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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST PAUL'S	3602 SOUTH IRONWOOD DRIVE SOUTH BEND, IN 46614

(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: July 31 & August 1, 2024 Facility number: 014602 Residential Census: 87 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 8/8/2024	R 0000	This Plan of Correction constitutes the 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. St. Paul's respectfully requests the Plan of Correction and supporting documentation be considered for Desktop review. We declare the date of compliance is 9/6/2024.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure Qualified Medication Aides (QMA) received prior authorization to administer an as needed (PRN) medication from a qualified licensed nurse for 2 out of 7 resident records reviewed for medication administration. (Resident 2 and 7)	R 0246	**1 What corrective action will be accomplished for those residents who have been affected by the deficient practice?** Answer: Residents 2 and 7 were assessed and had no ill effects from receiving PRN medication	09/06/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Billhimer	Administrator	08/29/2024

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.

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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST PAUL'S	3602 SOUTH IRONWOOD DRIVE SOUTH BEND, IN 46614

(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
	Findings include: 1. A record review was completed for Resident 2 on 7/31/2024 at 10:30 A.M. Diagnoses included, but were not limited to: type 2 diabetes mellitus, hypertension and anxiety disorder. A Medication Administration Record (MAR), dated 6/2024, indicated Resident 2 was administered Tylenol 325 milligrams (mg) two tablets, on 6/15/2024 at 12:00 P.M. and 4:30 P.M. and a Senna-docusate 8.6-50 milligrams two tablets,, on 6/16/2024 at 8:00 A.M. by QMA 3. A MAR, dated 6/2024, indicated Resident 2 was administered Tylenol 325 mg two tablets, on 6/16/2024 at 6:10 P.M. by QMA 4. There was no documentation in the MAR or in the Nursing Progress Notes to indicate QMA 3 and QMA 4 received prior authorization from a license nurse before administering the as needed (PRN) medication to Resident 2. During an interview on 7/31/2024 at 10:55 A.M., the Unit Coordinator indicated the PRN medications were not authorized by a nurse and there was no Licensed nurse's signature next to the QMA's signature, confirming a nurse authorized the PRN medication. 2. A record review was completed for Resident 7 on 7/31/2024 at 2:00 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease and anxiety disorder. A MAR, dated 6/2024, indicated Resident 7 was administered Tylenol 325 mg two tablets, on 6/7/2024 at 8:00 A.M. and 6/10/2024 at 1:00 P.M. by QMA 3.		without nurse authorization (see attachment 3). An in-service was initiated immediately for all Nurses and QMA's regarding PRN medication administration. (See attachments 4 & 13) **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Answer: All residents receiving PRN medication have the potential to be affected. A review was completed of all residents who receive PRN medications and there were no residents that were negatively affected (See attachment 3). All Nurses and QMA's were re-educated on QMA scope of practice (See attachments 4 & 13). **3 What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** Answer: All PRN medication will be audited by the DON or designee weekly to ensure that they have been authorized by a Nurse (See attachment 5). All QMA's & Nurses will be educated about the QMA scope of practice including but not limited to PRN medication upon hire and twice annually.	

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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST PAUL'S	3602 SOUTH IRONWOOD DRIVE SOUTH BEND, IN 46614

(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
	During an interview, on 7/31/2024 at 2:15 P.M., the DON indicated a nurse should have authorized the QMA to administer the medication and signed her initials next to the QMA's initials for the medication. On 7/31/2024 at 11:00 A.M., the Unit Coordinator provided a policy titled "Qualified Medication Aide Scope of Practice", and indicated the policy was the facility's current policy. The Scope of Practice policy indicated "...(11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty....."		**4 How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Answer: PRN medications will be audited (See attachment 5) randomly by the DON or designee weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly for 4 months or until which time QAPI has deemed the process as in compliance. **5 By what date the systemic changes will be completed?** Answer: 9/6/2024	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based observation, interview and record review, the facility failed to ensure food was stored, prepared and served in a sanitary manner related	R 0273	**1 What corrective action will be accomplished for those residents who have been**	09/06/2024

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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST PAUL'S	3602 SOUTH IRONWOOD DRIVE SOUTH BEND, IN 46614

(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
	to cooking equipment, cabinets and the inside of drawers 2 of 2 kitchens and 1 of 2 kitchenettes This had the potential to affect 87 out of 87 residents receiving food from the kitchen. (Main Kitchen, Vineyard Kitchen & 3rd floor Memory Care Unit Kitchenette) Findings include: 1. An initial kitchen observation of the Main Kitchen was conducted on 7/31/2024 at 9:48 A.M. with the Dietary Manager (DM). The following was observed: a. A heavy build up of thick, black food debris on the 4 top range, range grates and backsplash. b. Yellow and brown debris on the outside of the oven doors and oven door handles below the range. c. The inside of both ovens, next to the range contained a build up of black burnt food debris and food splatter on both sides, the top and the bottom. d. The flat top grill and surrounding backsplash had a build up of a black substance covering most of the back splash and a quarter of the flat top grill cooking surface. e. The grill and grill griddles were covered in burnt food. The shelf below the grill contained loose pieces of charred food. f. The inside of both ovens next to the grill contained a build up of black burnt food debris and food splatter on both sides, the top and bottom. 2. An initial kitchen observation of the 3rd floor Memory Care Unit kitchenette with the DM was conducted on 7/31/2024 at 10:25 A.M. The following was observed: a. 2 drawers containing single pot coffee packets had spilled coffee spots and loose coffee grounds		**affected by the deficient practice?** Answer: No residents were affected. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Answer: All residents have the potential to be affected. There were no residents identified as having been negatively affected. All areas in the kitchens and kitchenettes that were identified have been thoroughly cleaned. **3 What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** Answer: All team members of Food and Nutrition Department have completed an In-Service on a new system of accountability (See attachment 6). A master cleaning schedule has also been posted for daily, weekly, and monthly cleaning (See attachment 7). **4 How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST PAUL'S	3602 SOUTH IRONWOOD DRIVE SOUTH BEND, IN 46614

(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
	b. The 2 cabinets below the coffee pot had dried coffee spots on the outside of the cabinet doors and inside on the bottom shelf. Loose coffee grounds were scattered across the bottom shelf. 3. An initial kitchen observation of the Vineyard kitchen was conducted on 7/31/2024 at 10:35 A.M. with the Dietary Manager. The following was observed: a. The range had grates covered in black burnt food debris. b. A flat top grill had a black and yellow build-up covering most of the grill and the surrounding backsplash. c. 2 ovens had burnt food debris and food splatter on the inside and on the outside of the oven door. During an interview with the DM on 8/1/2024 at 11:00 A.M., the DM indicated most of the food for the facility was made in the main kitchen. Once the food was prepared, it was sent on heated carts to the Memory Care Units and the Vineyard for meal service. The Vineyard kitchen prepared food ordered from the "Always Available" menu. The cooking equipment in both the Main Kitchen and the Vineyard should not have been dirty and should have been cleaned daily. The staff used a checklist to know when equipment should be cleaned. The nursing staff was responsible for cleaning the kitchenettes. During an interview with the Director of Nursing (DON) on 8/1/2024 at 2:43 P.M., she indicated the nursing staff was responsible for cleaning the 3rd floor Memory Care Unit's kitchenette and staff used a daily checklist to ensure the daily cleaning was completed. On 8/1/2024 at 11:23 A.M. The DM provided a policy, dated, 1/2024, and titled, "Department		**into place?** Answer: A closing manager checklist (See attachment 8) has been implemented to ensure areas are cleaned daily. A manager must check off daily to ensure that these areas have been properly cleaned. A sanitation audit (See attachment 9) will be completed twice weekly for the next 8 weeks, then weekly for 1 month, then monthly for 3 months or until QAPI has deemed the process as in compliance. Findings will be reported to QAPI monthly. **5 By what date the systemic changes will be completed?** Answer: 9/6/2024	

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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST PAUL'S	3602 SOUTH IRONWOOD DRIVE SOUTH BEND, IN 46614

(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
	Daily Closing Procedures" and identified it as the policy currently used by the facility. The policy indicated, "...A methodology and checklist for closing and PM security and sanitation is outlined...Equipment cleaned, sanitized and reassembled...Shelves above and below counters clean and dry...." On 8/1/2024 at 11:23 A.M. The DM provided an undated daily checklist titled, "Closing Manager/Supervisors Checklist" and identified it as the daily checklist currently used by both the Main Kitchen and the Vineyard Kitchen. The checklist indicated, "...All hot equipment is turned off and no food left inside. Cleaned and sanitized...." On 8/1/2024 at 3:10 P.M. the DON provided an undated checklist titled, "Daily Task Validation" and identified it as the checklist currently used in both kitchenettes. The checklist indicated, "...Cleanse the dining room...."			
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation and interview, the facility failed to ensure infection control measures were maintained related to hand hygiene during blood sugar and insulin administration for 1 out of 1 residents observed for insulin administration. (Resident 4) Finding includes: During an observation ,on 7/31/2024 at 11:15 A.M., QMA 2 performed a blood sugar test for	R 0414	**1 What corrective action will be accomplished for those residents who have been affected by the deficient practice?** Answer: (Resident 4) was assessed and no adverse effects were noted. The QMA was educated immediately about hand hygiene and glove usage as it pertains to performing a blood	09/06/2024

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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST PAUL'S	3602 SOUTH IRONWOOD DRIVE SOUTH BEND, IN 46614

(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 4. After performing the blood sugar test by obtaining a drop of blood, she disposed of the lancet and the testing strip but did not remove her gloves and perform hand hygiene, before she administered insulin. During an interview on 7/31/2024 at 11:20 A.M., QMA 2 indicated she should have removed her gloves and washed her hands prior to touching the insulin medication. On 7/31/2024 at 11:35 A.M., the Unit Coordinator provided a policy titled, "Proper Hand Washing In-Service", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...When to perform hand hygiene? Clean your hands: after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings...."		sugar check (See attachments 10 & 11). **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Answer: All residents who receive blood sugar checks and insulin were assessed and there were no adverse effects identified (See attachment 3). All QMA's were educated on hand hygiene and glove usage when performing a blood sugar check (See attachments 10, 11, and 12). **3 What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** Answer: All QMA's will receive education upon hire and twice annually about hand hygiene and glove usage. In addition, QMA's will receive education twice annually about how to perform a blood sugar check, including hand hygiene and glove usage during that procedure. **4 How the corrective action will be monitored to ensure the deficient practice will not**	

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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST PAUL'S	3602 SOUTH IRONWOOD DRIVE SOUTH BEND, IN 46614

(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
			recur, i.e., what quality assurance program will be put into place? Answer: The DON or designee will observe 1 blood sugar check weekly (See attachment 14) for 4 weeks, then bi-weekly for 4 weeks, then monthly for 4 months or until which time QAPI determines the process is in compliance. **5 By what date the systemic changes will be completed?** Answer: 9/6/2024	