STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION       (X3) DATE         A. BUILDING       00       COMP         B. WING       08/22					
	ROVIDER OR SUPPLIEI	R		STREET ADDRESS, CITY, STATE, ZIP COD 530 W TANGLEWOOD LN MISHAWAKA, IN 46545				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP  TAG DEFICIENCY)		ATE	(X5) COMPLETION DATE	
R 0000 Bldg. 00			R 00	000				
R 0216	Residential Census These State Reside accordance with 41 Quality Review con	esidential Census: 64 hese State Residential Findings are cited in ecordance with 410 IAC 16.2-5. ruality Review completed on 8/29/2024						
Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance  Based on record review and interview, the facility failed to ensure Self Administration of Medication assessments were completed for 2 of 2 residents reviewed for self-administration of medications. (Residents 2 & 4)  Findings include:  1. The record for Resident 2 was reviewed on 8/20/2024 at 11:26 A.M. Diagnoses included, but were not limited to, depression, diabetes, lymphedema, anxiety and schizoaffective disorder.  Resident 2's current Physician Orders included, but were not limited to: - Carboxymethy 0.5% solution instill 1 drop in both eyes twice a day - Clotrim/beta cream apply topically to rash on ears and buttocks daily at bedtime - Diclofenac gel 1% apply topically to affected		R 02	216	1.What Corrective Action (s) be accomplished for those residents found to have been affected by the deficient practice. Deficient practice for affect residents will be corrected by the Director of Nursing or his/her designee.  2. How the facility will identify other residents having the potential to be affected by the same deficient practice and we corrective action will be taken All residents have the potent to be affected by the alleged deficient practice.  The Director of Nursing or his/her designee will audit a residents who are on self-administration medicati	tice. ted  by  chat tial tial	09/12/2024	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Barbara Gawel Executive Director 09/16/2024

Any define cyclatement and ing with an actorick (\*) denotes a deficancy which the institution may be excused from correcting providing it is determin

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 disclodays 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.

State Form Event ID: KIOU11 Facility ID: 009669 If continuation sheet Page 1 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
			B. WING		08/22/2024	
			STREET .	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIE	K	530 W	TANGLEWOOD LN		
TANGLE	WOOD TRACE		MISHA	WAKA, IN 46545		
(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	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	areas four times a	day		program to ensure that		
	- Hydrocortison oii	ntment 2.5% apply topically to		assessments are completed		
	affected area(s) eve	ery 12 hours as needed		according to policy and		
	-Tacrolumus ointm	ent 0.1% apply topically twice		procedure.		
	daily			3. What measures will be put	in	
	-Terbinafine cream	1% apply topically to affected		place or what systemic chang	es	
	areas once daily			the facility will make to ensure	)	
	-Zinc oxide ointme	ent 20% apply topically to		that the deficient practice doe		
	affected areas twic	e daily		recur.		
				Nursing staff completed		
	The Medication Ac	dministration Record (MAR),		in-service on		
	dated August 2024	, indicated Resident 2 had self		self-administration policy ar	nd	
	administered the m	nedications listed above.		procedures on 8/ 30/24.		
				and 9/4/24.		
	Resident 2's curren	t Physician Orders lacked an				
	order for the reside	ent to self administer		4. How the corrective action (	s)	
	medications/cream	s.		will be monitored to ensure th	e	
				deficient practice will not recu	r,	
	The record lacked	a Self-administration of		what quality assurance progra		
	Medication assessr	nent to show Resident 2 was		will be put into place.		
	competently able to	o self administer his eye drops,		The Director of Nursing or		
	topical creams and	lotions appropriately.		his/her designee will comple	ete	
				a weekly audit for residents		
	2. The record for R	lesident 4 was reviewed on		who are on self-administrati	on	
	8/21/2024 at 10:02	A.M. Diagnoses included but		program. Identified areas of		
	were not limited to	, hypertension and		concern will be corrected		
	osteoarthritis.			immediately. Audits will be		
				completed biweekly for 4		
	Resident 4's curren	t Physician Orders for		weeks, then bimonthly for fo	or 3	
	medications, include	ded, but were not limited to:		months until 100 % accuracy	/ is	
- Betimol solution 0.25% instill 1 drop in both eyes			achieved. If 100 % threshold	d is		
	once daily for eye pressure			not met than audits will be		
	- Estradiol cream 0	0.01% apply 1 Gram vaginally at		completed bimonthly until		
	urethral opening 3	times weekly		achieve 100 % compliance.		
				Thereafter will monitor		
	The Medication Ad	dministration Record (MAR),		monthly and any findings wi	II	
	dated August 2024	, indicated Resident 4 had self		be reported to QA meeting.		
	administered the n	nedications listed above.		The Administrator or his/her	,	
		1	designee will report monthly	to		

State Form Event ID: KI0U11 Facility ID: 009669 If continuation sheet Page 2 of 9

the Quality Assurance (QA)

Resident 4's current Physician Orders lacked an

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

PRINTED: 09/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUR         A. BUILDING       00       COMPLETE         B. WING       08/22/202			ETED		
NAME OF P	ROVIDER OR SUPPLIEF	·	•		ADDRESS, CITY, STATE, ZIP COD TANGLEWOOD LN		
TANGLE	WOOD TRACE				WAKA, IN 46545		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	order for the resider medications/creams	nt to self-administer her s.			committee the ongoing result of audits.	lts	
	The record lacked a Medication assessmable to competently topical creams and An Assisted Living Admission form for indicated the physic medications were to nurse/QMA.  During an interview the Director of Nurwanted to self-admissional have been as self-administer medorder indicating the administer their medorder indicating the administer their medorder indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility. The physician must indicated the policy by the facility and competent of services and the physician must indicate the policy by the facility. The physician must indicate the policy by the facility of the physician must indicate the policy by the facility. The physician must indicate the policy by the facility of the physician must indicate the policy by the facility. The physician must indicate the policy by the facility of the physician must indicate the policy by the facility. The physician must indicate the policy by the facility of the physician must indicate the policy by the facility of the physician must indicate the policy by the facility of the physician must indicate the policy by the facility of the physician must indicate the policy by the facility of the physician must indicate	a Self-administration of ment to show Resident 4 was administer her eye drops, lotions appropriately.  Ancillary Orders for Resident 4, dated 4/14/2024, cian had indicated the be administered by the ey, on 8/22/2024 at 11:17 A.M., sing indicated if the resident inister their medications, there in assessment to dications and a physician's resident was able to self dications.			of audits.  5 What date the systematic changes will be completed. 9/12/2024		
	self-administration. self-administering v per facility policy	will be reassessed periodically,					

State Form Event ID: KI0U11 Facility ID: 009669 If continuation sheet Page 3 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>		COMPLETED	
		B. W	B. WING 08/22/20			2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			TANGLEWOOD LN		
TANGLE	WOOD TRACE				WAKA, IN 46545		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
R 0246	410 IAC 16.2-5-4(	, , , ,					
	Health Services -	Deficiency					
Bldg. 00							
		view and interview, the facility	R 0	246			09/12/2024
		N (as needed) medications,			1.What Corrective Action (s) w	/III	
		ualified medication aide			be accomplished for those		
		rized by a licensed nurse prior or 3 of 10 residents whose			residents found to have been		
					affected by the deficient practi		
	medications were re	eviewed (Residents 6, 8 & 9)			QMA's who were responsib		
	Findings include:				for deficient practice receive	a	
	rindings include.				counseling and training on PRN medication administrati		
	1 The record for D	Resident 6 was reviewed on				OII	
		A.M. Resident 6's current			policy and procedures.		
		ncluded, but were not limited			2. How the facility will identify		
		i-anxiety) give one 0.5 mg tablet			other residents having the		
		ours as needed for anxiety or			potential to be affected by the		
	restlessness.	ours as needed for univiety of			same deficient practice and w	hat	
	10001000110000				corrective action will be taken.		
	The Medication Ad	lministration Record (MAR) for			All residents have the potent		
		d Resident 6 had received the			to be affected by the alleged		
	Lorazepam medicat	tion on 6/18/2024 from QMA 3			deficient practice.		
	and on 6/24/2024 fr				The Director of Nursing or		
					his/her designee will audit al	I	
	The clinical record	lacked the documentation so			PRN medication that are		
	show the QMA's ha	ad received prior approval from			administered by QMA's to		
	a licensed nurse pri	or to administering the PRN			ensure they follow policy and	d	
	medications to Resi	ident 6.			procedures on PRN medicati	ion	
					administration.		
	_	v, on 8/22/2024 at 12:03 P.M.,					
		sing indicated the QMA's			3. What measures will be put i		
		ed prior authorization from a			place or what systemic change		
		istering the medication and			the facility will make to ensure		
	documented it in th	e clinical record.			that the deficient practice does	s not	
					recur.		
		esident 8 was reviewed on			QMA's completed in-service	9	
		A.M. Resident 8's current			on PRN medication		
		ed, but were not limited to,			administration policy and		
	_	elet 325 mg (milligrams), give 2			procedures on 8/ 30/24 and		
tablets by mouth every 4 hours as needed for				9/4/24.			

State Form Event ID: KIOU11 Facility ID: 009669 If continuation sheet Page 4 of 9

STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
			B. WI	B. WING 08/22/202			24	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					TANGLEWOOD LN			
TANGLE	WOOD TRACE			MISHA	WAKA, IN 46545			
(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	C	OMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE	
	pain, and Benzonat	tate Capsule 100 mg give 2						
	_	every 8 hours as needed for			4. How the corrective action (s	3)		
	cough.	,			will be monitored to ensure the	<i>'</i>		
	8				deficient practice will not recu			
	The Medication Ac	lministration Record (MAR),			what quality assurance progra			
		cated Resident 8 had received			will be put into place.			
		5/3/2024 from QMA 2 and			The Director of Nursing or			
	_	e following dates: 5/2/2024,			his/her designee will comple	to I		
		4/2024 from QMA 3.			audit for residents who are			
	3/12/2021, and 3/1	7202 From QM11 3.			receiving PRN medication.			
	Resident 8's clinica	al record lacked the			Identified areas of concern w	vill		
		how a licensed nurse had			be corrected immediately.	····		
		for the administration of			Audits will be completed			
	Acetaminophen an				biweekly for 4 weeks, then			
	/ rectammophen an	a Benzonaute.			bimonthlyfor 3 months until	100		
	3 The record for R	esident 9 was reviewed on			% accuracy is achieved. If 1			
		A.M. Resident 9's current			% threshold is not met than			
		included, but were not limited			audits will be completed			
		tablet 325 mg give 2 tablets by			bimonthly until achieve 100	o/_		
	_	rs as needed for pain.			compliance. Thereafter will	<sup>76</sup>		
	moun every o nou	is as needed for pain.			monitor monthly and any			
	The Medication Ac	lministration Record (MAR) for			findings will be reported to 0	۱۵		
		ident 9 indicated he had			meeting.	<b>~</b>		
	· ·	ophen on 6/2/2024 administered			The Administrator or his/her			
	by QMA 2.	option on 0/2/2024 administered			designee will report monthly			
	by QMA 2.				the Quality Assurance (QA)	10		
	Resident 0's clinica	al record lacked the			committee the ongoing resu	lte		
		licensed nurses' prior			of audits.	13		
		e administration of the			or audits.			
	Acetaminophen.	e administration of the			5 What date the systematic			
	Accianinophen.				<u> </u>			
	During on interview	w, on 8/21/2024 at 11:13 A.M.,			changes will be completed.  9/12/2024			
	_				3/12/2024			
	the DON indicated QMA 2 and QMA 3 should							
	have received permission from the nurse prior to administering any PRN medication. The nurse's permission should have been documented in the							
	1 -	nave been documented in the						
	medical record.							
	0 9/22/2024 + 0	20 A.M. 4b - DON 11 1						
		30 A.M., the DON provided a						
	policy titled, "Prior	rity Life Care Medication						

State Form Event ID: KI0U11 Facility ID: 009669 If continuation sheet Page 5 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> CO		COMPL	COMPLETED	
		B. W	<u> </u>		08/22/	/2024	
				CTDEET /	ADDRECC CITY STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD TANGLEWOOD LN		
TANCLE	WOOD TRACE			1			
TANGLE	WOOD TRACE			IVIIOTA	WAKA, IN 46545		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Policy", undated, ar	nd indicated the policy was the					
	one currently used b	by the facility. The policy					
		ments for PRN medication					
	administration wi	ll be given in accordance with					
	physician's orders a	nd licensing requirements"					
R 0273	410 IAC 16.2-5-5.	• •					
D	Food and Nutritior	nal Services - Deficiency					
Bldg. 00							
		on and interview, the facility	R 0	273	1.What Corrective Action (s) w	/ill	09/12/2024
		under sanitary conditions			be accomplished for those		
		nd unlabeled food in 1 of 1			residents found to have been		
		ved. This had the potential to			affected by the deficient practi		
		lents who resided in the facility			Affected deficient practice was		
	and received food the	ne kitchen			corrected immediately. Food		
					items were labeled on 8/22/24	4.	
	Findings include:				2. How the facility will identify		
					other residents having the		
		48 A.M., during an initial tour of			potential to be affected by the		
		Culinary Manager, the			same deficient practice and wl		
	following items wer				corrective action will be taken.		
		ained a covered bin of split			All residents have the potent	ial	
	peas dated as prepar				to be affected by the alleged		
		f navy beans without an			deficient practice.		
	opened date.	4 (())			The Director of Food Servic	es	
		ezer, there were 6 (six)			will complete an audit to		
		s, unlabeled and undated.			ensure that all food items are	•	
		igerator, there was a container			labeled according to policy		
		hout a label or date and 2			and procedures.		
		te sliced cheese, wrapped in			3. What measures will be put i		
	plastic cling wrap, t	ooth unlabeled and undated.			place or what systemic change		
	D	9/20/2024 -+ 10:25 A M			the facility will make to ensure		
	_	y, on 8/20/2024 at 10:35 A.M.,			that the deficient practice does	s not	
		ger indicated all foods should			recur.		
	be labeled and dated	1.			The kitchen staff was		
	On 8/22/2024 at 0.4	15 A.M. the Culinear Manager			in-serviced on Storage of		
		15 A.M., the Culinary Manager			Refrigerated and Dry Food by	-	
		tled, "Food Rotation Quick t a date, undated, and			The Director of Food Service	5	
	•				on 8/29/24.		
	indicated the policy	was the one currently used	1		4. How the corrective action (s	5)	I

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

PRINTED: 09/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/22/2024	
	PROVIDER OR SUPPLIE	R	530 W	ADDRESS, CITY, STATE, ZIP COD TANGLEWOOD LN WAKA, IN 46545	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
	freezer items need open date, unless o should be sealed ar leftovers must be f	policy indicated" open to be discarded 6-12 months of verride by"best by date"it ad labeledCooler: any rozen or discarded within 3		will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.	,
		storage need to be sealed and en dateopen the item has a s"		The Food Services Director we complete an audit of all food items. Identified areas of concern will be corrected immediately. Audits will be completed biweekly for 4 weeks, then bimonthly for for months until 100 % accuracy achieved. If 100 % threshold not met than audits will be completed bimonthly until achieve 100 % compliance. Thereafter will monitor monthly and any findings will be reported to QA meeting. The Administrator or his/her designee will report monthly the Quality Assurance (QA) committee the ongoing result of audits.  5 What date the systematic changes will be completed. All alleged deficiencies will be corrected by 9/12/24.	is is to
R 0356 Bldg. 00	410 IAC 16.2-5-8 Clinical Records				
. ычу. 00	interview, the facil emergency informa	view, observation and ity failed to ensure an ation binder was accurate and equired resident information for	R 0356	1.What Corrective Action (s) we be accomplished for those residents found to have been affected by the deficient practice.      Deficient practice for affected.	ce.

State Form Event ID: KIOU11 Facility ID: 009669 If continuation sheet Page 7 of 9

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING 08/22/2024			2024	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t.			TANGLEWOOD LN		
TANGLE	WOOD TRACE				NAKA, IN 46545		
_		CT L TEN CENTE OF PROPERTY.	1	L	,		~~~
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE	COMPLETION
IAG	REGULATURY UN	R LSC IDENTIFYING INFORMATION		TAG	residents was corrected		DATE
	Finding includes:				immediately on 8/22/24		
	i manig merades.				2. How the facility will identify		
	The Emergency Rig	nder was reviewed on 8/20/2024			other residents having the		
	at 1:49 P.M., and la				potential to be affected by the		
		hospital preference listed			same deficient practice and wi	nat	
		hospital preference listed			corrective action will be taken.		
		hospital preference listed			All residents have the potent	ial	
		hospital preference listed			to be affected by the alleged		
		hospital preference listed			deficient practice.		
		hospital preference listed			The Director of Nursing or		
		hospital preference listed			his/her designee will review a	all	
		hospital preference listed			resident's emergency file to		
		hospital preference listed			make sure that hospital		
		hospital preference listed			preferences are listed on the		
	-Kesident 19 had no	hospital preference listed			resident's face sheet.	_	
	During on interview	y, on 8/20/2024 at 3:50 P.M., the			3. What measures will be put i		
	-	indicated the hospital			place or what systemic change the facility will make to ensure		
	-	have been on the face sheets			that the deficient practice does		
	but were not.	na. 2 occir on the face sheets			recur.	, 1101	
					Director of Nursing and		
	On 8/21/2024 at 9:4	40 A.M., the Director of Nursing			Assistant Director of Nursing	ı	
		y followed the State guidelines			completed in-service on	•	
		required to be included in the			clinical records policy and		
	emergency binder.	-			procedures on 9/4/24.		
					4. How the corrective action (s	s)	
					will be monitored to ensure the		
					deficient practice will not recur		
					what quality assurance progra	m	
					will be put into place.		
					The Director of Nursing or	4	
					his/her designee will comple	te	
					a weekly audit on resident's clinical records. Identified		
					areas of concern will be		
					corrected immediately. Audit	·e	
					will be completed biweekly for		
					4 weeks, then bimonthlyfor 3		
						•	

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

PRINTED: 09/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/22/2024			
	PROVIDER OR SUPPLIE	ER.	STREET ADDRESS, CITY, STATE, ZIP COD 530 W TANGLEWOOD LN MISHAWAKA, IN 46545				
(X4) ID PREFIX TAG	(EACH DEFICIE	T STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				months until 100 % accuracy achieved. If 100 % threshold not met than audits will be completed bimonthly until achieve 100 % compliance. Thereafter will monitor monthly and any findings will be reported to QA meeting. The Administrator or his/her designee will report monthly the Quality Assurance (QA) committee the ongoing result of audits.  5 What date the systematic changes will be completed. All alleged deficiencies will be corrected by 9/12/24.	I is II to Its		

State Form Event ID: KI0U11 Facility ID: 009669 If continuation sheet Page 9 of 9