STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155684	A. BUILDING 00 B. WING	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHFIELD VILLAGE	6450 MIAMI CIR SOUTH BEND, IN 46614

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00445775 and IN00446163. Complaint IN00445775 - No deficiencies related to the allegations are cited. Complaint IN00446163 - No deficiencies related to the allegations are cited. Survey dates: 10/24/2024, 10/25/2024, 10/26/2024, 10/27/2024, 10/28/2024, 10/29/2024, 10/30/2024 and 10/31/2024 Facility number: 002662 Provider number: 155684 AIM number: 200315930 Census Bed Type: SNF/NF: 38 SNF: 15 Residential: 40 Total: 93 Census Payor Type: Medicare: 6 Medicaid: 29 Other: 58 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 11/7/2024	F 0000	This Plan of Correction constitutes my 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.	

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

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on observation, record review and interview, the facility failed to notify the physician of elevated blood glucose levels for 2 of 2 residents reviewed for blood glucose levels (Residents 7 and 3). Findings include: 1. On 10/28/2024 at 10:02 A.M., a record review was completed for Resident 7. Diagnoses included, but were not limited to: type 2 diabetes A Physician's order, dated 6/11/2024, indicated the physician was to be notified if Resident 7's blood glucose levels were below 70 or above 200. A review of Resident 7's blood glucose results for the months of August, September and October 2024 indicated the record lacked documentation the physician was notified of elevated blood glucose levels above 200 mg/dl for the following dates: - On 8/4/2024, Resident 7's blood glucose level was 263 mg/dL. - On 8/10/2024 the resident's blood glucose level was 276 mg/dL. - On 8/17/2024 the resident's blood glucose level was 319 mg/dl. - On 8/18/2024 the resident's blood glucose level was 222 mg/dL. - On 8/19/2024 the resident's blood glucose level was 236 mg/dL. - On 8/20/2024 the resident's blood glucose level was 210 mg/dL. - On 8/25/2024 the resident's blood glucose level was 301 mg/dL.	F 0580	The physician for residents #3 and #7, was notified that the blood sugar levels were outside of the parameters established by the attending physician. An audit has been conducted of all other residents that have parameters established for blood sugar levels to assure the physician has been notified of any variances. No other residents were identified. To prevent reoccurrence, all nurses and qualified medication aides have been in-serviced on notifying the physician when blood sugar levels are outside of the parameters established by the physician. Additionally, new documentation has been created on the medication administration record (MAR), that requires staff to verify the physician was notified of any variances. Audits of the notification process will be completed by the Director of Nursing or her designee weekly, until 100% compliance is achieved for 30 days. Audits will end when 100% compliance is obtained for 60 days. The results of the audits will be reported to the QAPI Committee monthly.	11/30/2024

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	- On 9/14/2024 the resident's blood glucose level was 266 mg/dL. - On 9/28/2024 the resident's blood glucose level was 221 mg/dL. - On 10/25/2024 the resident's blood glucose level was 258 mg/dL. During an interview, on 10/28/2024 at 11:17 A.M., the Director of Nursing (DON) indicated a nursing note should have been associated with Resident 7's elevated blood glucose levels indicating the physician had been notified and would have been found in the residents electronic medication administration record (EMAR). During an interview, on 10/28/2024 at 2:15 P.M., the DON indicated Resident 7's EMAR lacked documentation the physician was notified of the residents elevated blood glucose levels and she indicated the physician should have been notified. 2. A record review was completed on 10/28/2024 at 10:08 A.M., for Resident 3. Diagnoses included, but were not limited to: type 2 diabetes mellitus with chronic kidney disease. A Physician's Order, dated 4/28/2023, indicated accuchecks were to be done weekly twice a day. The Physician the residents blood glucose level to be called if it was less than 70 or greater than 200. The Medication Administration Record (MAR) dated September 2024, indicated the following P.M. blood sugars: on 9/6/2024 was 321, and on 9/27/2024 was 221. The MAR dated October 2024, indicated the following P.M. blood sugars: on 10/4/2024 was 254 and on 10/18/2024 was 207.			

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	During an interview, on 10/28/2024 at 2:18 P.M., LPN 6 indicated when a physician was notified of an elevated blood sugar it would have been documented in the nursing progress notes. During an interview, on 10/28/2024 at 2:23 P.M., the DON indicated when a Physician was notified of an elevated blood sugar, the documentation could be found in a note with the order in the MAR, or in the nursing progress notes. DON was unable to locate in the electronic medical record any documentation of Resident 3's blood glucose levels of the Physician being notified. On 10/28/2024 at 2:44 P.M., the DON provided a policy titled, "Blood Glucose Monitoring," revised 4/3/2023, and indicated the policy was the one currently used by the facility. The policy indicated..."Policy: It is the policy of the facility to perform blood glucose monitoring to diabetic residents as per physician's orders. 20. Report critical test results to physician timely....." 3.1-5(a)(2)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to provide a copy of the Bed Hold Policy to a resident when admitted to the hospital for 1 of 3 residents reviewed for hospitalization. Finding includes: A record review was completed on 10/28/2024 at 10:00 A.M. for Resident 4. Diagnoses included, but were not limited to, Alzheimer's Disease,	F 0625	The facility's bed hold policy is always stapled to the Indiana state form, Notice of Transfer or Discharge, which was given to the resident and is part of their medical record. An audit was completed of all discharge/transfers for the last 30 days. No other residents were identified.	11/30/2024

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	chronic obstructive pulmonary disease and atrial fibrillation. A Nursing Progress Note, dated 9/7/2024, indicated Resident 4 had complained of shortness of breath and was confused at times. The resident's daughter indicated she thought the resident had pneumonia. The Medical Director was notified and gave an order for the resident be sent to the emergency room for an evaluation. An emergency room nurse called the facility and reported Resident 4 had pneumonia and was going to be admitted to the hospital. The record indicated the Notice of Transfer/Discharge was given but lacked documentation the Bed Hold Policy had been given to Resident 4. During an interview on 10/28/2024 at 11:04 A.M., the Employee 6 indicated a copy of the Bed Hold Policy, or documentation that it was given to the resident, was not located in the chart. On 10/30/2024 at 9:00 A.M., the MDS (Minimum Data Set) Nurse provided a copy of the Bed Hold Policy that should have been given to a resident when they were transferred and admitted to the hospital but the facility did not provide a policy indicating situations when the document was to be provided to the resident. 3.1-12(a)(25)(26)		To prevent reoccurrence, any staff member who may participate in a discharge/transfer will be in-serviced on how to fully complete the Notice of Transfer or Discharge form. All future transfers and discharges will be audited as they occur, by the Director of Nursing or her designee, to make sure the form is properly completed. Audits will continue with each transfer/discharge until 100% compliance is achieved for 30 days. The results of the audits will be reviewed by the facility's Quality Improvement and Process Improvement Committee (QAPI) monthly.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to have Care Plan meetings, quarterly, with residents and/or resident representatives for 2 of 2	F 0657	Residents #6 and 7 plans of care are current and the family and resident were both invited.	11/30/2024

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	residents who were reviewed for Care Plan meetings. (Resident 6 & 7) Findings include: 1. During an interview on 10/24/2024 at 10:35 A.M., Resident 6 indicated she had not been invited to Care Plan meetings with the facility staff. Resident 6's record review was completed on 10/25/2024 at 2:56 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, hemiplegia of the right side, dysphagia, aphasia, vascular dementia and emphysema. A Quarterly Minimum Data Set (MDS) assessment, dated 9/24/2024, indicated Resident 6 had intact cognition. Resident 6's record lacked the documentation a Care Plan meeting had been conducted on a quarterly basis with Resident 6 and/or her representative from 11/29/2023 through 5/2/2024. During an interview on 10/29/2024 at 10:42 A.M., the Social Services Director (SSD) indicated Care Plan meetings were completed after a MDS assessment, or at minimum, quarterly. The SSD indicated Resident 6 should have had a Care Plan meeting after she received an MDS assessment on 1/31/2024. 2. During an interview on 10/24/204 at 10:45 A.M., Resident 7's representative indicated he could not remember being invited to a Care Planning meeting. Resident 7's record review was completed on 10/28/2024 at 10:02 A.M. Diagnoses included, but		The Director of Social Services completed an audit of care plans for all other residents, verifying that their plans of care are current and families and residents were invited. To prevent reoccurrence, at the end of each month, the Director of Social Services will review the scheduled care plans and verify that all care plan conference were completed. This will continue indefinitely. The results will be reported to the QAPI Committee will be monitored for 60 days or until 100% compliance is achieved.	

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	were not limited to: type 2 diabetes mellitus, sick sinus syndrome, cardiomegaly and adjustment disorder. A Quarterly MDS assessment, dated 9/24/2024, indicated Resident 7 had severe cognitive impairment. Resident 7's record lacked the documentation indicating she had a Care Plan meeting had been conducted between 11/27/2023 through 4/8/2024. During an interview on 10/29/2024 at 10:42 A.M., the Social Services Director (SSD) indicated Resident 7 should have had a Care Plan meeting after November 2023 and before April 2024. On 10/29/2024 at 10:00 A.M., the SSD provided a policy, dated 1/2024, titled, "Care Plan Meetings", and identified it as the policy currently used by the facility. The policy indicated, "...Care plan meetings must occur every three months, and whenever there is a major change in a resident's physical or mental health that might require a change in care...." 3.1-(d)(2)(B)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review the facility failed to store and seal food in a sanitary manner related to sealing food appropriately in the walk-in cooler and failed to ensure serving utensils were clean in 1 of 1 kitchens. This had the potential to affect 53 of 53 residents who received their meals from the kitchen.	F 0812	All serving utensils were removed from the drawer, re-washed and the draw wiped out at the time. The lid on the pickle container was closed at the time it was discovered. A Sanitation audit was completed by the Culinary Manager for all	11/30/2024

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	Findings include: 1. During the initial kitchen tour with the Director of Food Services on 10/24/2024 at 9:43 A.M., the following was observed in the walk-in cooler: - a container of pickles was stored without a secure lid and was open to air. During an interview on 10/24/2024 at 9:45 A.M., the Director of Food Services indicated the lid of the pickles should have been secured. 2. During a follow-up kitchen tour with the Director of Food Services on 10/25/2024 at 9:45 A.M., the following was observed: - a metal scoop with dried food on it was stored in the clean utensils drawer. - a pair of metal tongs with dried food on it was stored in the clean utensils drawer. - the bottom of the clean utensils drawer had dried food and other debris. During an interview on 10/25/2024 at 9:52 A.M., the Director of Food Services indicated utensils should be clean before placing them in the drawers and the utensil drawer should have been cleaned. On 10/28/2024 at 11:27 A.M., the Director of Food Services provided the policy titled, "Date Marking for Food Safety Policy", dated 4/17/2024 and indicated it was the policy currently used by the facility. The policy indicated, "... 7. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed...."		areas of the kitchen. The Culinary Manager will do weekly audits of the kitchen for the next 30 days. After that time, weekly audits will continue until 100% compliance is achieved. Once this threshold is obtained, Sanitation audits will resume monthly. Additionally, all Culinary Staff will be in-serviced on the fundamentals of proper sanitation. The results of the audit and in-service will be reviewed by the facility's Quality Assurance and Process Improvement (QAPI) Committee to assure completion.	

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F 0880 SS=D Bldg. 00	3.1-21(i)(3) 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to ensure infection control practices were followed by 1 of 1 staff observed cleaning an isolation room and 1 of 1 staff observed providing catheter care. (Housekeeper 3 and CNA 4). Findings include: 1. During an observation on 10/25/24 at 11:18 A.M., Housekeeper 3 was observed cleaning Resident 251's room. The resident was on contact precautions due to Clostridium difficile. Housekeeper 3 wore a pair of gloves, but did not have on a gown. The Assistant Director of Nursing (ADON) was overheard telling Housekeeper 3 that she needed to have a gown on when in a residents room because the resident was on contact precautions. Housekeeper 3 indicated she thought the sign on Resident 249's room, which read Enhanced Barrier Precautions, and the sign on Resident 251's room, which read Contact Precautions were both the same. During an observation and interview on 10/25/2024 at 11:29 A.M., Housekeeper 3 was observed cleaning another room after leaving Resident 251's room. Housekeeper 3 indicated she did not remember having any training on the differences between contact precautions and enhanced barrier precautions and stated she only remembered learning that it was important to knock prior to entering a residents room. She indicated she did not realize there was a difference between the sign on Resident 249's room and the	F 0880	The Housekeeping staff that entered resident #251's room was sent home to shower and obtain clean clothing. The second unoccupied room that the Housekeeper was observed in, was recleaned. Resident #1 was given proper catheter care and observed for any signs and symptoms of infection. All Housekeeping staff will be in-serviced on the various forms of isolation and the proper use of personal protective equipment. Return demonstrations will be required. At least two direct observations by the Director of Housekeeping and the Director of Nursing or their designees, will occur per week, to monitor staff entering rooms with any type of isolation precautions. This will continue for 30 days. After that time, observation will continue until two weeks of 100% compliance is achieved. The results of the in-service and documented observations will be reviewed by the facility's Quality Assurance and Process Improvement (QAPI) Committee. With regards to the catheter care,	11/30/2024

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	sign on Resident 251's room. After reading the signs, she indicated she should have donned a gown prior to entering and cleaning Resident 251's room. During an interview on 10/25/2024 at 11:45 A.M., the ADON indicated Housekeeper 3 should have had a gown on prior to entering Resident 251's room. On 10/25/2024 at 1:38 P.M., a record review was completed for Resident 251. Diagnoses included, but were not limited to: entercolitis due to clostridium difficile. A Physician's Order, dated 10/22/2024 indicated Resident 251 may participate in activities outside the facility related to contact and droplet isolation. A review of Resident 251's Physicians Progress Notes indicated a positive Clostridium difficile result on 10/15/2024. 2. On 10/29/2024 at 9:35 A.M., a record review was completed for Resident 1. Diagnoses included, but were not limited to: neuromuscular dysfunction of bladder. A current Care Plan, initiated on 2/24/2020 indicated Resident 1 had an indwelling Foley catheter with the potential for infection related to neurogenic bladder and bladder spasms. Interventions included were to provided catheter care per protocol and Enhanced Barrier Precautions. During an observation of catheter care on 10/29/2024 at 10:20 A.M., CNA 4 put on a pair of gloves and a gown and removed Resident 1's brief. CNA 4 did not change her gloves prior to		resident #1 was given proper catheter care and observed for any signs and symptoms of infection. None were found. At the time of the observation, all other nursing personnel received the policy and procedures for proper catheter care. All nursing staff will be in-serviced on proper catheter care. Utilizing a mannequin, all staff will perform a return demonstration. At least two direct observations of catheter care will occur each week by the Director of Nursing or her designee. This will continue for 30 days. After that time, observations will continue until two weeks of 100% compliance is achieved. The results of the in-service and documented observations will be reviewed by the facility's Quality Assurance and Process Improvement (QAPI) Committee.	

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	beginning catheter care. She proceeded to wash the resident's lower abdomen and under the residents abdominal folds. She then washed the residents perineal area and catheter without changing gloves or getting a clean wash cloth. CNA 4 then dried Resident 1 with a towel and applied a clean brief on the resident. During an interview on 10/29/2024 at 10:46 A.M., CNA 4 indicated she did not think she did anything wrong during catheter care. Upon further discussion, CNA 4 agreed she should have changed her gloves and used a clean wash cloth before providing catheter care. On 10/25/2024 at 12:05 P.M., the ADON provided the policy titled, "Isolation Precautions", dated 6/5/2022 and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: it is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents. This policy specifies the different types of precautions, including when and how isolation should be used for a resident. "Contact precautions" are measures that are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms which are spread by direct or indirect contact with the resident or the residents environment. Recommendations for personal protective equipment: Contact; Gowns whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle...." On 10/25/2024 at 12:06 P.M., the ADON provided the policy titled, "Routine Cleaning and Disinfection Policy", dated 3/30/2024 and			

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	indicated it was the policy currently being used by the facility. The policy indicated, "...1. Staff will look for precautions signage prior to entering a resident's room. a. Use standard precautions, including appropriate personal protective equipment, for all rooms, unless transmission based precautions are identified. b. Adhere to transmission-based precautions as indicated on precaution signs...." On 10/31/2024 at 10:44 A.M., the ADON provided the policy titled, "Clostridium difficile (C.diff)", dated 1/23/2024 and indicated it was the policy currently being used by the facility. The policy indicated, "...8. Environmental infection control: a. Housekeeping team member(s) shall adhere to standard and contact precautions...." On 10/29/2024 at 2:10 P.M., the DON provided the policy titled, "Catheter Care Policy," dated 1/29/2024 and indicated it was the one currently being used by the facility. The policy indicated, "...Female: 9. Gently separate the labia to expose the urinary meatus. 10. Wipe from front to back with a clean cloth moistened with water and perineal cleaner (soap). 11. Use a new part of the cloth or different cloth for each side. 12. With a new moistened cloth, start at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter...." 3.1-18(a)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (u) In addition to the required inservice hours in	F 9999	The staff member identified has completed their 6 hours of dementia training.	11/30/2024

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SOUTHFIELD VILLAGE	6450 MIAMI CIR SOUTH BEND, IN 46614

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	subsection (l), staff who have regular contact with residents shall have a minimum of (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to have an employee complete 6 hours of dementia training for 1 of 10 employees whose records were reviewed. (Assistant Director of Nursing (ADON)) Findings include: During an record review of the employee records on 10/31/2024 at 10:00 A.M., the ADON's employment file did not contain documentation to indicate she had completed 6 hours of dementia training. The ADON had a hire date of 11/13/2023. During an interview on 10/31/2024 at 11:15 A.M., the Human Resources Manager indicated the ADON had not completed the required 6 hours of dementia training for new employees. She indicated the facility did not have a policy specific to maintaining employee records, but the facility had recently implemented a check list to help them maintain employee records. On 10/31/2024 at 11:30 A.M., the Human Resources Manager provided an undated and		The Human Resource Director completed an audit of the 6 hours of dementia training for all other staff members. No other staff members were identified. To prevent reoccurrence, the 6 hours of dementia training has been added to the new hire orientation checklist. The Director of Human Resources will complete an audit of each new hire by the 30th day of employment. Any new hire that is missing the dementia training will be scheduled by the manager to complete it. The elements of the plan of correction will be reported to the Quality Assurance and Process Improvement (QAPI) Committee.	

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	untitled checklist, and identified it as the checklist currently being used by the facility. The checklist included an educational curriculum and dementia training was listed as part of the curriculum.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00445775 and IN00446163. Complaint IN00445775 - No deficiencies related to the allegations are cited. Complaint IN00446163 - No deficiencies related to the allegations are cited. Survey dates: October 24, 25, 26, 27, 28, 29, 30, and 31, 2024. Facility number: 002662 Residential Census: 41 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	This Plan of Correction constitutes my 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.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure current emergency information was in the Resident Emergency Binder for 1 of 5 residents reviewed. (Residents 2) Finding includes:	R 0356	Resident #2's information was placed in the emergency binder. An audit of the emergency binder was conducted by the Director of Assisted Living to assure all other	11/30/2024

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	On 10/31/2024 at 11:00 A.M., the Assisted Living Director (ALD) provided the Residential Emergency Binder. Resident 2 did not have any emergency information in the Residential Emergency Binder. During an interview on 10/31/2024 at 11:10 A.M., the ALD indicated Resident 2's emergency information should have been included in the Residential Emergency Binder. On 10/31/2024 at 11:30 A.M., the ALD provided a policy, dated 8/5/2021, titled, "Clinical Records (AL)", and identified it as the policy currently used by the facility. The policy indicated, "... 8. An emergency information file shall be created upon admission to the facility. 9. The Emergency file shall contain the following: a. Resident's name, sex, room or apartment number, phone number, age, or date of birth. b. resident's hospital preference. c. The name and phone number of any legally authorized representative. d. The name and phone number of the resident's physician of record. e. The name and phone number of the family members or other persons to be contacted in the even of an emergency or death. f. Information on any known allergies. g. A photograph (for identification of the resident). h. Copy of advance directives, if available...."		residents' information was present. Staff will be in-serviced on the information required in the emergency binder. With each new admission for the next 6 months, the Medical Records Designee will audit the emergency binder to assure the proper documentation is present. If 100% compliance is achieved by the 6th month, the audits will stop. The results of the in-service and documented observations will be reviewed by the facility's Quality Assurance and Process Improvement (QAPI) Committee.	
R 0379 Bldg. 00	410 IAC 16.2-5-11.1(c) Mental Health Screening - Deficiency Based on record review and interview, the facility failed to obtain a Mental Health assessment for a resident prior to admission for 1 of 1 resident reviewed for major mental illness. (Resident 7)	R 0379	Resident #7 began receiving mental health counseling within 60 days of admitting and continues to receive those services.	11/30/2024

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	Finding includes: Resident 7's record review was completed on 10/30/2024 at 2:00 P.M. Diagnoses included, but were not limited to: paranoid schizophrenia, depression, stage 3 chronic kidney disease and obsessive-compulsive disorder. A Pre-admission or Admission Mental Health assessment was not found in Resident 7's record. During an interview on 10/30/2023 at 2:10 P.M., the Assisted Living Director (ALD) indicated if a resident had a major mental illness, a Mental Health assessment was completed either pre-admission or upon admission. The ALD indicated the resident had not had a Mental Health assessment completed. On 10/31/2024 at 10:35 A.M., the ALD provided a policy, dated 4/22/2022, titled, "AL Admission to Facility", and indicated it was the policy currently used by the facility. The policy indicated, "... 1. Pre-Admission Preparation:... iv. The social service designee or other designated staff member may be needed to assist in the admission process, in the gathering of information such as MR/MI screening forms, mental health diagnoses and background information... b. Nursing/Clinical... viii.... c. Residents with major mental health diagnoses should receive mental health screening to determine and implement individual care needs for care. Individual needs should be included in the resident's service plan...."		All other residents with mental health needs are receiving the appropriate services and it is reflected on their service plan. To prevent reoccurrence, a Mental Health Screening tool has been developed and will become part of each resident's admission packet. Additionally, an Admissions Check list was created and each new admission will be audited for completion by the Director of Nursing or her designee. This admission audit will continue on indefinitely. The facility Quality Assurance and Process Improvement (QAPI) Committee will monitor the plan of corrections for completion.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on record review and interview, the facility failed to establish an infection control program	R 0407	The facility will utilize a line list to track all known cases of infectious	11/30/2024

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	that included, but was limited to, a system that enables the facility to analyze patterns of known infection symptoms and ongoing analysis of surveillance data and review of data and documentation of follow-up activity. This had the potential to affect 41 of 41 residents who reside in the Residential section of facility. Finding includes: During an interview on 10/30/2024 at 12:13 P.M., the ADON indicated she did not complete a surveillance log for the Assisted Living only Health Care. She tracked COVID or influenza if they had any cases, but they have not any the past year. She indicated their policy did not indicate they needed to do a surveillance log. On 10/30/2024 at 12:20 P.M. the ADON provided a policy titled, "Infection Prevention and Control," revised 8/26/2024 and indicated it was the current policy used by the facility. The policy indicated..."Policy: The community promptly responds to outbreaks of infectious diseases within the community to stop transmission of pathogens and prevent additional infections....."		outbreaks. All residents will continue to be tracked on the facility line list with each known, new infectious outbreak by the infection Control Specialist. At the time of the survey, the Surveyor did not identify any outbreaks that were not tracked or individuals that posed any risk to the rest of the resident population. The Quality Assurance and Process Improvement (QAPI) Committee will monitor that the line list for all future outbreak to verify it is being used in accordance with the facility's policy. No outbreaks, besides Covid-19 have occurred in the facility over the past year that are not documented on the line list.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record reviews and interview, the facility failed to complete a 1st and 2nd step tuberculosis (TB) test for 3 of 7 records review for TB tests. (Residents 2, 4 and 6) Findings include: 1. A record review was completed on 10/30/2024 for Resident 2, who was admitted to the facility on	R 0410	Residents 2, 4 and 6 have been given new a new series of TB skin tests. An audit was completed by the Director of Nursing to determine if any other resident did not have both the first and second step testing. If any others were found, a new series was given to them as	11/30/2024

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	5/22/2024. Diagnoses included, but were not limited to, atrial fibrillation and anxiety. The record lacked documentation Resident 2 had a 2nd step TB test administered on admission to the facility. 2. A record review was completed on 10/30/2024 for Resident 4, who was admitted to the facility on 8/21/2023. Diagnoses included, but were not limited to, atrial fibrillation. The record lacked documentation Resident 4 had a 1st and 2nd step TB test was administered on admission to the facility. 3. A record review was completed on 10/30/2024 for Resident 6, who was admitted to the facility on 5/16/2024. Diagnoses included, but were not limited to, atrial fibrillation. The record lacked documentation Resident 6 had a 2nd step TB test administered on admission to the facility. During an interview on 10/30/24 at 2:35 P.M., the Assisted Living Director indicated some residents did not receive first or second step TB tests as required, nor had they received a T-spot blood test. On 10/30/2024 at 2:35 P.M. the Assisted Living Director provided a current policy, dated 3/2020 and titled, "Resident Screening for TB Policy." The policy indicated, "...a. Prior to or at the time of admission, all new residents will receive TB testing and/or chest radiograph in accordance with stat requirements...." and "...c. In the absence of preferred testing, the facility shall follow CDC recommendations for targeted testing for TB		well. To prevent reoccurrence, the Director of Nursing or her designee will meet with each new admission, on their first day to assure the first step was administered and the second step scheduled. This will be documented on the resident's medication administration record (MAR). Licensed Nurses will be in-serviced the requirements for TB testing and screening. The Quality Assurance and Process Improvement (QAPI) Committee will assure the plan of correction is implemented.	

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	testing...." and "...i. Two Mantoux TB skin tests will be given two weeks apart unless the resident reports a history of BCG vaccination or previous treatment for latent TB infection or TB disease...."			
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance Based on record review and interview, the facility failed to perform an annual Tuberculosis (TB) Risk Assessment for 2 of 7 residents who were reviewed for an annual TB Risk Assessment. (Residents 4 & 7) Findings include: 1. Resident 4's record review was completed on 10/30/2024 at 1:30 P.M. Resident 4 was admitted to the facility on 8/21/2023. Resident 4's record lacked the documentation indicating she had received an annual TB Risk Assessment. 2. Resident 7's record review was completed on 10/30/2024 at 2:00 P.M. Resident 7 was admitted to the facility on 2/4/2022. Resident 7's record lacked the documentation indicating he had received an annual TB Risk Assessment. During an interview on 10/30/2024 at 2:30 P.M., the Assisted Living Director (ALD) indicated the facility retests residents for TB annually. The ALD indicated Residents 4 and 7 had not been	R 0412	Residents #4 and 7 had an annual TB screening completed. An audit of TB Screens was completed by the Director of Nursing or her designee, for all other residents. If any missing screens were found, a new TB Screen was completed. To prevent reoccurrence, all residents' annual TB screens will be completed in the month of November, regardless of their admission date. Electronic calendar reminders will be given to the Director of Nursing and the Director of Assisted Living. Nursing staff will be in-serviced on the requirements for TB testing and screening. The facility's Quality Assurance and Process Improvement (QAPI) Committee will review the results of the audit and assure the execution of the plan of correction.	11/30/2024

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	assessed or tested for TB in over a year but should have been. On 10/30/2024 at 2:35 P.M., the ALD provided a policy, dated 3/2020, titled, "Resident Screening for TB Policy" and indicated it was the policy currently used by the facility. The policy indicated, "... 2. Current Resident Screening: ... b. In the absence of state requirements, retesting will be completed at least annually. i. Follow up testing shall be of the same type as initial testing for consistency...."			