STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155635	A. BUILDING 00 B. WING	05/24/2024

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GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

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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 Census Bed Type: SNF/NF: 46 Residential: 46 Total: 92 Census Payor Type: Medicare: 4 Medicaid: 26 Other: 62 Total: 92 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 6/4/2024	F 0000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village request consideration for desk review on all citations.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to			

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

Jerod Williams | HFA | 06/19/2024

Any defiencystatement 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.

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	applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure foods were stored appropriately and not expired and failed to ensure dishes and equipment was clean and in good working condition in 1 of 1 kitchens and 1 of 1 kitchenette observed. This deficient practice had the potential to affect 46 of 46 residents who receive meals from the kitchen and/or were served from the kitchenette. Findings include: 1. During an observation of the kitchen on 5/21/2024 at 9:50 A.M., with the Dietary Manager, the following was observed: in the refrigerator: 3 containers of drinks with a used by date of 5/19/2024. 2. During a revisit of the kitchen, on 5/22/2024 at 10:02 A.M.,with the Dietary Manager, the following was observed: 3 mini bowls with dried foods substances on them a dirty scoop a microwave with dried food on the sides and the ceiling of it	F 0812	F812 Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village request consideration for desk review on all citations. §483.60(i) Food safety requirements. The facility must – §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview	06/20/2024

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	2 of 2 refrigerators with cracked seals along the bottom of the 2 top doors. During an interview, on 5/22/2024 at 10:04 A.M., the Dietary Manager indicated the dishes should not be dirty, the microwave should be cleaned and the seals to the refrigerators should be repaired. 3. During an observation of the kitchenette on 5/23/2024 at 10:02 A.M., with Dietary Staff 4, the following was observed: a. Refrigerator: -An opened and undated package of lunch meat not sealed and with a clear liquid coming from the package. -A package of sliced cheese not sealed. -Another package of cheese slices not dated with a liquid substance on it. -An opened stick of butter, with no date and not sealed tightly. -The refrigerator had a broken door on the left side with a hanging plastic part. -A container of pineapple chunks with no date. -A container of parmesan cheese with no date b. Pantry: -Two (2) buns in a bag that was not sealed tightly in the cabinet. During an interview, on 5/22/2024 at 10:10 A.M., Dietary Staff 4 indicated the meat should have be thrown out, the foods should have a date on them, the buns should not be stored in that manner. On 5/23/2024 at 2:51 P.M., the Dietary Manager provided the policy titled." Production, Purchasing, Storage, Food and Supply Storage", dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated"... Foods past the "used by", "sell-by",		and record review, the facility failed to ensure foods were stored appropriately and not expired and failed to ensure dishes and equipment was clean and in good working condition in 1 of 1 kitchens and 1 of 1 kitchenette observed. This deficient practice had the potential to affect 46 of 46 residents who receive meals from the kitchen and/or were served from the kitchenette. Findings include: 1. During an observation of the kitchen on 5/21/2024 at 9:50 A.M., with the Dietary Manager, the following was observed: in the refrigerator: 3 containers of drinks with a used by date of 5/19/2024. 2. During a revisit of the kitchen, on 5/22/2024 at 10:02 A.M.,with the Dietary Manager, the following was observed: 3 mini bowls with dried foods substances on them a dirty scoop a microwave with dried food on the sides and the ceiling of it 2 of 2 refrigerators with cracked seals along the bottom of the 2 top doors. During an interview, on 5/22/2024 at 10:04 A.M., the Dietary Manager indicated the dishes should not be dirty, the microwave should be cleaned and the seals to the refrigerators should be repaired. 3. During an observation of the kitchenette on 5/23/2024 at 10:02 A.M., with Dietary Staff 4, the following was observed: a.	

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	"best-by", or "enjoy by" date should be discarded. Cover, and label and date unused portions and open packages...Unused portions of canned fruits and vegetables must be transferred to clean, approved storage containers...Label the container...." On 5/23/2024 at 2:53 P.M., the Dietary Manager provided the policy titled, "Safety and Equipment Maintenance Equipment Inspection Program", dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...Complete the Equipment Inspection Checklist monthly...Identify repairs needed...Refrigerators: Fans working. Condenser Clean. Seals on door in good repair...." 3.1-21(i)(3)		Refrigerator: -An opened and undated package of lunch meat not sealed and with a clear liquid coming from the package. -A package of sliced cheese not sealed. -Another package of cheese slices not dated with a liquid substance on it. -An opened stick of butter, with no date and not sealed tightly. -The refrigerator had a broken door on the left side with a hanging plastic part. -A container of pineapple chunks with no date. -A container of parmesan cheese with no date b. Pantry: -Two (2) buns in a bag that was not sealed tightly in the cabinet. During an interview, on 5/22/2024 at 10:10 A.M., Dietary Staff 4 indicated the meat should have be thrown out, the foods should have a date on them, the buns should not be stored in that manner. On 5/23/2024 at 2:51 P.M., the Dietary Manager provided the policy titled." Production, Purchasing, Storage, Food and Supply Storage", dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated"... Foods past the "used by", "sell-by", "best-by", or "enjoy by" date should be discarded. Cover, and label and date unused portions and open packages...Unused portions of canned fruits and vegetables must be transferred to clean, approved storage containers...Label the	

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			container...." On 5/23/2024 at 2:53 P.M., the Dietary Manager provided the policy titled, "Safety and Equipment Maintenance Equipment Inspection Program", dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...Complete the Equipment Inspection Checklist monthly...Identify repairs needed...Refrigerators: Fans working. Condenser Clean. Seals on door in good repair...." **Corrective Action for Affected:** Pitchers of drinks were immediately discarded and sent 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 thoroughly looked through and re-washed if needed. Microwave was immediately cleaned out. Educated staff to ensure they are completing their cleaning duties. Maintenance has been re-notified regarding new door seals and new seals were ordered. Staff received immediate training on how to properly store food in all storage areas. All Items were discarded	

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			and re-stocked with proper labels. Staff was educated on how to properly seal opened bread in addition to ensuring it has a label. **Other Residents Will Continue to 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 training and completes regular observation rounding 3-5 times weekly in pantries to assure sanitation on microwave and refrigerator and checks for dates and labels on resident's food. Department managers participate in compliance rounds in freezer to audit, which includes dating labeling, sealing up open product and sanitation. Any negative observation addressed at the time using the F812 audit tool will be corrected, and results reviewed for trends. **System Revision:** Use F812 audit tool for Dining manager or designee to complete random observations on *Pantries and Freezer Storage/Sanitation.* Forward audits to the facility Administrator.	

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			Maintenance's responsibility will be to look at all kitchen equipment to ensure proper working conditions and order. If Items are not in proper working order they will repair or call someone to repair said items. Dietary Manager will follow up with maintenance weekly until all open work orders are completed. **How Facility Will Monitor System:** Dining Manager to review F812 audits and address negative observations one to one with identified staff. Report findings to the QAPI Committee for review and resolution. Report for 3 months or until designated by the QAPI committee. F812 Audit will be completed daily for 2 weeks, then weekly for 3 months. We will start the audit immediately and will continue until September 30th, 2024. All recordings will be reviewed at the next QAPI meeting.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 21, 22, 23 and 24, 2024. Facility number: 000501	R 0000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who	

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	Residential Census: 46 These State Residential Findings are cited in accordance witih 410 IAC 16.2-5.		draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village request consideration for desk review on all citations.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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 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			

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	the services to be provided. Based on record review and interview, the facility failed to obtain signatures for updated service plans for 2 of 5 residents reviewed for service plans. (Residents 2 and 5) Findings include: 1. A record review for Resident 2 was completed on 5/23/2024 at 3:12 P.M. Diagnoses included, but were not limited to, bipolar disease, emphysema, and asthma. A Service plan, dated 7/6/2023, did not have a resident or resident representative signature. A Service Plan, dated 11/28/2023, did not have a resident or resident representative signature. There had been changes made to the service plan. 2. A record review for Resident 5 was completed on 5/24/2024 at 9:34 A.M. Diagnoses included, but were not limited to, dementia, hypertension, and hypothyroidism. A Service Plan,dated 10/15/2023, did not have a resident or resident representative signature. A Service Plan, dated 12/4/2023, did not have a resident or resident representative signature. Changes had been made to the service plan. A Service Plan, dated 4/29/2024, did not have a resident or resident representative signature. Changes had been made to the service plan. During an interview on 5/24/2024 at 2:25 P.M., the Director of Nursing (DON) indicated the service plans should be in the chart and signed by the resident or resident representative. She was not	R 0217	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village request consideration for desk review on all citations. 1 Immediate action(s) taken for the resident(s) found to have been affected include: Service plans signed by residents and scanned into EMR. 2 Identification of other residents having the potential to be affected was accomplished by: Facility-wide impact. Service plans were updated to have an electronic signature option for resident/reception. Service plans signed. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** Updating option for e-sign. Procedure updated for obtaining/ensuring signatures. On 6/14/2024. **4 How the corrective action(s) will be monitored to**	06/20/2024

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	aware the service plan needed to be signed every time the service plan was updated. The DON had a binder of the admission service plans that were signed by the resident or resident representative. None of the most recent service plans were signed. A current policy was provided on 5/24/2024 at 4:39 P.M., by the DON. The policy titled, "Service Plans", indicated, "...A designee will complete a service plan for Resident Upon admission and every 6 months. Designee will meet with Resident and/or POA/Family to assess Resident needs and complete service plan and/or update...."		**ensure the practice will not recur:** The DON/Designee will complete random weekly audits of 6 residents for 12 consecutive weeks, then monthly x 3 months.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure PRN (as needed) medications administered by a QMA (Qualified Medication Aide) were approved by a licensed nurse for 2 of 8 residents reviewed for medications. (Residents 7 & 2) Findings include: 1. A closed record review was completed on 5/24/2024 at 3:16 P.M.for Resident 7. Diagnoses included, but were not limited to, acute/on chronic congestive heart failure, hypertension and	R 0246	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	06/20/2024

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	hyperlipidemia.` A Medication Administration Record (MAR), dated February 2024, indicated a PRN Acetaminophen (Tylenol) had been administered on 2/1/2024 at 4:12 P.M. and on 2/6/2024 at 4:10 P.M. by QMA 5, on 2/11/2024 at 8:12 P.M. by QMA 6, all without documentation of a licensed nurse approving the administration of the Acetaminophen. A MAR, dated March 2024, indicated a PRN Acetaminophen (Tylenol) had been given on 3/24/2024 at 9:17 A.M., by QMA 7 without documentation of a licensed nurse approving the administration of the Acetaminophen. A MAR, dated March 2024, indicated a PRN Morphine Sulfate oral solution had been administered by QMA 8 on 3/28 at 9:15 A.M., and 1:34 P.M., on 3/29 at 8:43 A.M., and 12:32 P.M., on 3/31 at 7:00 A.M., 11:00 A.M., and 2:50 P.M. The morphine had been administered by QMA 6 on 3/29 at 4:15 P.M., all without documentation of a licensed nurse approving the administration of the PRN Morphine. During an interview, on 5/24/2024 at 3:53 P.M. the Assistant Director of Nursing indicated the PRN medications should be approved by a nurse and documented in the chart.2. A record review for Resident 2 was completed on 5/23/2024 at 3:12 P.M. Diagnoses included, but were not limited to, bipolar disease, emphysema, and asthma. A Service Plan, initiated on 1/1/2024, included a plan for Resident 2 to maintain medication management with assistance . An intervention included: " requires assistance for all medication distribution, labs, and communication with the		Grace Village request consideration for desk review on all citations. 1 Immediate action(s) taken for the resident(s) found to have been affected include: Notification sent to all QMAs & nurses of the requirements of giving PRN medication per regulation. 2 Identification of other residents having the potential to be affected was accomplished by: All residents who have PRN orders could be affected and monitoring/interventions put in place facility-wide completed on 6-12. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** Education sent to staff on 5-30-2024 electronically that all PRN meds have an added required field of documentation stating whether or not prior approval was given. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON/Designee will complete for 12 consecutive weeks of 6 random residents, then monthly x 3mos. Audits will be reviewed by QA committee.	

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	pharmacy." A review of the Medication Administration Record, dated May 2024, indicated Resident 2 received the following PRN medication of acetaminophen (Tylenol) 325 milligrams, administered by a QMA: - 5/3/2024 12:36 P.M. - 5/4/2024 1:36 P.M. & 1:42 P.M. - 5/5/2024 1:37 P.M. - 5/8/2024 12:07 P.M. - 5/10/2024 1:36 P.M. - 5/13/2024 2:07 P.M. - 5/14/2024 2:30 P.M. - 5/15/2024 1:24 P.M. - 5/17/2024 1:23 P.M. - 5/18/2024 1:58 P.M. - 5/19/2024 1:42 P.M. - 5/20/2024 1:29 P.M. - 5/21/2024 2:08 P.M. - 5/22/2024 2:31 P.M. - 5/23/2024 1:56 P.M. During an interview on 5/24/2024 at 2:37 P.M., the Director of Nursing (DON) indicated a QMA needed to have a licensed nurse's permission to provide PRN medication. The nurse charted the effectiveness of the PRN acetaminophen, but there was no documentation of prior permission to administer the medication. A policy was provided on 4/24/2024 at 4:39 P.M. by the DON. The policy titled, "PRN [as needed] Medications", indicated, "...PRN medications are administered by staff who legally authorized to do so through certification or licensure, in accordance with a physician's order...."			

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	155635	A. BUILDING 00 B. WING	05/24/2024

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure foods were stored appropriately and not expired and failed to ensure dishes and equipment was clean and in good working condition in 1 of 1 kitchens observed. This deficient practice had the potential to affect 46 of 46 residents who receive meals from the kitchen. Findings include: 1. During an observation of the kitchen on 5/21/2024 at 9:50 A.M., with the Dietary Manager, the following was observed in the refrigerator: 3 containers of drinks with a used by date of 5/19/2024. 2. During a revisit of the kitchen, on 5/22/2024 at 10:02 A.M., with the Dietary Manager, the following was observed: 3 mini bowls with dried foods substances on them a dirty scoop a microwave with dried food on the sides and the ceiling of it 2 of 2 refrigerators with cracked seals along the bottom of the 2 top doors. During an interview, on 5/22/2024 at 10:04 A.M., the Dietary Manager indicated the dishes should not be dirty, the microwave should be cleaned and the seals to the refrigerators should be repaired.	R 0273	R273 Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village request consideration for desk review on all citations. 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) Al 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. This RULE is not met as evidenced by: R 273 Based on observation, interview and record review, the facility failed to ensure foods were stored appropriately and not expired and failed to ensure dishes	06/20/2024

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	On 5/23/2024 at 2:51 P.M., the Dietary Manager provided the policy titled." Production, Purchasing, Storage, Food and Supply Storage", dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated"... Foods past the "used by", "sell-by", "best-by", or "enjoy by" date should be discarded. Cover, and label and date unused portions and open packages...Unused portions of canned fruits and vegetables must be transferred to clean, approved storage containers...Label the container...." On 5/23/2024 at 2:53 P.M., the Director of Dietary provided the policy titled, "Safety and Equipment Maintenance Equipment Inspection Program", dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...Complete the Equipment Inspection Checklist monthly...Identify repairs needed...Refrigerators: Fans working. Condenser Clean. Seals on door in good repair...."		and equipment was clean and in good working condition in 1 of 1 kitchens observed. This deficient practice had the potential to affect 46 of 46 residents who receive meals from the kitchen. Findings include: 1. During an observation of the kitchen on 5/21/2024 at 9:50 A.M., with the Dietary Manager, the following w a s observed in t h e refrigerator: 3 containers of drinks with a u s e d by d a t e of 5/19/2024. 2. During a revisit of the kitchen, on 5/22/2024 at 10:02 A.M., with the Dietary Manager, the following was observed: 3 mini bowls with dried foods substances on them a dirty scoop a microwave with dried food on the sides and the ceiling of it 2 of 2 refrigerators with cracked seals along the bottom of the 2 top doors. During an interview, on 5/22/2024 at 10:04 A.M., the Dietary Manager indicated the dishes should not be dirty, the microwave should be cleaned and the seals to the refrigerators should be repaired. On 5/23/2024 at 2:51 P.M., the Dietary Manager provided the policy titled." Production, Purchasing, Storage, Food and Supply Storage", dated 1/2024, and indicated the policy was the one	

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			cleaned out. • Educated staff to ensure they are completing their cleaning duties. • Maintenance has been re-notified regarding new door seals and new seals were ordered. • Staff received immediate training on how to properly store food in all 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 label. Other Residents Will Continue to 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 training and completes regular observation rounding 3-5 times weekly in pantries to assure sanitation on microwave and refrigerator and checks for dates and labels on resident's food. Department managers participate in compliance rounds in freezer to audit, which includes dating labeling, sealing up open product and sanitation. Any negative observation addressed at the time using the R723 audit tool	

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			will be corrected, and results reviewed for trends. System Revision: Use R723 audit tool for Dining manager or designee to complete random observations on Pantries and Freezer Storage/Sanitation. Forward audits to the facility Administrator. Maintenance's responsibility will be to look at all kitchen equipment to ensure proper working conditions and order. If Items are not in proper working order they will repair or call someone to repair said items. Dietary Manager will follow up with maintenance weekly until all open work orders are completed. How Facility Will Monitor System: Dining Manager to review R723 audits and address negative observations one to one with identified staff. Report findings to the QAPI Committee for review and resolution. Report for 3 months 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 will continue until September 30th, 2024. Ali recordings will be reviewed at the next QAPI meeting	

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R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on record review and interview, the facility failed to develop a comprehensive care plan for a mental illness in cooperation with the mental health service providers for 1 of 5 residents reviewed for mental illness. (Resident 2) Finding includes: A record review for Resident 2 was completed on 5/23/2024 at 3:12 P.M. Diagnoses included, but were not limited to, bipolar disorder, emphysema, and asthma. Resident 2's last psychiatry visit was on 1/9/2023 for follow-up of bipolar disorder. A Service Plan, initiated 4/1/2024, indicated the focus of "behaviors" with the goal of the ability to identify factors/interventions that help to prevent/minimize inappropriate behaviors. The interventions included: "exhibits normal and functional behavioral patterns."	R 0383	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village request consideration for desk review on all citations. 1 Immediate action(s) taken for the resident(s) found to have been affected include: Service plan updated to include DX of Bipolar Disorder. Consent given by family to be	06/20/2024

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	During an interview on 5/24/2024 at 3:36 P.M., The Director of Nursing (DON) indicated the facility called Resident 2's family member to identify the mental health professional the family would like Resident 2 to see. She indicated the care plan was not available or approved by a mental health professional. A policy was provided on 4/24/2024 at 4:39 P.M., by the DON. The policy titled, "Admission Criteria and Service Agreement", indicated" ...Mental and Psycho-Social Status 1. Must be able to demonstrate good judgement and emotional status ...3. Prior to admittance, a mental illness screen form must be completed and returned to facility for review. Determination of eligibility as a result of mental illness screen rests with the Administrative Admissions Committee ...."		treated by in-house mental health services provider to review plan of care. 2 Identification of other residents having the potential to be affected was accomplished by: Three residents with mental health DX identified. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** Social Services/DON in-serviced on regulation guidelines. Procedures put in place to prevent further occurrences. Put in place 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 illness DX completed on 6/12/2024. The DON/Designee will complete for 12 consecutive weeks an audit of all residents with major mental illnesses. Audits will then continue monthly x 3 months. Audits will be reviewed by QA committee.	