stick of butter, with no date an	d	
	Maintenance Equip	ment Inspection Program",			not sealed tightlyThe refrige		
	dated 1/2024, and in	ndicated the policy was the one			had a broken door on the left	side	
	currently used by th	e facility. The policy indicated			with a hanging plastic partA		
	"Complete the Eq	uipment Inspection Checklist			container of pineapple chunks	with	
	monthlyIdentify r	epairs neededRefrigerators:			no dateA container of parme	esan	
	Fans working. Cond	denser Clean. Seals on door in			cheese with no date b. Pantry	:	
	good repair"				-Two (2) buns in a bag that wa	as	
					not sealed tightly in the cabine	et.	
	3.1-21(i)(3)				During an interview, on 5/22/2	024	
					at 10:10 A.M., Dietary Staff 4		
					indicated the meat should hav	e be	
					thrown out, the foods should h	ave	
					a date on them, the buns shou	ıld	
					not be stored in that manner.		
					On 5/23/2024 at 2:51 P.M., th		
					Dietary Manager provided the		
					policy titled." Production,		
					Purchasing, Storage, Food an		
					Supply Storage", dated 1/2024		
					and indicated the policy was t		
					one currently used by the facil	ity.	
					The policy indicated" Foods		
					past the "used by", "sell-by",		
					"best-by", or "enjoy by" date		
					should be discarded. Cover, a		
					label and date unused portion	s	
					and open packagesUnused		
					portions of canned fruits and		
					vegetables must be transferre	d to	
					clean, approved storage		
					containersLabel the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ISQ11

Facility ID: 000501

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155635	B. W	ING		05/24/2	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				RACE VILLAGE DR		
GRACE \	/ILLAGE HEALTH	CARE FACILITY			IA LAKE, IN 46590		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	I		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					container" On 5/23/2024 at	2.53	
					P.M., the Dietary Manager	2.00	
					provided the policy titled, "Saf	etv	
					and Equipment Maintenance	, I	
					Equipment Inspection Prograr	n",	
					dated 1/2024, and indicated the		
					policy was the one currently u		
					by the facility. The policy indic	ated	
					"Complete the Equipment		
					Inspection Checklist		
					monthlyIdentify repairs		
					neededRefrigerators: Fans		
					working. Condenser Clean. Se	eals	
					on door in good repair"		
					Corrective Action for Affecte	d:	
					Pitchers of drinks were		
					immediately discarded and se	nt to	
					be washed.		
					Staff was immediately		
					trained to wash and redo all		
					drinks.		
					Staff was also educated	on	
					how to properly label all drink		
					pitchers. All dishes were thorough		
					looked through and re-washed	-	
					needed.	· '	
					Microwave was immedia	_{itely}	
					cleaned out.	, I	
					Educated staff to ensure	,	
					they are completing their clear		
					duties.		
					Maintenance has been		
					re-notified regarding new door	.	
					seals and new seals were ord		
					Staff received immediate	•	
					training on how to properly sto	re	
					food in all storage areas.		
					All Items were discarded	ı l	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155635		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/24/2024			
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DESCRIPTION OF THE OR ACTION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	and re-stocked with proper lab Staff was educated on he to properly seal opened bread addition to ensuring it has a lal Other Residents Will Continuto Be Identified: Upon hire, dining staff receive education and training with the use of an orientation checklist dating, labeling and storage of food. Training includes Food Storag Practices. Dining Manager assists in train and completes regular observational rounding 3-5 times weekly in pantries to assure sanitation on microwav and refrigerator and checks for dates and labels on resident's food. Department managers particip in compliance rounds in freeze audit, which includes dating labeling, sealing up open prod and sanitation. Any negative observation addressed at the tusing the F812 audit tool will be corrected, and results reviewer trends.	pels. pow in bel. pe e e on : e ning ation re r uate er to uct time pe		
				System Revision: Use F812 audit tool for Dining manager or designee to compl random observations on Pantr and Freezer Storage/Sanitation. Forward audits to the facility	ries		

Administrator.

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		X1) PROVIDER/SUPPLIER/CLIA	r ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155635	A. BUI	ILDING NG	00	COMPL 05/24/	
		100000	D. WII			03/24/	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ACE VILLAGE DR		
GRACE \	VILLAGE HEALTH	CARE FACILITY			A LAKE, IN 46590		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	<u> </u>	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Maintenance's responsibility was to look at all kitchen equipment to ensure proper working conditions and order. If Items anot in proper working order the will repair or call someone to repair said items. Dietary Manager will follow up maintenance weekly until all owork orders are completed.	nent are ≽y with	
D 0000					How Facility Will Monitor System: Dining Manager to review F81 audits and address negative observations one to one with identified staff. Report findings the QAPI Committee for review and resolution. Report for 3 months or until designated by QAPI committee. F812 Audit will be completed of for 2 weeks, then weekly for 3 months. We will start the audit immediately and will continue September 30th, 2024. All recordings will be reviewed at next QAPI meeting.	to v the daily until	
R 0000							
Bldg. 00	Survey. This visit is State Licensure Sur	21, 22, 23 and 24, 2024.	R 00	000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals who	e ts. e fault	

State Form Event ID: 1ISQ11 Facility ID: 000501 If continuation sheet Page 7 of 19

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	OF CORRECTION	IDENTIFICATION NUMBER 155635		LDING	00	COMPL 05/24/	ETED
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD ACE VILLAGE DR		
GRACE '	VILLAGE HEALTH	CARE FACILITY			A LAKE, IN 46590		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Residential Census: These State Resider accordance witih 41	ntial Findings are cited in			draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's cred allegation of compliance. Grace Village request consideration for desk review all citations.	ible	
R 0217 Bldg. 00	facility, using apprimembers, shall ideservices to be profollows: (1) The services of resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of revised as appropresident and facility change. Either the request a service	ency pletion of an evaluation, the opriately trained staff entify and document the vided by the facility, as ffered to the individual appropriate to the: ffered shall be reviewed and riate and discussed by the by as needs or desires a facility or the resident may plan review.					
	signed and dated of the service plan resident upon requ (4) No identification services provided subsequent to the no need for a characteristic provision of resides both, is needed, a	n and documentation of is needed if evaluations initial evaluation indicate					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		155635	B. WI	NG		05/24	/2024
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEI	R			RACE VILLAGE DR		
GRACE \	VILLAGE HEALTH	CARE FACILITY			IA LAKE, IN 46590		
			1		I		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the services to be	•	D 00	217	Brancostion of the state of	- £	06/20/2024
		view and interview, the facility	R 02	217	Preparation and/or execution	Of	06/20/2024
	_	natures for updated service			this plan do not constitute	_	
	-	idents reviewed for service			admission or agreement by the		
	plans. (Residents 2	and 3)			provider that a deficiency exis		
	Findings include:				This response is also not to b construed as an admission of		
	r manigs include:					iauii	
	1 A record marriage	for Pacident 2 was completed			by the facility, its employees,		
	1. A record review for Resident 2 was completed on 5/23/2024 at 3:12 P.M. Diagnoses included, but				agents or other individuals whe		
	were not limited to, bipolar disease, emphysema,				response and plan of correction		
	and asthma.				This plan of correction is	JII.	
	and astimia.				submitted as the facility's cred	Hible	
	A Service plan dat	red 7/6/2023, did not have a			allegation of compliance.	אוטוב	
	-	representative signature.			Grace Village request		
	1001delli di residelli	representative digitature.			consideration for desk review	on	
	A Service Plan dat	ted 11/28/2023, did not have a			all citations.	OH	
		representative signature.			1 Immediate action(s) take	en	
		anges made to the service plan.			for the resident(s) found to ha		
		6 3411144 P			been affected include:		
	2. A record review	for Resident 5 was completed			Service plans signed by resid	ents	
		34 A.M. Diagnoses included, but			and scanned into EMR.		
		, dementia, hypertension, and			2 Identification of other		
	hypothyroidism.				residents having the potential	to	
	· · ·				be affected was accomplished		
	A Service Plan,date	ed 10/15/2023, did not have a			Facility-wide impact. Service		
		representative signature.			were updated to have an elec		
					signature option for		
	A Service Plan, da	ted 12/4/2023, did not have a			resident/reception. Service pla	ans	
	resident or resident	representative signature.			signed.		
	Changes had been	made to the service plan.					
					3 Actions taken/systems	put	
		ted 4/29/2024, did not have a			into place to reduce the risk	of	
	resident or resident representative signature.				future occurrence include:		
	Changes had been made to the service plan.				Updating option for e-sign.		
					Procedure updated for		
	-	w on 5/24/2024 at 2:25 P.M., the			obtaining/ensuring signatures	. On	
	_	g (DON) indicated the service			6/14/2024.		
	-	the chart and signed by the			4 How the corrective		
	resident or resident	representative. She was not	- 1		action(s) will be monitored t	0	1

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155635		r í	ILDING	onstruction 00	(X3) DATE COMPL 05/24 /	ETED	
	PROVIDER OR SUPPLIER			337 GR	ADDRESS, CITY, STATE, ZIP COD ACE VILLAGE DR A LAKE, IN 46590		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	time the service plana binder of the admissigned by the reside	an needed to be signed every n was updated. The DON had ission service plans that were nt or resident representative. ecent service plans were			ensure the practice will not recur: The DON/Designee will compl random weekly audits of 6 residents for 12 consecutive weeks, then monthly x 3 month		
	4:39 P.M., by the D Plans", indicated, ". service plan for Re every 6 months. De	s provided on 5/24/2024 at ON. The policy titled, "ServiceA designee will complete a sident Upon admission and signee will meet with Resident to assess Resident needs and an and/or update"					
R 0246 Bldg. 00	a qualified medica authorization by a physician. The QN authorization for e PRN medication. physician not on the authorization to accept	Deficiency ons may be administered by tion aide (QMA) only upon licensed nurse or MA must receive appropriate ach administration of a All contacts with a nurse or the premises for dminister PRNs shall be a nursing notes indicating					
	Based on record rev failed to ensure PR administered by a Q Aide) were approve 8 residents reviewed & 2) Findings include: 1. A closed record r 5/24/2024 at 3:16 P included, but were residents reviewed at 3:16 P included, but were resident record residents.	niew and interview, the facility N (as needed) medications MA (Qualified Medication d by a licensed nurse for 2 of d for medications. (Residents 7 eview was completed on M.for Resident 7. Diagnoses not limited to, acute/on chronic lure, hypertension and	R 02	.46	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's crediallegation of compliance.	e ss. fault o nis n.	06/20/2024

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155635	B. Wl	NG	_	05/24/	/2024
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					RACE VILLAGE DR		
GRACE '	VILLAGE HEALTH	CARE FACILITY		WINON	IA LAKE, IN 46590		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	hyperlipidemia.`				Grace Village request		
					consideration for desk review	on	
	A Medication Adm	inistration Record (MAR),			all citations.		
	dated February 202	4, indicated a PRN			1 Immediate action(s) take	en	
	Acetaminophen (Ty	ylenol) had been administered			for the resident(s) found to ha	ve	
	on 2/1/2024 at 4:12 P.M. and on 2/6/2024 at 4:10				been affected include:		
	P.M. by QMA 5, on 2/11/2024 at 8:12 P.M. by				Notification sent to all QMAs &	×	
	QMA 6, all without documentation of a licensed				nurses of the requirements of		
	nurse approving the administration of the				giving PRN medication per		
	Acetaminophen.				regulation.		
					2 Identification of other		
	A MAR, dated March 2024, indicated a PRN				residents having the potential	to	
	Acetaminophen (Tylenol) had been given on				be affected was accomplished		
	3/24/2024 at 9:17 A.M., by QMA 7 without				All residents who have PRN o	-	
	documentation of a licensed nurse approving the				could be affected and		
	administration of th				monitoring/interventions put in	1	
		-			place facility-wide completed		
	A MAR, dated Mar	ch 2024, indicated a PRN			6-12.		
		ral solution had been			3 Actions taken/systems	put	
	_	MA 8 on 3/28 at 9:15 A.M., and			into place to reduce the risk	-	
		at 8:43 A.M., and 12:32 P.M., on			future occurrence include:		
		11:00 A.M., and 2:50 P.M. The			Education sent to staff on		
		administered by QMA 6 on			5-30-2024 electronically that a	all	
	_	all without documentation of a			PRN meds have an added red		
		oving the administration of the			field of documentation stating	'	
	PRN Morphine.	S			whether or not prior approval	was	
					given.		
	During an interview	v, on 5/24/2024 at 3:53 P.M. the			4 How the corrective		
		of Nursing indicated the PRN			action(s) will be monitored to)	
		be approved by a nurse and			ensure the practice will not		
		chart.2. A record review for			recur:		
		npleted on 5/23/2024 at 3:12			The DON/Designee will compl	lete	
		eluded, but were not limited to,			for 12 consecutive weeks of 6		
		physema, and asthma.			random residents, then month		
					3mos. Audits will be reviewed	-	
	A Service Plan, init	tiated on 1/1/2024, included a			QA committee.	- J	
		to maintain medication					
		ssistance . An intervention					
		s assistance for all medication					
	_	nd communication with the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			IULTIPLE CO UILDING	00	COMPL				
	155635		B. W	ING		05/24/			
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY				STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION		
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE		
	pharmacy."								
	A ' C4 M	1' 4' A 1 1 1 4 4'							
		edication Administration							
		2024, indicated Resident 2 ing PRN medication of							
		lenol) 325 milligrams,							
	administered by a (· ·							
	daministered by a	ζινι <i>ι</i> .							
	- 5/3/2024 12:36 P.	M.							
	- 5/4/2024 1:36 P.N	Л. & 1:42 Р.М.							
	- 5/5/2024 1:37 P.N	И.							
	- 5/8/2024 12:07 P.								
	- 5/10/2024 1:36 P.								
	- 5/13/2024 2:07 P.								
	- 5/14/2024 2:30 P.	M.							
	- 5/15/2024 1:24 P.								
	- 5/17/2024 1:23 P.	M.							
	- 5/18/2024 1:58 P.								
	- 5/19/2024 1:42 P.								
	- 5/20/2024 1:29 P.								
	- 5/21/2024 2:08 P.								
	- 5/22/2024 2:31 P.								
	- 5/23/2024 1:56 P.	M.							
	During an interview	v on 5/24/2024 at 2:37 P.M., the							
	_	g (DON) indicated a QMA							
	_	censed nurse's permission to							
		cation. The nurse charted the							
	-	PRN acetaminophen, but							
		nentation of prior permission to							
	administer the med								
		ded on 4/24/2024 at 4:39 P.M.							
		olicy titled, "PRN [as needed]							
	Medications", indic	eated, "PRN medications are							
		ff who legally authorized to do							
	so through certifica								
	accordance with a p	physician's order"							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155635		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/24/2024	
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
TAG R 0273 Bldg. 00	410 IAC 16.2-5-5. Food and Nutritior (f) All food prepara (excluding areas it maintained in accollocal sanitation an standards, including Based on observation review, the facility is stored appropriately ensure dishes and engood working condition observed. This defict to affect 46 of 46 rethe kitchen. Findings include: 1. During an observed observed at 9:50 At the following was one containers of drinks 5/19/2024. 2. During a revisit of 10:02 A.M., with the following was observed at the following was observed	nal Services - Deficiency ation and serving areas in residents ' units) are ordance with state and d safe food handling ing 410 IAC 7-24. In the interview and record failed to ensure foods were and not expired and failed to equipment was clean and in ation in 1 of 1 kitchens cient practice had the potential sidents who receive meals from the interview in the Dietary Manager, between the by date of the kitchen, on 5/22/2024 at the Dietary Manager, the	R 0273		DATE O6/20/2024 of es. Fault onis n. deby (f) g ded in eliging
	the Dietary Manage not be dirty, the mic	r, on 5/22/2024 at 10:04 A.M., r indicated the dishes should crowave should be cleaned and gerators should be repaired.		evidenced by: R 273 Based or observation, interview and recording the facility failed to ensure foods we stored appropriately and not expired and failed to ensure dishes	ord

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155635		A. BUILDING B. WING	00	COMPLETED 05/24/2024					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590						
GRACE N (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCE REGULATORY OR On 5/23/2024 at 2:5 provided the policy Purchasing, Storage dated 1/2024, and ir currently used by th indicated" Foods p "best-by", or "enjoy discarded. Cover, ar portions and open p canned fruits and ve to clean, approved s container" On 5/23/2024 at 2:5 provided the policy Maintenance Equipi dated 1/2024, and ir currently used by th "Complete the Eq- monthlyIdentify re-	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION 1 P.M., the Dietary Manager titled." Production, , Food and Supply Storage", dicated the policy was the one e facility. The policy past the "used by", "sell-by",			e e e e e e e e e e e e e e e e e e e				
			1	1	1				

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155635	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/24/2024			
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	TION (X5) D BE COMPLETION OPRIATE DATE				
				currently used by the facility. The p indicated" Foods past th by", "sell-by", "best-by", or by" date should be discard Cover, and label and date portions and open packagesUnused portio canned fruits and vegetab be transferred to clean, approved storage contain Label the container" On 5/23/2024 at 2:53 P.M Director of Dietary provide policy titled, "Safety and Equipment Maintenance Equipment Inspection Program", date 1/2024, and indicated the was the one currently used by the facil policy indicated "Comple Equipment Inspection Che monthly identify repairs needed Refrigerators: F working. Condenser Clear on door in good repair" Corrective Action for Affect Pitchers of drinks were immediately discarded an be washed. Staff was immediately tra wash and redo all drinks. Staff was also educated to properly label all drink p All dishes were thorough looked through and re-wa needed. Microwave was immediately Microwave was immediately	ne "used r "enjoy ded. r "enjo			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155635		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	(3) DATE SURVEY COMPLETED 05/24/2024	
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY			337 GR	ADDRESS, CITY, STATE, ZIP COD ACE VILLAGE DR IA LAKE, IN 46590				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	cleaned out. • Educated staff to ensure the are completing their cleaning duties. • Maintenance has been re-noregarding new door seals and seals were ordered. • Staff received immediate train on how to properly store food storage areas. • All Items were discarded and re-stocked with proper labels. • Staff was educated on how to properly seal opened bread in addition to ensuring it has a last other Residents Will Continue Be Identified: Upon hire, dining staff receive education and training with the use of an orientation checklist on dating labeling and storage of food. Training includes Food Storage Practices. Dining Manager assists in train and completes regular observing rounding 3-5 times weekly in pantries to assure sanitation on microway and refrigerator and checks for dates and label on resident's food. Department managers participate in compliance rounds in freeze audit, which includes dating labeling sealing up open product and sanitation. Any negative observation addresse the time using the R723 audit	otified I new Ining In all Id	DATE	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>			COMPLETED		
		155635	B. WING 05/24/20			/2024		
				_				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
					ACE VILLAGE DR			
GRACE '	VILLAGE HEALTH	CARE FACILITY		WINON	A LAKE, IN 46590			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROWING BY AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
					will be			
					corrected, and results reviewe	d for		
					trends.	u 101		
					System Revision:			
					Use R723 audit tool for Dining			
					manager or designee to comp			
					random	1010		
					observations on Pantries and			
					Freezer Storage/Sanitation.			
					Forward audits to the facility			
					Administrator.	.:11		
					Maintenance's responsibility w			
					be to look at all kitchen equipr	nent		
					to ensure proper working			
					conditions and order. If Items			
					not in proper working order the	Э У		
					will repair or call someone			
					to repair said items.			
					Dietary Manager will follow up			
					maintenance weekly until all o	pen		
					work orders are			
					completed.			
					How Facility Will Monitor Syst			
					Dining Manager to review R72	23		
					audits and address negative			
					observations one to			
					one with identified staff. Repo			
					findings to the QAPI Committe	ee		
					for review and			
					resolution. Report for 3 month	s or		
					until designated by the QAP			
					committee.			
					R723 Audit will be completed	daily		
					for 2 weeks, then weekly for 3			
					months. We will			
					start the audit immediately and	d		
					will continue until September 3			
					2024. Ali	•		
					recordings will be reviewed at	the		
					next QAPI meeting			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER				COMPL	COMPLETED	
		155635	B. WI	B. WING 05/2			5/24/2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDED'S BLANGE CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION				DEFICIENCY)		DATE	
R 0383 Bldg. 00	410 IAC 16.2-5-11 Mental Health Scr (g) The residential with the mental he develop the compo- resident that include (1) Psychosocial re- are to be provided (2) A comprehens meet multiple lever following: (A) Recreational at (B) Social skills. (C) Training, occu- programs. (D) Opportunities of restrictive and more arrangements. Based on record reversely failed to develop a comental illness in cool health service provice reviewed for mental. Finding includes: A record review for 5/23/2024 at 3:12 P were not limited to, and asthma. Resident 2's last psy for follow-up of bip A Service Plan, initifocus of "behaviors' identify factors/inter prevent/minimize in-	eening - Deficiency care facility, in cooperation calth service providers, shall rehensive careplan for the des the following: ehabilitation services that within the community. ive range of activities to ls of need, including the and socialization activities. pational, and work for progression into less re independent living riew and interview, the facility comprehensive care plan for a apperation with the mental ders for 1 of 5 residents a illness. (Resident 2) Resident 2 was completed on and. Diagnoses included, but bipolar disorder, emphysema, rechiatry visit was on 1/9/2023 olar disorder. inted 4/1/2024, indicated the "with the goal of the ability to repropriate behaviors. The ed: "exhibits normal and	R 03	383	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's crediallegation of compliance. Grace Village request consideration for desk review of all citations. 1 Immediate action(s) take for the resident(s) found to have been affected include: Service plan updated to include of Bipolar Disorder. Consent given by family to be	ess. esfault o nis n. ible on	06/20/2024	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155635		A. BUILDING 00 COMPI B. WING 05/24			(X3) DATE COMPL 05/24 /	ETED		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR					
GRACE VILLAGE HEALTH CARE FACILITY			WINONA LAKE, IN 46590					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF During an interview Director of Nursing called Resident 2's imental health profe Resident 2 to see. S not available or app professional. A policy was provide by the DON. The peand Service Agreen Psycho-Social Statu demonstrate good ju status3. Prior to a screen form must be facility for review.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION of on 5/24/2024 at 3:36 P.M., The f (DON) indicated the facility family member to identify the ssional the family would like the indicated the care plan was broved by a mental health ded on 4/24/2024 at 4:39 P.M., tolicy titled, "Admission Criteria ment", indicated"Mental and the state of the	ID PREF	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) treated by in-house mental he services provider to review pla care. 2 Identification of other residents having the potential be affected was accomplished Three residents with mental h DX identified. 3 Actions taken/systems into place to reduce the risk future occurrence include: Social Services/DON in-servic on regulation guidelines. Procedures put in place to pre further occurrences. Put in pla 6/13/2024. 4 How the corrective action(s) will be monitored to ensure the practice will not recur: A complete full audit of all residents with major mental ill DX completed on 6/12/2024. DON/Designee will complete 12 consecutive weeks an aud	alth an of to d by: ealth put of eed event ace ness The for	(X5) COMPLETION DATE	
					all residents with major menta illnesses. Audits will then cont monthly x 3 months. Audits wi reviewed by QA committee.	inue		

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