STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKDALE SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: June 5 & 6, 2024 Facility number: 010667 Residential Census: 16 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completted on 6/21/2024	R 0000	6/27/2024 On June 6th, a health survey was conducted at Brookdale Senior Living South Bend. Attached is the plan of correction for tags R120, R217, R-273, R295, R356 and R406. The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of			

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

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	dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure the required dementia, abuse, and resident rights education in-service trainings were completed for 2 of 5 employees. (LPN 4 & Cook 2) Findings include: 1. An employee record review was completed, on 6/6/2024 at 10:00 A.M., for LPN 4. The file lacked the documentation to show completion of the required 3 hours of dementia training. 2. An employee record review was completed, on 6/6/2024 at 10:10 A.M. for Cook 2. The file for Cook 2 lacked the documentation to show completion of the required 3 hours of dementia training and lacked the required in-service training for resident's rights and abuse. During an interview on 6/6/2024 at 10:52 A.M., the Administrator indicated the employees did not have the required training and they should have. On 6/6/2024 at 10:56 A.M., the Administrator	R 0120	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** LPN no longer employed at Brookdale. Cook to complete inservices by 7.31.24. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**Training records for all associates reviewed on 7.8.24. Area Director notified associates of overdue trainings on 7.8.24. ED or designee to verify completion of trainings by 7.31.24 **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	07/31/2024

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	indicated the facility did not have a policy regarding education and in-servic trainings and they followed a training calendar.		**practice does not recur;** Business Office Manager or designee to verify completion of monthly inservices by the 15th of each month. Area Director or designee will audit training completion monthly for 6 months.	
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			

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	involved in identification and documentation of the services to be provided. Based on record review and interview the facility failed to ensure the resident reviewed and signed the service plan for 1 out of 7 residents reviewed for service plans. (Resident B) Finding includes: A record review for Resident B was completed on 6/5/2024 at 10:30 A.M. Diagnoses included, but were not limited to: chronic pain, cerebrovascular disease, type 2 diabetes and hypertension. Resident B was admitted on 9/20/2023. Resident B had a service plan completed on 8/14/2024. The service plan had not been signed by the resident and/or their representative. During an interview on 6/5/2024 at 12:13 P.M., LPN 5 indicated the service plan should have been signed and dated by the resident. On 6/5/2024 at 12:55 P.M., the Administrator provided a policy titled, Service Plan Process Policy, dated 4/2025, and indicated the policy was the one currently used by the facility. The policy indicated " ...6) Upon initial review and subsequent changes, members of the community care team that contributed to the service plan, including the ED or designee, or nurse and the resident/legally responsible party should sign the service plan....."	R 0217	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident service plan is current and signed at this . **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Health and Wellness Director performed a chart audit review on 7.9.24 and all service plans are current. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Health and Wellness Director or designee will review service plans with resident or resident representative timely. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** !--[if="" !supportannotations]--="">Area Director or designee will audit personal service plans 1x per month for 6 months to verify service plans have been signed by	07/31/2024

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			resident or responsible party.	
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 and interview, the facility failed to ensure food was stored, prepared and served in a sanitary manner in 1 of 1 kitchens and 1 of 1 dining rooms. This had the potential to affect all 16 residents who received food from the kitchen and 14 of 14 residents who ate in the dining room. Findings include: 1. On 6/5/2024 at 9:09 A.M., during the initial kitchen tour with Cook 2, the following was observed: - 2 gallons of milk with an expiration date of 6/3/2024 - An expired hamburger with a use by date of 5/27/2024 - A bag of whipped topping and a bowl of oranges with no open date - A crushed box with 3 unwrapped sticks of butter - A dented can of sliced apples - A bag of bismati rice not sealed and open to the air - A bag of moldy dinner rolls 2. During a follow-up tour with the Kitchen Manager, on 6/6/2024 at 12:18 P.M., the following was observed:	R 0273	Food identified during survey that was allegedly out of compliance was immediately disposed of. No residents were affected by the alleged deficient practice. Alleged deficient practice had the potential to affect current residents. Deep clean of kitchen including equipment completed by 7/5/2024. Completed audit of food in fridges, freezers and dry pantry on or before 7/5/2024. Kitchen manager and staff to be in-serviced on dating and labeling food per community policy. Area Director or designee to do audit of kitchen sanitation 1x for 4 weeks then 1x's monthly for 5 months to verify that foods are properly dated labeled and stored. Dietician visits increased from quarterly to monthly for 6 months. !--[if="" !supportannotations]--="">	07/31/2024

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	- 4 serving plates, stored as clean with dry food on them. During an interview, on 6/5/2024 at 9:21 A.M., Cook 2 indicated the expired milk, hamburger, opened sticks of butter, and moldy bread should have been thrown away, the rice should have been sealed appropriately, the bag of whipped topping and bowl of oranges should have been labeled with an open date and the dented can should have been sent back to the store. During an interview, on 6/6/2024 at 12:23 P.M., the Kitchen Manager indicated the dirty plates should have been cleaned before storing. On 6/5/2024 at 3:00 P.M., the Administrator provided the policy titled, "Sanitation and Food Safety," and indicated it was the policy currently being used by the facility. The policy indicated..."Food Labeling: All stored foods must be properly covered, labeled and dated using an approved food label. Labels should include the item name, date prepared, time prepared, and discard date. No expired products should be present...." 3. During an observation on 6/5/2024 at 1:10 P.M., the ED, LPN 4, and CNA 6 were serving lunch in the dining room to 14 residents. The 3 staff members were observed serving plates of food to all 14 residents with their thumbs on the eating surface of the plate near the food. During an interview on 6/5/2024 at 1:20 P.M., the DON indicated food should be served without touching the eating surface of the plate. On 6/6/2024 at 8:48 A.M., the DON provided a policy titled, "How to Set, Serve and Clear," dated 7/5/14, and indicated the policy was the one currently used by the facility. The policy			

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	indicated, "...Do not touch the eating surface of glass, plates, or silverware...."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, record review, and interview, the facility failed to ensure medications were secured appropriately in a resident's room for 1 of 1 resident who was reviewed for self-administration of medication. (Resident E) Finding includes: During a room observation, on 6/5/2024 at 10:06 A.M., Resident E had prescription and over the counter medication bottles stored in a wicker box located on the counter next to her kitchen sink. During an interview, on 6/5/2024 at 10:07 A.M., Resident E indicated she self-administered all of her medications, and the wicker box did not have a lock. A record review was completed on 6/5/2024 at 10:35 A.M., Resident E's current Self Medication Assessment, dated 3/19/2024, indicated the resident was capable of self-administering her medications. During an interview, on 6/5//2024 at 2:39 P.M., the DON indicated the resident self-administered her medications and they should have been in a locked box. On 6/5/2024, at 3:00 P.M., the Administrator provided the policy titled, "Medications and	R 0295	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Lock box provided to resident for appropriate medication storage. Resident educated on appropriate medication storage practices. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by deficient practice. 1 resident currently self-administers medications. Lock box provided to resident for appropriate medication storage. Resident educated on appropriate medication storage practices. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	07/31/2024

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	Treatment-Self-Administration of Medication," dated 8/2023, and indicated it was the policy currently being used by the facility. The policy indicated,"...6. Residents who self-administer their own medications; a. May store and secure their non-controlled medications in their apartment by locking the apartment door each time upon departure. b. Should store their controlled medications in a locked drawer or cabinet so they are not accessible to others. Controlled medications are considered double locked when locked in a drawer/cabinet and when the apartment door is locked...."		**practice does not recur;** Community will verify that residents who self-administer medications have a lock box for medication storage upon admission. Health and Wellness Director or designee will do education with residents who self-administer medications on medication storage practices upon admission and as part of self-administration assessment process. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Health and Wellness Director or designee will check to verify residents who self-administer medications are storing medications correctly 1x monthly for 3 months then every 6 months with self administration evaluation.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference.			

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	(3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the emergency binder was complete and accurate, with all required resident information, for 1 of 5 residents whose emergency information was reviewed. (Resident B) Finding includes: A record review for Resident B was completed on 6/5/2024 at 10:30 A.M. Diagnoses included, but were not limited to: chronic pain, cerebrovascular disease, type 2 diabetes and hypertension. A review of the Emergency Information binder indicated the record did not include a photograph of the resident. During an interview on 6/5/2024 at 11:57 A.M., the DON indicated she should have had a photograph of the resident in the binder. On 6/6/2024 at 10:40 A.M., the DON indicated the facility did not have a policy regarding the Emergency Information File.	R 0356	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident photo added to emergency binder for resident identified. Resident's binder is complete and accurate on 6.6.24. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by alleged deficient practice. Health and Wellness Director or designee will complete audit [date] of emergency binder to verify that binder is complete and accurate for current residents. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Health and Wellness Director or designee will complete emergency binder for	07/31/2024

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			each new admission. Health and Wellness Director or designee will review binder quarterly to verify emergency binder is complete and accurate. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Executive Director or designee to review emergency binder to verify it is complete and accurate 1x monthly for 6 months.	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation and interview the facility failed to administer medication following accepted infection control standards for 1 of 5 residents observed for medicaiton administration. (Resident 3) Finding includes: During an observation of medication administration on 6/6/2024 at 9:19 A.M., LPN 4 dropped an atorvastatin tablet on the top of the medication cart. She picked up the tablet and put it back into the medication cup. She indicated the top of the cart was clean and this was the process she normally followed. She then proceeded to administer the medication to Resident 3.	R 0406	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** LPN educated on medication administration and infection control on 6.6.24 **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents who receive medications from nursing staff have the potential to be affected. Audit of medication pass will be completed by 7.12.24 to verify	07/31/2024

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	During an interview on 6/6/2024 at 9:19 A.M., the DON indicated LPN 4 should have destroyed the tablet. On 6/6/2024 at 11:02 A.M., the DON provided a policy titled, "Medication Administration," dated 12/2020, and indicated the policy was the one currently used by the facility. The policy indicated, "...Punch or remove the medication from bubble pack or other container into the client's hand or into a medicine cup."		compliant infection control practices. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Associates who administer medications will be re in-serviced on medication administration and infection control. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Health and Wellness Director or designee will observe medication pass 5xweekly for 4 weeks and then 1x weekly for 2 months, and then 1x monthly for 3 months.	