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	03/15/2024

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 the Investigation of Complaints IN00427872 and IN00430496. Complaint IN00427872 - State deficiency related to the allegations is cited at R0240. Complaint IN00430496 - State deficiency related to the allegations is cited at R0349. Survey date: March 14 & 15, 2024 Facility number: 009669 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/20/24.	R 0000		
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review the facility failed to ensure proper care was provided related to a resident not being assessed by licensed staff after a fall, for 1 of 3 residents reviewed for falls. (Resident C) Finding includes: A record review for Resident C was completed on 3/14/2024 at 2:39 P.M. Diagnosis included, but were not limited to: anxiety disorder, chronic kidney disease, major depressive disorder, cardiac	R 0240	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice. **An affected resident's falls will be evaluated and monitored by licensed Practical Nurse or by Director of Nursing** 2. How the facility will identify other residents having the potential to be affected by the	03/29/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barbara Gawel	Executive Director	03/26/2024

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	03/15/2024

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
	pacemaker, muscle weakness and congestive heart failure. A Progress Note, dated 1/26/2024 at 8:33 P.M., documented by a Qualified Medication Aide (QMA), indicated she was told by a CNA that the resident fell in her room outside of the bathroom. She checked the resident's vital signs and asked her if she was in pain, and the resident responded, "No". There was no documentation licensed staff had been notified or the resident's condition had been assessed by licensed staff after the fall. During an interview, on 3/14/2024 at 11:47 A.M., QMA 2 indicated that if a resident fell, they would call a nurse. If a nurse was not working, she would call the Director of Nursing (DON) and then Emergency Medical Services if needed to assess. QMA's cannot complete assessments. During an interview, on 3/14/2024 at 3:06 P.M., the DON indicated after a fall, staff would ask the resident if they were hurting. If the resident responded with a yes, then staff would call 911 and notify the DON that they were sending the resident out. The Nurse or the QMA could fill out the incident report. The DON had initiated an investigation of the incident due to Resident C reporting she was pushed by staff and had swelling and bruising to her left jaw, this was Incident number 264 to IDOH. The resident had swelling and bruising to the left jaw area and the follow up indicated she had several falls in the past 2 weeks. The incident report for the 1/26/2024 fall was not filed until 1/31/2024. During an interview, on 3/14/2024 at 3:39 P.M., CNA 3 indicated if she found a resident on the		same deficient practice and what corrective action will be taken. **All residents have the potential to be affected by the alleged deficient practice.** **Falls will be reviewed for all residents by Licensed Practical Nurse or Director of Nursing.** 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 Director of Nursing completed in-service for nursing staff on fall policy and procedures on 3/19/24.** 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 falls.** **Identified areas of concern will be corrected immediately.** **Audits will be completed biweekly for 4 weeks, then bimonthly for 3 months to ensure compliance.** **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.	

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	03/15/2024

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
	floor, she would call a nurse or a QMA. Once the assessment was done, staff would assist the resident back up. They would check the extremities and head for injuries and check eye movement. If the resident had any pain, staff would send them to the emergency room. During an interview, on 3/15/2024 at 9:38 A.M., CNA 4 indicated she was going to punch out after her shift when Resident C returned from an appointment, so she went to assist her to the toilet. When she was transferring the resident back to her wheelchair, Resident C sat on the edge of the chair and fell on her bottom, and her side went into the doorway, hitting her cheek/jaw area. She called the front desk for a QMA. The QMA arrived and assessed her. The QMA asked the resident if she was in any pain, which she denied, and asked her if she would like to go to the emergency room, and the resident refused. CNA 4 assisted getting the resident up off the floor with the QMA. The next day, Resident C had bruising to the jaw area, which continued to worsen the following days. During an interview, on 3/15/2024 at 12:22 P.M., the DON indicated the documentation of a resident fall and assessment should be found in the Progress Notes. On 3/14/2024 at 2:48 P.M., the DON provided a policy titled, "Fall Policy Practice, undated, and indicated the policy was the one currently used by the facility. The policy indicated "...In the event of a fall the following procedures are to be implemented immediately: 1. Find a nurse immediately and report the fall. 2. No one other than a qualified licensed nurse is to attempt to move the resident for any injuries related to the fall. 3. A qualified licensed nurse will assess the		**All alleged deficiencies will be corrected by 3/29/24.**	

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	03/15/2024

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
	resident for any injuries related to the fall. 4. The resident may bee assisted to their chair or bed, after careful assessment by the qualified license nurse. 5. Vital signs (Temperature, Pulse, Respiration, and Blood Pressure) will be taken at the time of fall. 6. Call Waiver (if applicable), call PACE (if applicable), call the family member, and call the doctor. 7. Document in the nursing notes the vital signs, the time and date of the fall, your assessment of the resident at the fall site, any and all first aid given, and your communication with the family, doctor, Waiver, and/or PACE. 8. Fill out the incident report/log book and give a copy to the DON and administrator. 10. Falls are then to be documented on every shift for 3 days. The note should include any follow up first aide, a full set of vital signs, any complaints of pain, and any other pertinent information. Each day is to be noted in the nursing note....." This citation relates to Complaint IN00427872.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, interview, and record review, the facility failed to ensure a resident's record was complete and accurately documented related to medication, for 1 of 3 records reviewed. (Resident B)	R 0349	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice. **Deficient practice for affected**	03/29/2024

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	03/15/2024

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
	Finding includes: A record review for Resident B was completed on 3/14/2024 at 12:10 P.M. Diagnoses included, but were not limited to: type 2 diabetes, chronic kidney disease, Alzheimer's Disease and chronic gout. A Service Plan, dated 5/1/2023, indicated the resident was to be supported to take all medications as ordered with interventions as follows: requires assistance with ordering medications, needs assist with mediation due to cognitive loss, unable to self administer pre-poured meds and requires daily supervision of medications. A Progress Note, dated 1/9/2024 at 2:13 P.M., indicated Resident B returned from a doctor's appointment with new orders to start tapering prednisone by 2.5 mg monthly. A Physician's Order, dated 1/9/2024, indicated Prednisone 5 mg tab, 2.5 tabs, 12.5 milligrams (mg) daily for 30 days, tapering the medication. A Medication Administration Record, dated 2/1/2024 to 2/29/2024, indicated for Prednisone 5 mg tab, give 2 tablets, 10 mg daily for 30 days, to start on 2/9/2024. A Medication Administration Record, dated 2/12/2024, indicated HD=hold/see progress note. An Administration Note in the Progress Notes, dated 2/12/2024, indicated not available. A Medication Administration Record, dated 2/13/2024, indicated NA- not available.		**resident was corrected on 2/23/24.** 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 medication administration system will be changed from multi dose packs to medication cards.** **The Director of Nursing or his/her designee will review medication administration record for other residents on a weekly basis.** 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 Director of Nursing completed in-service for all nursing staff on medication administration record policy and procedures on 3/19/24.** 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 will complete a weekly audit on medication administration records. Identified areas of concern will be corrected**	

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	03/15/2024

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
	A Medication Administration Record, dated 2/9/2024, 2/10/2024, 2/11/2024, 2/14/2024, 2/15/2024, 2/16/2024, & 2/17/2024, indicated Prednisone, give 2 tablets 10 mg daily, was signed off by the nurse or QMA on duty. During a response via e-mail from Synchrony pharmacy, on 3/14/2024, the Director of Pharmacy Services indicated the dispensing history of Prednisone for Resident B for February 2024 was the following: Firstly Prednisone 12.5 mg dose (5 mg - 2.5 tablets daily) were dispensed for 2/1/2024 through 2/8/2024, secondly Prednisone 10 mg dose, (5 mg - 2 tablets daily were dispensed for 2/23/2024 through the end of the month and finally no doses were dispensed from 2/9/2024 through 2/22/2024. During an interview, on 3/14/2024 at 10:29 A.M., QMA 2 indicated if she did not have a specific medication in the morning medication pack, she would tell the nurse. The nurse then contacted the pharmacy and the pharmacy would send it out that night and it would be there in the morning with its own 7-day roll. During an interview, on 3/15/2024 at 8:45 A.M., the DON indicated if a medication was not available, staff would call the pharmacy and they would deliver it to the facility within 4 hours. The QMA/nurse would alert the DON and ask them to call the pharmacy. Sometimes Synchrony would use a local pharmacy to bring the medication. During an interview, on 3/15/2024 at 9:30 A.M., the DON indicated she worked the medication cart on 2/15/2024 and 2/16/2024, and the Prednisone was in the morning pack those days. During an interview, on 3/15/2024 at 11:37 A.M.,		**immediately. Audits will be completed biweekly for 4 weeks, then bimonthly for 3 months to ensure compliance. 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 3/29/24.**	

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	03/15/2024

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
	QMA 5 indicated if she did not have a medication, she would call the pharmacy to let them know and to send it as soon as possible. She would then mark the MAR as not available (NA). She cannot recall what happened on 2/10/2024 and 2/11/2024 with Resident B's Prednisone. During an interview, on 3/15/2024 at 11:55 A.M., LPN 6 indicated she believed the Prednisone was in the pack when she gave medications to Resident C, but she cannot recall that far back for certain. She would have to call the pharmacy if it was not available because they do not have an Emergency Drug Kit (EDK). She would then sign it NA and attempt to get it from pharmacy. On 3/14/2024 at 3:58 P.M., the DON indicated they did not have a policy on what to do when a medication was not available. This citation relates to Complaint IN00430496.			