STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155635	A. BUILDING 00 B. WING	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00448907. This visit included a State Residential Licensure Survey. Complaint IN00448907- No deficiencies related to the allegations are cited. Survey dates: March 18, 19, 20, 21 and 24, 2025 Facility number: 000501 Provider number: 155635 AIM number: 100266260 Census Bed Type: SNF/NF: 44 SNF: 12 Residential: 39 Total: 95 Census Payor Type: Medicare: 12 Medicaid: 24 Other: 20 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 4/2/2025	F 0000		
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record review and interview, the facility failed to provide a bed hold form for 2 of 4 residents reviewed for hospitalization. (Resident 1	F 0625	Preparation and/or execution of this plan do not constitute admission or agreement by the	04/14/2025

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

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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	& 35) Findings include: 1. During an interview, on 3/19/2025 at 8:43 A.M., Resident 1 indicated he had recently been hospitalized. A record review for Resident 1 was completed on 3/19/2025 at 1:19 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, congestive heart failure and acute respiratory failure. A Significant Change Minimum Data Set (MDS) assessment, dated 2/24/2025, indicated Resident 1 had moderate cognitive impairment. A Nursing Progress Note, on 2/12/2025 at 8:36 A.M., indicated Resident 1 was sent to the hospital because an in-house treatment was ineffective and confusion continued. A Physician's Progress Note, on 2/19/2025 at 8:56 A.M., indicated Resident 1 was readmitted to the facility after a hospitalization for an acute kidney injury. During an interview, on 3/20/2025 at 2:14 P.M., the Director of Nursing (DON) indicated a copy of Resident 1's discharge packet was not available. She provided a copy of the bed hold policy, but could not provide proof the bed hold policy was provided to Resident 1 for the hospital discharge on 2/12/2025. 2. During an interview, on 3/19/2025 at 11:06 A.M., Resident 35 indicated he had recently been hospitalized.		provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. **1 Immediate action(s) taken for the resident(s) found to have been affected include:** Facility implemented new standards of practice and a new form for transfer/discharges. All nursing staff educated. **2 Identification of other residents having the potential to be affected was accomplished by:** Facility-wide impact. In an effort to prevent further incidents the facility implemented new standards of practice and a new form for transfer/discharges. All nursing staff educated. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** All nursing staff went through a skills fair for additional training and transfer discharges forms to be uploaded in resident's documents for transparency and auditing purposes. **4 How the corrective**	

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	A record review for Resident 35 was completed, on 3/19/2025 at 11:06 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, intellectual disabilities and anxiety disorder. A Significant Change MDS assessment, dated 2/7/2025, indicated Resident 35 was cognitively intact. A Nursing Progress Note, on 3/15/2025 at 12:29 P.M., indicated Resident 35's brother was called to provide transportation to the hospital for low blood pressure, difficulty walking and lack of eating. A Nursing Progress Note, on 3/15/2025 at 4:53 P.M., indicated Resident 35's brother called the facility and Resident 35 informed the facility that the resident would be staying at the hospital for an observation. During an interview, on 3/20/2025 at 2:14 P.M., the DON indicated a copy of Resident 35's discharge packet was not available. She provided a copy of the bed hold policy, but could not provide proof the bed hold policy was provided to Resident 35 and/or his representative for the hospital discharge on 3/15/2025. A policy was provided, on 3/24/2025 at 11:59 A.M., by the DON. The policy titled, "Transfer/Discharge Policy", indicated, " ...Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharge, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy ...Notice of Transfer or Discharge [Emergent or Therapeutic Leave]...5. Notice of		**action(s) will be monitored to ensure the practice will not recur:** The DON/Designee will audit all transfer and discharges for the next 12 weeks and then random audit 5 residents x 3 months. All audits will be reviewed by QA committee.	

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	Facility Bed-Hold and Return policies are sent with the resident at the time of transfer ...." 3.1-12(a)(26)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to ensure staff providing care for a resident in EBP (enhanced barrier precautions) wore appropriate PPE (Personal Protective Equipment) for 1of 2 residents reviewed for EBP. (Resident 10) Finding includes: During an observation, on 3/20/2025 at 11:51 A.M., along the left side of the door frame going into Resident 10's room was a small 1" x 2" white magnet that was attached to the door frame on the left side with letters written in black "EBP". Resident 10 had a Foley catheter for urine drainage. CNA's 2 and 4 were observed to enter Resident 10's room to transfer her to her wheelchair with a mechanical lift. The door was opened and both CNAs were observed with no gloves or gowns on. During an interview, on 3/20/2025 at 11:55 A.M., RN 3 indicated the aides were just putting on gloves when she had entered the residents room. RN 3 indicated the aides should have been wearing gloves and a gown when they provided care to Resident 10. On 3/20/2025 at 1:25 P.M., the Director of Nursing provided the policy tilled, "Enhanced Barrier	F 0880	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. **1 Immediate action(s) taken for the resident(s) found to have been affected include:** Staff were educated. Ensured that affected residents on EBP had appropriate signage and PPE in room. Affected resident was monitored for any adverse reaction. **2 Identification of other residents having the potential to be affected was accomplished by:** All residents on EBP. All nursing staff educated. All rooms monitored for appropriate signage and PPE. **3 Actions taken/systems put**	04/14/2025

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	Precautions", dated 2/21/2025, and indicated the policy was the one currently used by the facility. The policy indicated..."Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities...." 3.1-18(a)		**into place to reduce the risk of future occurrence include:** In person staff training was completed on 3/27/2025. Staff were required to demonstrate appropriate EBP procedures. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON/Designee will audit and monitor all residents on EBP for proper PPE usage for 12 weeks. Then monitor 5 residents x 3 months. All audits will be reviewed by QA committee.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 18, 19, 20, 21 and 24, 2025 Facility number: 000501 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based o record review and interviews, the facility	R 0241	Preparation and/or execution of	04/14/2025

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	failed to ensure a Qualified Medication Aide (QMA) did not work outside the scope of practice for 1 of 1 reisdent reviewed for wound care. Finding includes: A record review for Resident 8 was completed, on 3/21/2025 at 10:53 A.M. Diagnoses included, but were not limited to: dementia, peripheral vascular disease and hypertension. A Nursing Progress Note, on 9/3/2024 at 3:21 P.M., indicated the physician assistant was notified of a left lower leg wound with pain measuring 1.6 centimeters by 1.6 centimeters. A new order was received for Xeroform gauze and a dry sterile dressing daily. A Physican and/or Nurse Practioner Note was not available to describe the type of wound. A Physician's Order, dated 9/4/2024, indicated to apply Xeroform gauze and a dry sterile dressing to a wound on the shin of the left lower extremity daily until healed. This order was discontinued on 9/10/2024. A Treatment Administration Record, dated September 2024, indicated QMA 5 provided the ordered treatment on 9/7/2024 and 9/8/2024. A Physician's Order, dated 9/14/2024, indicated to apply silver calcium alginate (a debriding agent) to the left lower extremity wound bed and cover with a foam dressing daily. A Treatment Administration Record, dated September 2024, indicated QMA 5 provided the ordered treatment on 9/16/2024 and 9/19/2024.		this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. **1 Immediate action(s) taken for the resident(s) found to have been affected include:** Educated QMA who signed off on treatment of scope of practice. Ensured that no active treatments that involved direct nurse staff were active at this time. **2 Identification of other residents having the potential to be affected was accomplished by:** AL-wide impact. All QMAs educated on scope of practice. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** All QMAs went through a skills fair for additional training on their scope of practice. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:**	

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	During an interview, on 3/24/2025 at 10:32 A.M., the Assistant Director of Nursing indicated a QMA should not have provided the ordered treatments to the leg wound. A document titled, "Qualified Medication Aide Scope of Practice", from the Indiana Department of Health, indicated, " The following tasks are within the scope of practice for the QMA unless prohibited by facility policy: ...(12) Apply topical medication to minor skin conditions such as dermatitis, scabies, pediculosis, fungal-infection, psoriasis, eczema, first degree burn, stage one decubitus ulcer ... The following tasks shall NOT be included in the QMA scope of practice: ...(6) Administer a treatment that involves advanced skin conditions, including stage II, III, and IV decubitus ulcers ...." A policy was provided, on 3/24/2025 at 11:59 A.M., by the Director of Nursing. The policy titled, "Documentation of Wound Treatments", indicated, " ...The facility completes accurate documentation of wound assessments and treatments ...."		The DON/Designee will monitor 6 residents with treatments in AL to ensure scope of practice is followed by QMA for 12 weeks. Then monitor 6 residents x 3 months. All audits will be reviewed by the QA committee.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to provide an annual health statement indicating the residents were free from communicable diseases for 5 of 8 residents reviewed for the annual health statement. (Residents 4, 7, 5, 8 & 9) Findings include: 1. A record review for Resident 4 was completed on 3/21/2025 at 11:14 A.M. Diagnoses included,	R 0409	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is	04/14/2025

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	but were not limited to: chronic kidney disease, osteoarthritis and hyperlipedemia. Physician's admission orders, dated 7/14/2022, indicated Resident 4 was free of communicable disease including TB (tuberculosis) in the infections stage. During an interview, on 3/24/2025 at 11:27 A.M., the Director of Nursing indicated she could not provide a current annual health statement for Resident 4.2. A record review was completed for Resident 7 on 3/21/2025 at 2:00 P.M. Diagnoses included, but were not limited to: hypertension and hypokalemia. Resident 7 was admitted to the facility on 1/10/2024. Resident 7's record lacked documentation of an annual health statement. During an interview, on 3/21/2025 at 2:52 P.M., the ED indicated Resident 7 should have had an annual health statement. 3. A record review for Resident 5 was completed, on 3/21/2025 at 11:23 A.M. Diagnoses included, but were not limited to: atrial fibrillation, anxiety disorder and hypertension. An annual health statement could not be located in the medical record. During an interview, on 3/24/2025 at 11:29 A.M., the Director of Nursing indicated Resident 5 did not have an admission health statement, nor a current health statement. 4. A record review for Resident 8 was completed, on 3/21/2025 at 10:53 A.M. Diagnoses included, but were not limited to: dementia, peripheral vascular disease and hypertension.		submitted as the facility's credible allegation of compliance. **1 Immediate action(s) taken for the resident(s) found to have been affected include:** Annual health statement added to physician orders for all AL residents. **2 Identification of other residents having the potential to be affected was accomplished by:** AL-wide impact. Annual health statements are sent to physician for acknowledgment and signature. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** All nursing staff went through a skills fair for additional training on the need for Annual Health Statements. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON/Designee will monitor 6 residents weekly in AL to ensure the annual health statement is signed/up to date for 12 weeks. Then monitor 6 residents monthly x 3 months. All audits will be reviewed by QA committee.	

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	An annual health statement could not be located in the medical record. During an interview, on 3/24/2025 at 11:25 A.M., the Director of Nursing indicated Resident 8 had an annual health statement when she was admitted to the facility in 2020, but did not have a current health statement. 5. A record review for Resident 9 was completed, on 3/21/2025 at 9:49 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, collapsed vertebra and chronic kidney disease stage 3. An annual health statement could not be located in the medical record. During an interview, on 3/24/2025 at 11:25 A.M., the Director of Nursing indicated Resident 8 had an annual health statement when he was admitted to the facility in 2018, but did not have a current health statement. A policy was provided, on 3/24/2025 at 11:59 A.M., by the DON. The policy titled, "Resident Screening for Tuberculosis", indicated, " ...2. Current Resident Screening: f. Residents will have an annual health statement obtained by the provider stating that the resident is free of communicable disease, including TB [tuberculosis] in the infectious state in accordance with state requirements ...."			