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	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TANGLEWOOD TRACE	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: August 20, 21 and 22, 2024 Facility number: 009669 Residential Census: 64 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 8/29/2024	R 0000		
R 0216 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 0216	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice. **Deficient practice for affected 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 what corrective action will be taken. **All residents have the potential to be affected by the alleged deficient practice.** **The Director of Nursing or his/her designee will audit all residents who are on self-administration medication**	09/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barbara Gawel	Executive Director	09/16/2024

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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	areas four times a day - Hydrocortison ointment 2.5% apply topically to affected area(s) every 12 hours as needed -Tacrolumus ointment 0.1% apply topically twice daily -Terbinafine cream 1% apply topically to affected areas once daily -Zinc oxide ointment 20% apply topically to affected areas twice daily The Medication Administration Record (MAR), dated August 2024, indicated Resident 2 had self administered the medications listed above. Resident 2's current Physician Orders lacked an order for the resident to self administer medications/creams. The record lacked a Self-administration of Medication assessment to show Resident 2 was competently able to self administer his eye drops, topical creams and lotions appropriately. 2. The record for Resident 4 was reviewed on 8/21/2024 at 10:02 A.M. Diagnoses included but were not limited to, hypertension and osteoarthritis. Resident 4's current Physician Orders for medications, included, but were not limited to: - Betimol solution 0.25% instill 1 drop in both eyes once daily for eye pressure - Estradiol cream 0.01% apply 1 Gram vaginally at urethral opening 3 times weekly The Medication Administration Record (MAR), dated August 2024, indicated Resident 4 had self administered the medications listed above. Resident 4's current Physician Orders lacked an		**program to ensure that assessments are completed according to policy and procedure.** 3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur. **Nursing staff completed in-service on self-administration policy and procedures on 8/ 30/24. and 9/4/24.** 4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. **The Director of Nursing or his/her designee will complete a weekly audit for residents who are on self-administration program. Identified areas of concern will be corrected immediately. Audits will be completed biweekly for 4 weeks, then bimonthly for for 3 months until 100 % accuracy is achieved. If 100 % threshold is 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 to the Quality Assurance (QA)**	

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	order for the resident to self-administer her medications/creams. The record lacked a Self-administration of Medication assessment to show Resident 4 was able to competently administer her eye drops, topical creams and lotions appropriately. An Assisted Living Ancillary Orders for Admission form for Resident 4, dated 4/14/2024, indicated the physician had indicated the medications were to be administered by the nurse/QMA. During an interview, on 8/22/2024 at 11:17 A.M., the Director of Nursing indicated if the resident wanted to self-administer their medications, there should have been an assessment to self-administer medications and a physician's order indicating the resident was able to self administer their medications. On 8/22/2024 at 11:32 A.M., the Director of Nursing provided the policy titled, "Self-Administration Procedure", undated, and indicated the policy was the one currently used by the facility. The policy indicated"... B. The physician must indicate the resident is capable and competent of self-administration. C. A resident who is capable of self-administering must pass the self-medication assessment and meet criteria...E. If the physician states that the resident is capable and competent to self-administer medication, the facility must assess the resident to ensure they are capable and competent of self-administration... J. Individuals self-administering will be reassessed periodically, per facility policy...."		**committee the ongoing results of audits**. 5 What date the systematic changes will be completed. 9/12/2024	

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R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on record review and interview, the facility failed to ensure PRN (as needed) medications, administered by a qualified medication aide (QMA) were authorized by a licensed nurse prior to administration for 3 of 10 residents whose medications were reviewed (Residents 6, 8 & 9) Findings include: 1. The record for Resident 6 was reviewed on 8/20/2024 at 11:25 A.M. Resident 6's current medication orders included, but were not limited to, Lorazepam (anti-anxiety) give one 0.5 mg tablet by mouth every 4 hours as needed for anxiety or restlessness. The Medication Administration Record (MAR) for June 2024, indicated Resident 6 had received the Lorazepam medication on 6/18/2024 from QMA 3 and on 6/24/2024 from QMA 8. The clinical record lacked the documentation so show the QMA's had received prior approval from a licensed nurse prior to administering the PRN medications to Resident 6. During an interview, on 8/22/2024 at 12:03 P.M., the Director of Nursing indicated the QMA's should have obtained prior authorization from a nurse before administering the medication and documented it in the clinical record. 2. The record for Resident 8 was reviewed on 8/20/2024 at 11:00 A.M. Resident 8's current medications included, but were not limited to, Acetaminophen tablet 325 mg (milligrams), give 2 tablets by mouth every 4 hours as needed for	R 0246	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice. **QMA's who were responsible for deficient practice received counseling and training on PRN medication administration policy and procedures.** 2. 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 the alleged deficient practice.** **The Director of Nursing or his/her designee will audit all PRN medication that are administered by QMA's to ensure they follow policy and procedures on PRN medication administration.** 3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur. **QMA's completed in-service on PRN medication administration policy and procedures on 8/ 30/24 and 9/4/24.**	09/12/2024

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	pain, and Benzonatate Capsule 100 mg give 2 capsules by mouth every 8 hours as needed for cough. The Medication Administration Record (MAR), for June 2024, indicated Resident 8 had received Acetaminophen on 5/3/2024 from QMA 2 and Benzonatate on the following dates: 5/2/2024, 5/12/2024, and 5/14/2024 from QMA 3. Resident 8's clinical record lacked the documentation to show a licensed nurse had given authorization for the administration of Acetaminophen and Benzonatate. 3. The record for Resident 9 was reviewed on 8/21/2024 at 10:10 A.M. Resident 9's current medication orders included, but were not limited to, Acetaminophen tablet 325 mg give 2 tablets by mouth every 6 hours as needed for pain. The Medication Administration Record (MAR) for June 2024, for Resident 9 indicated he had received Acetaminophen on 6/2/2024 administered by QMA 2. Resident 9's clinical record lacked the documentation of a licensed nurses' prior authorization of the administration of the Acetaminophen. During an interview, on 8/21/2024 at 11:13 A.M., 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 medical record. On 8/22/2024 at 9:30 A.M., the DON provided a policy titled, "Priority Life Care Medication		4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. **The Director of Nursing or his/her designee will complete audit for residents who are receiving PRN medication. Identified areas of concern will be corrected immediately. Audits will be completed biweekly for 4 weeks, then bimonthlyfor 3 months until 100 % accuracy is achieved. If 100 % threshold is 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 to the Quality Assurance (QA) committee the ongoing results of audits**. 5 What date the systematic changes will be completed. 9/12/2024	

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	Policy", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...requirements for PRN medication administration... will be given in accordance with physician's orders and licensing requirements...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to store food under sanitary conditions related to undated and unlabeled food in 1 of 1 kitchen areas observed. This had the potential to affect 64 of 64 residents who resided in the facility and received food the kitchen Findings include: On 8/20/2024, at 9:48 A.M., during an initial tour of the kitchen with the Culinary Manager, the following items were observed: -the dry pantry contained a covered bin of split peas dated as prepared on 6/3/2023. - an unsealed bag of navy beans without an opened date. - in the walk-in freezer, there were 6 (six) containers of donuts, unlabeled and undated. - in the walk-in refrigerator, there was a container of sliced onions without a label or date and 2 (two) stacks of white sliced cheese, wrapped in plastic cling wrap, both unlabeled and undated. During an interview, on 8/20/2024 at 10:35 A.M., the Culinary Manager indicated all foods should be labeled and dated. On 8/22/2024 at 9:45 A.M., the Culinary Manager provided a policy titled, "Food Rotation Quick Reference," without a date, undated, and indicated the policy was the one currently used	R 0273	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice. **Affected deficient practice was corrected immediately. Food items were labeled on 8/22/24.** 2. 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 the alleged deficient practice.** **The Director of Food Services will complete an audit to ensure that all food items are labeled according to policy and procedures.** 3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur. **The kitchen staff was in-serviced on Storage of Refrigerated and Dry Food by The Director of Food Services on 8/29/24.** 4. How the corrective action (s)	09/12/2024

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	by the facility. The policy indicated"... open freezer items need to be discarded 6-12 months of open date, unless override by..."best by date"...it should be sealed and labeled...Cooler: any leftovers must be frozen or discarded within 3 days...Items in dry storage need to be sealed and labeled with an open date...open the item has a shelf life of 90 days...."		will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. **The Food Services Director will 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 3 months until 100 % accuracy is achieved. If 100 % threshold is 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 to the Quality Assurance (QA) committee the ongoing results of audits.** 5 What date the systematic changes will be completed. **All alleged deficiencies will be corrected by 9/12/24.**	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review, observation and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 11 of 64 residents.	R 0356	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice. **Deficient practice for affected**	09/12/2024

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	Finding includes: The Emergency Binder was reviewed on 8/20/2024 at 1:49 P.M., and lacked the following: -Resident 8 had no hospital preference listed -Resident 10 had no hospital preference listed -Resident 11 had no hospital preference listed -Resident 12 had no hospital preference listed -Resident 13 had no hospital preference listed -Resident 14 had no hospital preference listed -Resident 15 had no hospital preference listed -Resident 16 had no hospital preference listed -Resident 17 had no hospital preference listed -Resident 18 had no hospital preference listed -Resident 19 had no hospital preference listed During an interview, on 8/20/2024 at 3:50 P.M., the Director of Nursing indicated the hospital preferences should have been on the face sheets but were not. On 8/21/2024 at 9:40 A.M., the Director of Nursing indicated the facility followed the State guidelines for documentation required to be included in the emergency binder.		**residents was corrected immediately on 8/22/24** 2. 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 the alleged deficient practice.** **The Director of Nursing or his/her designee will review all resident's emergency file to make sure that hospital preferences are listed on the resident's face sheet.** 3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur. **Director of Nursing and Assistant Director of Nursing completed in-service on clinical records policy and procedures on 9/4/24.** 4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. **The Director of Nursing or his/her designee will complete a weekly audit on resident's clinical records. Identified areas of concern will be corrected immediately. Audits will be completed biweekly for 4 weeks, then bimonthlyfor 3**	

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			months until 100 % accuracy is achieved. If 100 % threshold is 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 to the Quality Assurance (QA) committee the ongoing results of audits. 5 What date the systematic changes will be completed. **All alleged deficiencies will be corrected by 9/12/24.**	