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	05/10/2024

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 IN00432408 & IN00432035. Complaint IN00432408 - No deficiencies related to the allegations are cited. Complaint IN00432035 - No deficiencies related to the allegations are cited. Survey dates: May 9 & 10, 2024 Facility number: 013555 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/17/24.	R 0000	This will serve as the Plan of Correction for noted deficiencies from Annual Survey that was completed on 5/9/24 and 5/10/24 at Grand Emerald Place in South Bend Indiana. We, respectfully, request paper compliance for this Survey.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leigh	Keirn	06/10/2024

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.

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	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure twelve fire drills were conducted a year. This had the potential to affect the 50 residents residing at the facility. Finding includes: During an interview on 5/9/2024 at 9:30 A.M., the Maintenance Director indicated he had started this position at the beginning of the year. He was unsure how to locate last year fire drills but would look for them. He did have a fire drill in conjunction with the local fire department scheduled next month. On 5/9/2024 at 11:30 A.M., the Maintenance Director provided the fire drills for 2024, and May and June of 2023 and indicated that was all he could locate. On 5/9/2024 at 1:30 P.M., the Executive Director indicated the facility did have a fire drill set up with the fire department last year, but they did not show up. On 5/10/2024 at 1:20 P.M., the Executive Director indicated that she could not locate any other documentation of fire drills that were conducted last year and they should be done monthly every	R 0092	Residents of the Facility have the potential to be affected by the alleged deficiency. While Fire Drills were conducted, the facility has been unable to locate the previous fire drills and we are unable to request location due to death of previous Maintenance Director this year. Fire Drills were completed on each of 3 shifts in the Month of May post Survey. Monthly Fire Drills will be completed on rotating shifts each month and placed in the Emergency Book by the Maintenance Director. The Fire Department has been requested to join Grand Emerald Place in an Evacuation Drill during the Month of June - we will hold this drill on June 26, 2024. The Executive Director will monitor Fire Drill compliance monthly for 6 months and address any lack of compliance immediately and take	06/28/2024

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	shift. On 5/10/2024 at 12:58 P.M., the Executive Director provided a policy titled, "Disaster/Emergency Drills", dated 10/3/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...1. The Fire Drills will be conducted at least once per shift per quarter. It is recommended that fire drills are conduced once a month for every shift. a. Documentation will be in the Emergency Book. Total Evacuation Drill will be performed bi-yearly in conjunction with the local fire department....."		findings to the quarterly QA meeting.	
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 record review and interview, the facility failed to ensure weights were obtained and documented semiannually for 1 of 7 residents reviewed. (Resident 4). Finding includes: A record was reviewed for Resident 4 on 5/9/2024 at 11:00 A.M. Resident 4 was admitted on	R 0216	Residents of the Facility have the potential to be affected by the alleged deficiency. Resident 4 was weighed on May 10, 2024 and documented weight. The Director of Nursing will complete an audit of current	06/28/2024

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	10/28/22. There was no semi-annual weight documented in the resident's record for 2023 or 2024. During an interview on 5/9/2024 at 11:29 A.M., the Director of Nursing indicated she had no documentation of the resident's weights since admission.		Residents to ensure Semi annual weights are obtained and documenting, correcting any issues by weighing resident immediately if lack of compliance is found. Current Residents of the Facility will have documented weights in June 2024 and December 2024 and more often as ordered or indicated. DON Audit will be reported to Quarterly QA meeting with this committee determinining at what time audits can be stopped.	
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 on observation and interview, the facility failed to ensure food was stored in a sanitary manner, failed to ensure outdated foods were removed, failed to ensure dented cans were removed, failed to ensure utensils were clean before storing, and failed to ensure proper beverage handling related to staff members thumbing clean glasses when distributing drinks. This had the potential to affect all 50 residents who received food from the kitchen. Findings include: 1. On 5/9/2024 at 9:05 A.M., during a kitchen observation with Cook 4, the following was observed:	R 0273	Residents of the Facility have the potential to be affected by the alleged deficiency. The Dietary Manager will re-educate Dietary staff on Safe food handling, cleaning and proper food storage on June 5 and 6 2024. Clinical Staff will be re-educated on Safe Food Handling on June 5 and 6, 2024 by the Dietary manager. The Dietary Manager will conduct an audit of Dry and Cold food	06/28/2024

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	a. In the walk-in freezer there was a bag of opened peas not sealed appropriately. b. The dry storage had a bag of chocolate pudding mix not sealed appropriately, 2 dented cans of cream of mushroom soup, 1 dented can of beans, and a container of oregano with an expiration date of 10/13/2023. 2. During a follow-up observation on 5/10/2024 at 9:08 A.M., the following was observed. There were 2 ice cream scoops and 1 spatula in the kitchen drawer with dry food left on them. During an interview on 5/9/2024, at 9:20 A.M., Cook 4 indicated the bag of peas should have been sealed appropriately, the expired oregano should have been thrown out, and the dented cans should have been returned to the store. During an interview on 5/10/024, at 9:13 A.M., Cook 4 indicated the 2 ice cream scoops and spatula should have been cleaned prior to placing them in the drawer.2. During an observation on 5/9/2024 at 12:00 P.M., CNA 2 placed her fingertips on the rim of two water glasses and one coffee cup when she passed the drinks to the residents. An interview was completed on 5/9/2024 at 12:05 P.M. CNA 2 indicated she did not know if she should touch the rims of the glasses with her fingertips. On 5/9/2024 at 2:13 P.M., the Executive Director provided a current policy, dated 10/1/2021, and titled, "Food Safety." The policy indicated "...To provide food that is free from contamination thus risking the health and well-being of the residents and staff....."		storage weekly for 4 weeks and monthly ongoing to ensure that there are not improperly sealed items, dented cans or outdated foods or spices. Any findings will be addressed as found. The Dietary Manager will audit food handling utensils to ensure cleanliness weekly for 4 weeks and monthly ongoing to ensure only clean utensils are in storage for use. Results of audits will be reviewed at Quarterly QA meetings and recommendations will be acted on immediately.	

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	On 5/9/2024, at 2:13 P.M., the Executive Director provided a policy titled," Cold Food Storage and Dry Food Storage," dated 10/1/2023. The policy indicated "...Food being returned to storage after cooking or preparation must be covered....." On 5/10/2024, at 10:30 A.M., the Executive Director provided a policy titled, "Cleaning", dated 1/10/2024. The policy indicated "...1. All equipment, food contact surfaces, and utensils shall be cleaned: D. Whenever contamination may have occurred....."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, record review, and interview, the facility failed to secure medications appropriately in a resident's room for 1 of 1 resident who was reviewed for self-administration of medication. (Resident 6) Finding includes: During a room observation on 5/9/2024 at 1:50 P.M., Resident 6 had prescription and over the counter medication bottles stored in a wooden box located on her dresser. During an interview on 5/9/2024 at 1:51 P.M., Resident 6 indicated she self-administered all of her medications, and the wooden box did not have a lock. A record review was completed on 5/9/2024 at 1:56 P.M. Resident 6's current Self Medication Assessment, dated 3/1/2024, indicated the	R 0295	Residents of the Facility have the potential to be affected by the alleged deficiency. Residents who self medicate will be re-educated on proper Medication Storage by the Director of Nursing on 6/5/24. The Director of Nursing will ensure that residents who self medicate have proper storage in their individual apartments. The Director of Nursing will audit the storage of medications in appropriate Resident rooms monthly with concerns being addressed immediately. Results of DON audit will be	06/28/2024

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	resident was capable of self-administering her medications. During an interview on 5/9//2024, at 2:00 P.M., QMA 4 indicated the resident self-administered her medications and they should have been in a locked box. On 5/9/2024, at 2:13 P.M., the Administrator provided the policy titled, "Self-Administration," dated 1/10/2024, and indicated it was the policy currently being used by the facility. The policy indicated,"...5. Storage of self-administered medications will comply with state and federal regulations. All bedside medications will be maintained in the resident's room...."		reported at Quarterly QA meetings and any recommendations will be acted on immediately,	
R 0379 Bldg. 00	410 IAC 16.2-5-11.1(c) Mental Health Screening - Deficiency (c) If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record. Based on interview and record review, the facility failed to refer a resident with a major mental illness for mental health services for 1 of 5 residents review for mental health services. (Resident C)	R 0379	Residents of the Facility have the potential to be affected by the alleged deficiency. Resident C has been referred to	06/28/2024

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	Finding includes: A record review for Resident C was conducted on 5/9/2024 at 2:58 P.M. Resident C's diagnoses included major depressive disorder. The record lacked documentation of any mental health services provided or offered to the resident. During an interview on 5/10/2024 at 12:36 P.M., the DON indicated Resident C should have received mental health services and none had been provided. A current policy, dated 10/1/2021, and titled, "Health Counseling" was provided on 5/10/2024 at 1:00 P.M., by the DON. The policy included, but was not limited to, "... Health counseling should occur when the resident has a concern or the staff has identified a concern ...."		the Facility Psych NP and will be seen on 6/6/24. The Service Plan will be updated with the Nurse Practitioner recommendations post visit. The Director of Nursing will audit current residents who have mental health diagnosis to ensure that proper referrals have been made and executed as appropriate and Service plans will be updated to reflect such actions. DON Audits will be reviewed at Quarterly QA meetings and any recommendations will be acted on immediately	
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements.			

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	Based on interview and record review, the facility failed to develop a comprehensive care plan in coordination with mental health service providers for 1 of 5 residents reviewed for mental health services. (Resident C). Finding includes: A record review for Resident C was conducted on 5/9/2024 at 2:58 P.M. Resident C's diagnoses included, but were not limited to, major depressive disorder. The record lacked a comprehensive care plan for care that was coordinated with a mental health provider. During an interview on 5/10/2024 at 12:36 P.M., the DON indicated Resident C should have received mental health services, but coordinated care had not been completed. A current policy, dated 10/1/2021, and titled, "Health Counseling" was provided on 5/10/2024 at 1:00 P.M., by the DON. The policy included, but was not limited to "...Health counseling should occur when the resident has a concern or the staff has identified a concern....."	R 0383	Residents of the Facility have the potential to be affected by the alleged deficiency. Resident C has been referred to the Facility Psych NP and will be seen on 6/6/24. The Service Plan will be updated with the Nurse Practitioner recommendations post visit. The Director of Nursing will audit current residents who have mental health diagnosis to ensure that proper referrals have been made and executed as appropriate and Service plans will be updated to reflect such actions. DON Audits will be reviewed at Quarterly QA meetings and any recommendations will be acted on immediately	06/28/2024