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	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKDALE SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(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. This visit included the Investigation of Complaint IN00402312. Complaint IN00402312 - No deficiencies related to the allegations are cited. Survey dates: June 27 and 28, 2023 Facility number: 010667 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 7/6/2023.	R 0000	No response needed.	
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 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robyn Challinor	Administrator	07/24/2023

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	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 record review and interview, the facility failed to ensure a fire and disaster drill was conducted every 6 months in conjunction with the local fire department. This had the potential to affect 29 of 29 residents residing in the facility. Finding includes: A review of fire drills for the last 12 months, conducted on 6/27/2023 at 2:22 P.M., indicated that the fire department had not been involved in any fire drills held from May of 2022 through June of 2023. During an interview, on 6/28/2023 at 9:07 A.M., the Wellness Director indicated she spoke to the former Maintenance Director, and the fire department had not been present during any fire drills and had not been contacted to be present, as the Maintenance Director was unaware of the regulation. A current policy provided by the Business Office Manager, on 6/28/2023 at 9:28 A.M., titled, "Fire Drills" and revised April 2022, indicated a general procedure for conducting a fire drill and specific procedures for various states but did not contain procedures for the state of Indiana.	R 0092	The following is the Plan of Correction for Brookdale South Bend regarding the Statement of Deficiencies dated 7/6/2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. R0092 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected.How the facility will	07/31/2023

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			identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; all residents have the potential to be affected.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Maintenance Director in-serviced on state regulation that fire drills must be conducted in conjunction with local fire department every 6 months by the Executive Director on 7/24/23 Fire drill with local fire department conducted on 7/19/23. Maintenance manager will schedule fire drill with fire department every 6 months going forward.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Maintenance Director will schedule and hold fire drill with the fire department every 6 months. The Maintenance Director will document fire drills with fire department in work order documentation system. Executive Director and/or designee to monitor work order system 1x monthly for 12 months to verify monthly fire drill occurs including fire drill with the fire department every 6 months.By what date the systemic changes will be completed by July 31st, 2023.	

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R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff met requirements regarding First Aid and CPR (Cardiopulmonary Resuscitation) training of 1 certified staff per shift for 13 of 21 shifts reviewed. This had the potential to affect 29 of 29 residents. Finding includes: On 6/28/2023 at 11:20 A.M., a review of schedules for all three shifts, dated 6/25/2023 through 7/1/2023 indicated 13 shifts were not covered with personnel that had CPR and First Aid training.	R 0117	The following is the Plan of Correction for Brookdale South Bend regarding the Statement of Deficiencies dated 7/6/2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory	07/31/2023

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	The shifts were as follows: -6/25/2023 6:30 A.M.-2:30 P.M., 2:30 P.M.-10:30 P.M., and 10:30 P.M.-6:30 A.M. -6/26/2023 6:30 A.M.-2:30 P.M. and 10:30 P.M.-6:30 A.M. -6/27/2023 6:30 A.M.-2:30 P.M. and 10:30 P.M.-6:30 A.M. -6/28/2023 10:30 P.M.-6:30 A.M. -6/29/2023 2:30 P.M.-10:30 P.M. and 10:30 P.M. -6:30 A.M. -6/30/2023 6:30 A.M.-2:30 P.M. and 10:30 P.M.-6:30 A.M. -7/1/2023 10:30 P.M.-6:30 A.M. During an interview, on 6/28/2023 at 2:07 P.M., the Wellness Director indicated those 13 shifts were not covered by personnel with CPR and First Aide training and should have been. During an interview, on 6/28/2023 at 2:30 P.M., the Business Office Manager indicated they did not have a policy regarding staffing every shift with personnel with CPR and First Aide training.		requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. R0117 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Health and Wellness Director completed an audit of nursing employee files to ensure they have a current CPR and First Aid Certification on 7/18/23. Community will ensure that there is always an associate with current CPR and First Aid certification scheduled each shift. QMAs and nurses will be certified in CPR and First Aid. Going	

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			forward nursing staff will be certified in CPR and First Aid prior to working on the floor. Executive Director and/or designee will audit all first aid and CPR certifications on a monthly basis. Nurses and QMAs who are not CPR and First Aid certified will be removed from schedule and replaced with someone who is certified until certifications are renewed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Executive Director and/or designee will audit nursing work schedule 5x weekly x4 weeks; 1x weekly x4 weeks and 1x monthly x 3 months and until deficient practice is resolved to ensure there is an employee with a current CPR and First Aid certification on the schedule at all times. By what date the systemic changes will be completed July 31st, 2023.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication			

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	administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure staff had the required in-services completed yearly for 1 out of 5 employees reviewed for employee files. (CNA 2) Finding includes: During the record review, on 6/28/2023 at 10:30 A.M., the Certified Nurse Aide (CNA) 2 with a hire date of 10/8/2014 did not have abuse training in-service completed since 2/26/2020.	R 0120	The following is the Plan of Correction for Brookdale South Bend regarding the Statement of Deficiencies dated 7/6/2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our	07/31/2023

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	During an interview, on 6/28/2023 at 2:54 P.M., the Business Office Manager indicated that they use Relias for in-services and abuse is done upon hire and yearly. They do not have a policy.		ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. R0120 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. CNA 1 of 2 CNA's had not completed their new hire onboarding before quitting; C.N.A 2 of 2 completed abuse training on or before her next shift 7/20/23. The Executive Director completed an audit on associates in-service records in Relias to ensure associates have had the yearly abuse training on July 10, 2023.	

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			Associates to be in-serviced on July 27, 2023 by the Executive Director and the Health and Wellness Director on the Brookdale Abuse Policy and the updated Indiana Abuse Policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Executive Director and/or designee will audit monthly x6 months new hires to ensure abuse training is completed on hire. Executive Director and/or designee will monitor trainings monthly x 12months to ensure associates have the required trainings yearly. By what date the systemic changes will be completed July 31st, 2023.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test			

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	must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure a second step tuberculosis skin test was completed for a new hire for 1 out of 5 reviewed for employee files. (CNA3) Finding includes: A record review was completed for Certified Nurse Aide (CNA) 3 on 6/28/2023 at 11:00 A.M. The hire date was 4/13/2023 with first step completed on 4/7/2023. During an interview on 6/28/2023 at 2:25 P.M., the Business Office Manager indicated that they do a 1st and 2nd step for all employees.	R 0121	The following is the Plan of Correction for Brookdale South Bend regarding the Statement of Deficiencies dated 7/6/2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions	07/31/2023

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	On 6/28/2023 at 3:54 P.M., the Business Office Manager indicated the employee did not have a 2nd step tuberculosis skin test completed and should have. On 6/28/2023 at 3:54 P.M., the Business Office Manager provided a policy titled, "Tuberculosis Testing", revised 6/2021, and indicted the policy was the one currently used by the facility. The policy indicated "...[Name of facility] performs intradermal Tuberculosis (TB) testing on new hires either by skilled professional in-house or sending the new associate to a contracted vendor...."		in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. R0121 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. CNA 3 is no longer working for the community. The Executive Director and/or designee will audit associate files to ensure associates have the 2 step TB testing completed on hire by 7/18/23. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The ED and/or designee will audit new hires for 12 months to ensure	

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			a 2 step PPD has been completed upon hire. By what date the systemic changes will be completed July 31st, 2023.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure the kitchen was clean and maintained in good repair for 1 of 1 kitchens reviewed. This deficient practice had the potential to affect 29 of 29 residents who received meals out of the kitchen. Finding includes: 1. During initial tour of the kitchen on 6/27/2023 from 9:45 to 10:25 A.M., the following was observed: -The following items were in the refrigerator without an open date: metal container covered with plastic wrap of mashed potatoes, bottle of ketchup, cheese slices, large pan of jello, fruit cocktail, gallon of milk, bottle of tomato juice, a tomato sliced, and 8 slices of cake with whipped topping uncovered and undated. -The freezer had the following items unlabeled: 2 bags of breaded fish, 3- gallon container of ice cream 1/4 gone, a gallon of ice cream 3/4 empty, 2 Ziploc bags with ham, bag of peas, diced chicken, and 2 bags with fish filets with freezer burn not sealed properly or labeled. -The floors behind the stove, under the	R 0154	The following is the Plan of Correction for Brookdale South Bend regarding the Statement of Deficiencies dated 7/6/2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. R0154	07/31/2023

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	refrigerators and freezer had visible food particles and dirt under them. -The stove top, black splash had buildup of grease and brown substance on the stainless steel and oven was chalky white substance and dark discoloration on inside the door. During an interview, on 6/27/2023 at 9:49 A.M., the cook 6 indicated that the temperatures and sanitizer pail should be taken daily several times and they were not on those dates. During an interview, on 6/27/2023 between 10:00 A.M. to 10:15 A.M., the Dining Service Coordinator indicated that the food items should have been wrapped properly and labeled with an open date. The floors were cleaned every evening but he did not have a cleaning schedule for the kitchen. The stove and oven are cleaned every 2-3 months. 2. During a return observation of the kitchen on 6/27/2023 at 12:15 P.M., a window air conditioner was running with black substance on the vents with the air pointing to the food prep island in the center of the room. During an interview, on 6/27/2023 at 12:20 P.M., the Dining Service Coordinator indicated that the front of the air conditioner was dirty, and it is aimed at the food prep area and should be cleaned. On 6/27/2023 at 11:30 A.M., the Director of Nursing provided a policy titled. "Cleaning Schedule", revised 5/10. and indicated the policy was the one currently used by the facility. The policy indicated "...Policy Overview: In order to serve food in a safe and sanitary manner, a cleaning schedule must be posted and initiated to		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Executive Director will in-service Dining Manager and dining associates on dating and labeling food items policy and the cleaning schedule policy. The Executive Director and Dining Manager to implement a cleaning schedule for the kitchen. A thorough cleaning of the kitchen was completed by 7/28/23. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director and/or designee will audit 5 times a week for 4 weeks, then twice a week times 4 weeks, then weekly x 4 weeks and then monthly x 3 months. y what date the systemic changes will be completed July 31st, 2023.	

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		A. BUILDING 00 B. WING	06/28/2023

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	ensure that all cleaning tasks are completed...." On 6/27/2023 at 11:30 A.M., the Director of Nursing provided a guideline titled, "Clean Stove Top and Clean Kitchen Floors, dated May 2007, and indicated the policy was the one currently used by the facility. The guideline indicated "...To provide a guideline for cleaning and sanitizing equipment and work areas surrounding food storage, food preparation, food service and dining. The kitchen and dining areas, equipment, furniture, and janitor closets shall remain free from debris and clean...." On 6/27/2023 at 2:46 P.M., the Business Office Manager indicated they did not have a policy on air conditioner/fan in the kitchen. On 6/27/2023 at 2:47 P.M., the Business Office Manager provided a policy titled, "Labeling", revised 5/10, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy Overview: All food items must be labeled and dated before storing. Policy Detail: 1. All food items upon receipt from food vendors must have a date marked before putting in any storage (dry, refrigerator, freezer, pantry). This should be done even if the food item has a use by or sell by date marked by the manufacturer. 2. All prepared items (i.e. leftovers or prepared for next meal) must have a label with the name of item, date prepared, by whom, and date of discard...." On 6/28/2023 at 11:22 A.M., the Director of Nursing provided the policy titled, "Temperature Log - Equipment", revised 8/2018, and indicated the policy was the one currently used by the facility.The policy indicated, "...Food holding equipment temperatures must be monitored every four hours during operating hours. Refrigerator			

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	35 to 40 degrees F and freezer -10 to 0 degrees F. On 6/28/2023 at 11:22 A.M., A current policy titled, "Sani-Pail Test Log", revised 4/2021, was provided by the Director of Nursing. The policy indicated "...Sanitation solution must be tested and recorded at minimum every two hours for all sanitizers. Solution must be replaced every 4 hours for Smarpower Sink Surface. Appropriate test strips must be available and utilized...."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to complete and provide an emergency record for 1 of 7 residents reviewed for emergency records. (Resident E) Finding includes:	R 0356	The following is the Plan of Correction for Brookdale South Bend regarding the Statement of Deficiencies dated 7/6/2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and	07/31/2023

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	During a record review, on 6/28/2023 at 9:43 A.M., Resident E had no emergency information located in the facility emergency binder. During an interview, on 6/28/2023 at 9:50 A.M., DON (Director of Nurses) indicated that she did not believe that the resident E had an emergency record on file. DON looked through the binder and indicated that resident E's record should be in there but was not. On 6/28/2023 at 10:35 A.M., the business manager provided a current policy titled "Emergency Preparedness-Planning for Evacuations", effective 2/2020 with no revision date. The policy indicated " ...Policy Overview: the emergency information packet shall include: resident face sheet/admission record including contact information of responsible party/family/POA, social security, date of birth, Medicare/Medicaid numbers/insurance numbers, allergies, diagnoses/medical conditions, photograph, current medication list, DNR status, power of attorney/advance directives, diet and special provisions, mode of transfer. Resident packets are updated at least quarterly during care planning to ensure accurate information. These arrangements shall be documented and maintained in the resident's medical record ...."		conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. R0356What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident E's emergency information was placed in the facility emergency binder on 7/5/23.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; an audit of the emergency files for residents was completed on 7/5/23 by the Health and Wellness Director to ensure all emergency information was present for the resident.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Health and	

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			Wellness Director and/or designee will verify emergency information is placed in the facility emergency binder on each resident upon move in to the community.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Executive Director and/or designee will review the facility emergency binder 1x monthly for 6 months and then randomly to verify emergency information is noted for residents. By what date the systemic changes will be completed by July 31st, 2023.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to			

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	have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a Tuberculin Test was given on, or prior to admission and a second step was completed for 1 out of 7 charts reviewed . (Resident H) Findings include: A record review for Resident H was completed on 6/28/2023 at 10:00 A.M. Resident H was admitted on 5/4/2023. A Medication Administration Record (MAR), dated 5/4/2023, indicated to administer Tuberculin PPD intradermal one time a day yearly and was administered on 5/5/2023 and on 5/19/2023. During an interview, on 6/28/2023 at 10:45 A.M., the Director of Nursing indicated that the order to read the results appeared under admission orders but was not placed on the Medication Administration Record, so there was no documentation that the Tuberculin Test was read. On 6/282023 at 11:00 A.M., the Director of Nursing provided a policy titled, "Tuberculosis Screening/Testing", revised 5/2023, and indicated the policy is the one currently used by the facility. The policy indicated "...Policy Overview: Residents will be screened or tested for Tuberculosis (TB) per state guidelines. Policy Detail: 1. Testing should be performed on each new resident within three months prior to admission, or within one week of admission or per state regulation, 2. Testing Method may include: Mantoux skin test- using the two-step method...."	R 0410	The following is the Plan of Correction for Brookdale South Bend regarding the Statement of Deficiencies dated 7/6/2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. R0410 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident H expired on 6/6/23.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The Health and Wellness Director will complete an audit on all	07/31/2023

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			current residents by 7/10/23 to ensure all residents have received a 2 step PPD on admission with documented read results. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Health and Wellness Director will in-service nursing staff on Tuberculosis Screening/Testing Residents Policy and how to enter PPD step 1 and step 2 with read dates in the electronic medical record on 7/25/23.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; By what date the systemic changes will be completed. The Health and Wellness Director and/or designee will complete audits on new admissions to ensure their PPD step 1 and step 2 are entered correctly in the electronic medical record to include the read date. By what date the systemic changes will be completed July 31st, 2023.	