STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155684	A. BUILDING 00 B. WING	02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHFIELD VILLAGE	6450 MIAMI CIR SOUTH BEND, IN 46614

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00427667. Complaint IN00427667 - State deficiencies related to the allegations are cited at R0216. Survey date: February 21, 2024 Facility number: 002662 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/27/24.	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure residents' ability to self administer medications were	R 0216	The facility was allegedly found to be out of compliance for failure to ensure residents' ability to	03/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joseph M. Doran	Administrator	03/14/2024

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	followed per their medication self-administration assessment form, for 3 of 4 residents reviewed for self-administration of medications. (Residents C, D & E) Findings include: 1. During an observation on 2/21/2024 at 11:10 A.M., Resident C had a cup of medications sitting by the sink, with eight medications in it, and a cup of pills with two pills on the window sill. During an interview on 2/21/2024 at 11:12 A.M., Resident C indicated when the staff bring in her medications, they would leave it on the counter by the sink. When she woke up, she would take them. The pills on the windowsill were from yesterday and she forgot to take them. She usually wakes up about 6:30 A.M. and her pills were always waiting for her. It would take her awhile to take her medication, so she did not have the nurse watch her take them. Her son provided a pill cutter so she could cut the bigger ones. The record review for Resident C on 2/21/2024 at 11:45 A.M. Diagnoses included, but were not limited to: atrial fibrillation, chronic obstructive pulmonary disease, heart failure, hypertension, hypothyroidism, edema and cardiomegaly. The Service Plan, dated 2/7/2024, indicated medication assistance: assist with 10 or more medications. The Medication Self Administration Assessment form, dated 7/19/2022, indicated she did not want to self administer her medications. The Medication Record, dated 2/21/2024, indicated that the following medications were		self-administer medications were followed per their medication self-administration assessment form, for 3 of 4 residents reviewed for self-administration of medications. Resident C was assessed for self-administration of medications and service plan updated. An order was obtained to leave medications at bedside. Resident D was assessed for self-administration of medications and service plan updated. An order was obtained to leave medications at bedside. Resident E was assessed for self-administration of medications and service plan updated. An order was obtained to leave medications at bedside. A letter was drafted for residents and family members to notify nursing when OTC are brought in for resident use. Nursing was educated to observe residents who do not have an order to leave meds at bedside, to take their medications. Assisted living residents were assessed for self-administration of medication. No other residents were affected. Nursing was educated on medication administration and to observe residents consume medication without an order for self-administration of medication. For those that self-administered, medications still need to be	

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	provided this morning by LPN 2: acidophilus capsule 1, cranberry extract 250 milligram (mg) 1 capsule, fiber laxative 500 mg 2 tablets, isosorbide mononitrate ER 30 mg 1 tablet, lactaid fast act 9,000 units 1 tablet, omperazole 40 mg 1 tablet, potassium chloride ER 10 mEq 2 tablets, thera-M 1 tablet, oxybutynin chloride 5 mg 1 tablet, duloxetine 40 mg 1 capsule, eliquis 2.5. mg 1 tablet, lasix 40 mg 1 tablet, aldactone 25 mg 1 tablet. During an interview on 2/21/2024 at 12:15 P.M., Licensed Practical Nurse (LPN) 2 indicated she left Resident C's medication on the counter by the sink this morning. When she delivered them, she would sign them off in the electronic medical record. She would then return later to see if the medications were taken, but had not done that yet today. Resident C had an order that stated it was ok once the nurse pulls her medications, she can leave them on the counter, and when she wakes she can take them. LPN 2 could not find the order in her physician orders. 2. During an observation on 2/21/2024 at 11:30 A.M., Resident D's recliner was by the door, with an end table containing two empty medication cups, a bottle of extra strength Tylenol 500 milligrams (mg), Sleep Aid diphenhydramine hydrochloride 25 mg, and allergy relief loratadine 10 mg. During an interview on 2/21/2024 at 11:34 A.M., Resident D indicated the nurse would hand him his medication, but did not watch him take them. Sometimes they would just leave the medication for him to take. He has sciatica pain in his hip, so he has been taking Tylenol for it. He will take the Sleep Aid if he has problems sleeping at night, and the allergy medication if he has a stuffy nose		securely stored in resident's rooms, not left at bedside. The Director of Nursing or her designee will conduct med pass observations twice a week for 4 weeks, then once a week for 4 weeks. Med pass observations will not end until 4 consecutive weeks of 100% compliance is achieved. The results will be reviewed in QAA and reported to QAPI.	

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	in the morning, but he did not have to take the latter two all the time. The record review for Resident D was reviewed on 2/21/2024 at 1:10 P.M. Diagnoses included, but not limited to: hypertension, cerebral infarction, and malignant neoplasm of the prostate. The Physician Orders, dated 2/21/2024, indicated he did not have an order for Tylenol, sleep aid or allergy medications. The Physician Order, dated 7/1/2019, indicated nursing staff to prepare medications and may be left at resident's bedside to be taken when he wakes up with a cup of water. The Service Plan, dated 2/7/2024, indicated medication assistance: assist with 10 or more medications. The Medication Self-Administration Assessment Form, dated 7/19/2022, indicated that he does not want to self-administer his own medications. During an interview on 2/21/2024 at 12:33 P.M., Licensed Practical Nurse (LPN) 2 indicated Resident D had an order that read his meds may be left at the bedside to be taken when he wakes up with a cup of water. The residents who self-administer their own medications can have OTC medications in their room. Resident D should not have OTC medications in the room since staff administers medications to him. 3. During an interview on 2/21/2024 at 11:59 P.M., Resident E indicated the nurse would bring in the medications and leave them on the counter by the kitchen sink, they do not watch her take them. They leave her thyroid medication in her			

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	bathroom by the sink, so when she got up to use the bathroom, she would take it and go back to bed. She usually woke up between 9:00 and 11:00 A.M., then she would take her morning medications. She had a bottle of Tylenol in her kitchen and indicated she usually took 2 every night, so she put them in the plastic cup during the day so she does not forget. During an observation on 2/21/2024 at 12:08 P.M., a bottle of extra strength Tylenol 500 mg was on the kitchen shelf with Tylenol already in a plastic cup. A Physician Order, dated 2/21/2024, indicated Tylenol extra strength 500 mg capsule, 2 capsules every 6 hours as needed for mild pain or fever. A Physician Order, dated 4/2023, indicated may leave levothyroxine at bedside each night for resident to take in early morning, 88 micrograms (mcg) daily. The Service Plan, dated 1/6/2024, indicated medication assistance: assist with 10 or more medications. The Medication Self-Administration Assessment Form, dated 7/15/2022, indicated that her son prefers nursing to prepare her medications. During an interview on 2/21/2024 at 12:27 P.M., LPN 2 indicated Resident E should not have Tylenol in her room and she administers her medications. She does have an order for her thyroid medication to be left at the bedside. During an interview on 2/21.2024 at 3:00 P.M., the Director of Nursing (DON) indicated that the nurses were supposed to observe the			

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	consumption of medication unless they have an order to leave it in the room. When residents were admitted, if they want staff to do their medications, they do not do a Medication Self Administration Assessment Form. Residents who do not self administer medication should not have any medications in their rooms. Residents do go shopping and family members bring in items without staff knowledge. She could not locate a policy addressing leaving medication at the bedside if they have an order or one for OTC medications. On 2/21/2024 at 1:10 P.M., the Director of Nursing provided a policy titled, "Medication Administration," revised 5/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...15. Observe resident consumption of medication...." On 2/21/2024 at 2:05 P.M., the Resident Service Coordinator provided a policy titled, "Resident Self Administration of Medications," revised 12/14/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: It is the Policy of this campus to support each resident's right to self -administer medication. A resident may only self-administer medications after the campus's interdisciplinary team has determined which medications may be self-administered safely. 1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the campus's interdisciplinary team. 2. Resident's preference will be documented on the appropriate form and placed in the medical record. 4. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. 8. All			

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	nurses and aides are required to report the charge nurse on duty any medications found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of policy and procedures regarding resident self-administration when necessary...." This citation relates to Complaint IN00427667.			