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	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND EMERALD PLACE	4010 S IRONWOOD DR SOUTH BEND, IN 46614

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00455383. Complaint IN00455383 - State deficiencies related to the allegation was cited at R0144. Survey dates: April 3 and 4, 2025. Facility number: 013555 Residential Census: 49 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 4/15/2025	R 0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to implement and maintain an effective fire safety training program for all facility staff for 1 of 5 staff reviewed for fire safety. (Employee 3) Findings include: During an interview, on 4/3/2025 at 9:45 A.M., Employee 3 indicated she was able to use her cell phone for language interpretation. Employee 3 indicated in the event of a fire, she would first rescue any residents that were endangered. Next, Employee 3 indicated she would meet outside in	R 0120	The Facility has the potential to be affected by the alleged deficiency. Staff files will be audited for required documentation including in-services and education by Corporate HR on 4/28/25. The deficiency was corrected immediately. Employee records found during our survey without specific orientation, fire safety and dementia completed 4/4/25. The Executive Director will be	05/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leigh A Keirn	RN, RCA	05/12/2025

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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	the parking lot in the event of a facility fire and was unsure of the next step to take afterwards in case of a fire. Employee 3 indicated she had not been made aware of the RACE protocol or any other type of fire safety protocol during her training. The personel file review did not include specific orientation of fire safety procedures. On 4/4/2025 at 2:15 P.M., the Interim Director of Nursing (DON) provided a policy titled, "Orientation and Training", dated 10/1/2021 and indicated the policy was the one currently used by the facility. The policy indicated "...training will be provided to employees...in the following areas...emergency procedures...."		in-serviced by OPS HR on 4/28/25. The Executive Director is responsible for the completeness of the HR files. The Executive Director will complete weekly audits of HR system for completeness for 2 weeks and monthly ongoing. The Administrative Assistant will be directed by the Executive Director to keep records up to date and compliant going forward. Date of completion: 5/18/25	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency Based on observation and interview, the facility failed to ensure the residential environment was free from odors for 1 of 6 hallways observed. (north, first floor hallway) Finding includes: On 4/3/2025 at 10:55 A.M., a strong, pervasive urine odor was noted on the north end of the first floor hallway. On 4/3/2025 at 12:25 P.M., a facility staff member was observed vaccuuming the carpet on the north end of the first floor hallway. However, after the staff had finished vaccuuming, the urine odor was still pervasive. On 4/4/2025 at 1:12 P.M., a strong odor of urine was present in the north corridor of the first floor	R 0144	The Residents of the facility have the potential to be affected by this alleged deficiency. The deficiency was corrected immediately. The North Hallway Shampooed 4/4/25. The Maintenance Director was educated on the regulation for a clean community by the Executive Director on 4/28/25. The Maintenance Director is responsible to update and enforce the cleaning schedule. Ongoing Carpeted areas in the community will be be shampooed regularly per new carpet cleaning schedule and as needed between scheduled dates. The Executive Director is	05/18/2025

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	of the residential area. A facility policy for environment was requested on 4/4/2025. A policy was not provided prior to the survey exit. This Residential finding relates to complaints IN00455383.		responsible for the oversight of cleanliness of the building – Executive Director will complete rounds of the facility to ensure cleanliness and odor free weekly for 4 weeks and monthly ongoing. Any issues will be corrected immediately by the appropriate team member as directed by the Executive Director. Date of completion: 5/18/25	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared in a sanitary manner related to labeling, dating, disposing of expired foods and safe thawing techniques. This deficient practice had the potential to affect 49 of 49 residents who received meals from the kitchen. Finding includes: 1. During a tour of the kitchen with the cook, on 4/3/2025 from 9:45 A.M. - 10:20 A.M., the following was observed: -There was frozen hamburger sitting on the counter in a container covered with plastic wrap, thawing. It was unknown how long the meat had been thawing on the counter. -An opened box of elbow noodles without an open date. -Twelve spice containers on a shelf had the lids opened. - In the refrigerator, there was a metal pan with vegetable soup dated 3/28 and used by date of 3/30, three pitchers with beverages undated, and	R 0273	The Resident's of the facility have the potential to be affected by this alleged deficiency. The refrigerators and dry good storage were immediately inspected for dating, labeling and expiration, fridge and freezer temperatures, storage of dry goods and proper thawing. Daily kitchen audits performed by Executive Director or designee start 4/28/25 though 5/11/25, then biweekly 5/12/25 though 5/26/25 and regularly monitored therefore after. Results of these audits will be discussed at the Quarterly QA meeting and ongoing need will be determined by this committee. Dietary Staff Inservice will be provided by Executive Director and Dietary Manager on 4/28/25 educating on dating, labeling and expiration, fridge and freezer	05/18/2025

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	an employee's bottle of iced tea. -In the freeze,r there was a container of ice cream, bag of peas, bags of green peppers, bags of vegetable blend, packages of hot dogs, boxes of battered pollack fish opened without an open date. In addition, there was a metal pan with six leftover black bean burgers undated. - There was a scoop stored on top of the brown sugar stored in a small, plastic container. -There were three containers with dry cereal undated. -Logs for the refrigerator/freezer and dishwasher temperatures were not completed from 3/22/2025 through 3/31/2025. During an interview on 4/3/2025 at 10:15 A.M., the cook indicated the food/beverages should have been labeled when opened, food should have been disposed of when expired, food in containers should not have a scoop in them, temperature logs should have been completed daily and meat should have been thawed correctly. A policy was provided by the ED on 4/3/2025 at 11:06 A.M., titled "Thawing Food," dated 10/1/2021, and indicated the policy was the one currently used by the facility. The policy indicated..." Food that is frozen should be thawed in such a manner as to prevent the temperature of the food from rising above 41 degrees Fahrenheit. Methods For Thawing Food 1. Under refrigeration. a. Food to be thawed will be placed in the refrigerator one,two, or three days before it is needed to allow it to be thawed at 41 degrees or less over a period of time. 2. Submerging in running water. 3. As part of the cooking process. 4. By use of a microwave oven....." A policy titled, "Labeling and Dating for Safe Storage," dated 10/1/2021. The policy		temperatures, storage of dry goods and proper thawing. The Executive Director and/or Dietary Manager are responsible for compliance of kitchen regulations. Date of Completion: 5/18/25	

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	indicated..."Labeling and Dating are critical in order to promote food safety. All products should be dated upon receipt. Use "use-by-dates" on all food once opened and stored under refrigeration. 9. When to throw food away. a. Leftover food can be kept for a few days but should be thrown out before they spoil....."			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency Based on record review and interview, the facility failed to ensure pharmacy medication reviews were completed for 7 of 7 residents reviewed. (Residents B, 2, C, 3, D, 4 and 5) Findings included: The clinical records for Resident's B, 2, C, 3, D, 4 and 5 were reviewed on 4/4/2025. There was no documentation a pharmacy medication review had been completed every sixty days during the past year for any of the records reviewed. During an interview, on 4/4/2025 at 1:45 P.M., the interim Director of Nursing (DON) indicated she was unable to locate the pharmacy reviews for the requested residents for the last year other than the March 2025 pharmacy reviews. The interim DON indicated the pharmacy reviews should have been reviewed and documented for all of the residents every 60 days. On 4/4/2025 at 2:15 P.M., the Administrator indicated the facility did not have a policy regarding pharmacy medication reviews but instead, followed the state regulations.	R 0298	The Resident's of the facility have the potential to be affected by this alleged deficiency. Current Pharmacy recommendations were provided to Nurse Practitioner 4/14/2025 and orders followed. OPS Corporate Nurse Consultant to educate new DON on pharmacy consult policy on 4/29/25. The Director of Nursing is responsible for compliance with pharmacy recommendations. The Director of Nursing will ensure that all recommendations are provided to the proper practitioners following each pharmacy audit ongoing. Once the recommendations are sent to PCP the DON will be responsible for tracking response from PCP and follow up as needed. Audits will be tracked for 6 months and results of responses from PCP will be reviewed at the Quality Meeting quarterly with recommendations determined by the committee to be followed by the DON.	05/18/2025

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R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency Based on observation and interview, the facility failed to ensure the medication cart was locked when not in use for 1 of 2 medication carts reviewed. Finding includes: During an observation, on 4/4/2025 at 8:10 A.M., a medication cart was located at the end of the north hall on the second floor. There were no facility staff present in the hallway. The medication cart was unlocked and the medication drawers were able to be opened. During an interview, on 4/4/2025 at 8:13 A.M., QMA 2 indicated the medication cart should have been locked at all times and the computer closed when the facility staff were not present. On 4/4/2025 at 2:15 P.M., the Administrator provided a policy titled, "Medication Treatment Administration Assistance", dated 10/1/2021 and indicated the policy was the one currently used by the facility. The policy indicated "...while assisting with medication administration, the medication cart is kept closed and locked when out of sight by the nurse or medication aide...."	R 0304	Date of Completion: 5/18/25 The Resident's of the facility have the potential to be affected by this alleged deficiency. The cart was observed to locked at the time of notification of the deficiency. Staff Member educated on locking medication cart. Clinical Staff will be educated on locking medication cart and other privacy policies on 4/28/28 by the Director of Nursing and Executive Director. The Director of Nursing is responsible for ongoing compliance of this regulation. Director of Nursing will complete daily rounds ongoing at random times to ensure that Medication is properly stored. Rounds will be documented daily Monday thru Friday for 3 weeks results will be discussed by QA Committee and QA Committee will determine the stop date for documented rounds QA meeting date to determine further need will be June 4, 2025. Completion date: 5/18/25	05/18/2025