STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 9, 10, 11, 12 and 13, 2024 Facility number: 000048 Provider number: 155115 AIM number: 100275330 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicaid: 45 Other: 14 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 6/21/2024	F 0000	**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.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after July 5, 2024.**	
F 0812 SS=D 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 applicable State and local laws or regulations.			

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

Jamie Corpe | Executive Director | 07/05/2024

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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	(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 and interview the facility failed to store and prepare food in a sanitary manner in 1 of 1 kitchens and 1 of 2 nourishment pantries. This deficient practice had the potential to affect 58 residents who food from the kitchen and/or pantry. Finding includes: During a tour of the kitchen with Cook 2 on 6/9/24 at 9:02 A.M., the following was observed: -Uncovered coffee filters were stored on the lower shelf of a table right next to a trash can for the hand washing sink. -Dead bugs and dirt were noted in the light fixtures in the dry storage area and in the food prep areas of the kitchen. -Metal wire racks in the dry storage area were dusty and had rust and grime on them. -A fan and filter in the walk-in refrigerator were black with dust and dirt. -The knife storage rack was grimy and dusty. -Walls in the food preparation area were dirty with a build up of brown and black grime. During an interview on 6/11/24 at 9:17 A.M., the Dietary Supervisor indicated maintenance was working on replacing the light fixtures covers. She	F 0812	**F 821 – Food Procurement, Store/Prepare/Serve - Sanitary** The standard was not met; facility failed to store and prepare food in a sanitary manner **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1 Uncovered coffee filters were stored on the lower shelf next to the trash can for the handwashing sink: filters were thrown away and replaced; filters will be stored in appropriate location 2 Dead bugs and dirt were noted in light fixtures: areas have been cleaned, and placed on monthly cleaning checklist 3 Metal wire racks in dry storage area were dusty/grimy: racks have been deep cleaned 4 A fan/filter in walk-in refrigerator were dirty/dusty: fan was cleaned and filter replaced;	07/05/2024

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	agreed the walls and the knife storage unit were dirty and should be cleaned. During an interview on 6/11/24 at 2:25 P.M., the Executive Director (ED_she indicated the facility did not have a policy regarding kitchen sanitation and cleaning of the kitchen but she did provide a copy of the cleaning schedule. During an observation of the 1st floor nutrition pantry with the Dietary Supervisor on 6/13/24 at 9:13 A.M., there was an employee's purse on the counter. The Dietary Supervisor indicated the purse should not be stored in the nutrition pantry. During an interview on 6/13/24 at 10:56 A.M., the ED indicated they did not have a policy that specifically covered the nutrition kitchen pantry.. 3.1-21(i)(1)(3)		added to monthly deep clean checklist 5 Knife storage rack was dusty/dirty: area was cleaned and added to cleaning checklist 6 Walls in food preparation area were dirty: walls have been cleaned and area has been added to cleaning checklist 7 Purse was found in nutrition pantry: purse was immediate removed from pantry and education provided to staff regarding proper storage of personal items **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents residing in the facility have the potential to be affected by this practice. All items were immediately addressed and have been added to cleaning/preventative maintenance checklists for consistent monitoring. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Dietary Manager or designee will in-service staff on or before July 5th regarding appropriate storage and cleaning; items added to cleaning audit checklist. Dietary Manager or designee will audit areas weekly and to ensure proper	

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			storage and sanitation, and address accordingly. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement (QAPI). The Dietary Manager/designee will be responsible for completing audit tool for cleaning/sanitation weekly for 4 weeks and monthly thereafter. If threshold of 90% is not met, an action plan will be developed. Finds will be submitted to the QAPI committee for review and follow-up.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain the cleanliness of resident's personal refrigerators, for 2 of 3 personal refrigerators that were observed. (Resident 42 & 24) Findings include: 1. An observation of Resident 42's refrigerator was completed on 6/10/2024 at 9:13 A.M and on 6/11/2024 at 11: 16 A.M. with the Director of	F 0921	**F 921 – Safe/Functional/Sanitary/Comfortable Environment** The standard was not met; facility failed to maintain the cleanliness of resident's personal refrigerators for 2 of 3 residents observed **What corrective action(s) will be accomplished for those**	07/05/2024

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	Nursing (DON). The following was observed: - 7 undated peanut butter and jelly sandwiches without expiration dates - A dark brown, sticky solution covering the bottom of the refrigerator - A heavy amount of ice build-up on freezer compartment During an interview on 6/10/2024 at 9:14 A.M., Resident 42 indicated he used his refrigerator for snacks and drinks. 2. An observation of Resident 24's refrigerator was completed on 6/10/2024 at 10:30 A.M and on 6/11/2024 at 11: 16 A.M. with the DON. The following was observed: - A foul odor was detected when the refrigerator door was opened - A small, clear container labeled ground turkey and with an expiration date of 6/4/2024 - 2 opened diet cokes without opened dates - A thick red substance was inside on the bottom, sides, and condiment holder - Food crumbs throughout the inside of refrigerator and along the seal of the door. - A large amount of ice build up on freezer During an interview with the DON on 6/11/2024 at 11:18 A.M, she indicated there should not be expired food in resident's personal refrigerators and all refrigerators should be clean and maintained without an ice buildup. During an interview on 6/12/2024 at 2:54 P.M., the Housekeeping Supervisor indicated housekeeping was responsible for cleaning personal refrigerators in residential rooms. On 6/11/2024 at 12:52 P.M., the ED (Executive Director) provided a policy, dated 7/2015, titled,		**residents found to have been affected by the deficient practice:** Resident 42 – refrigerator was disposed of, Resident 24 – refrigerator was cleaned **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any residents residing in the facility that has a personal refrigerator has the potential to be affected by this practice. All items were immediately addressed and have been added to cleaning/preventative maintenance checklists for consistent monitoring. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Housekeeping Manager or designee will in-service staff on or before July 5th regarding resident's personal refrigerators and the appropriate storage, cleaning and labeling/dating of items kept in such refrigerators; Housekeeping Manager or designee will audit refrigerators daily to ensure compliance. **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**	

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	"Cleaning Refrigerators". The ED identified it as the policy currently used by the facility. The policy indicated, "...The refrigerators will be kept clean. Spills and leaks will be wiped up... 2. Remove shelves, drawers and other removable parts. Clean and sanitize. 3. Wash walls and base with warm detergent...." 3.1-19(f)		**into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement (QAPI). The Housekeeping manager/designee will be responsible for completing audit tool for cleaning refrigerators for 4 weeks and monthly thereafter. If threshold of 90% is not met, an action plan will be developed. Finds will be submitted to the QAPI committee for review and follow-up.	
F 9999 Bldg. 00	Based on record review and interview, the facility failed to ensure the 3 hour annual dementia training was completed for 5 of 10 employees reviewed for dementia training. (Cook 3, CNA 4 and 7, QMA (Qualified Medication Aide) 5, and Therapy Assistant 7) Finding includes: The employee record review was completed, on 6/13/2024 at 10:00 A.M. The following employee files lacked the documentation to indicate they had completed 3 hours of annual dementia training: -Cook 3 -CNA 4 -QMA 5 -TA 6 -CNA 7 During an interview on 6/13/2024 at 10:52 A.M.,	F 9999	**Employee Dementia 3 hour training** The standard was not met; facility failed to ensure 3 hour annual dementia training was completed for 5 of 10 employees reviewed **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Employees identified as not having training completed have since completed the required training. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	07/05/2024

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	the ED (Executive Director) indicated Cook 3, CNAs 4 & 7, QMA 5, and TA 6 did not have the required 3 hours of annual dementia training completed. On 6/13/2024 at 10:56 A.M. the ED provided a policy, dated 3/2014, titled, "Education In-services and Training." The ED indicated the policy was the one currently used by the facility. The policy indicated, "... 1. Dementia Training... iii. 3 hours annually for all employees...."		All residents residing in the facility have the potential to be affected by this practice. CEN completed thorough audit of employee compliance trainings completions and employees not having the required trainings completed were removed from their schedules until trainings were completed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** CEN or designee will in-service staff regarding yearly training requirements. CEN or designee will audit compliance training completions monthly. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement (QAPI). The CEN/designee will be responsible for completing audit tool for Relias trainings monthly. If threshold of 90% is not met, an action plan will be developed. Finds will be submitted to the QAPI committee for review and follow-up.	