	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       05/30/2024		
	ROVIDER OR SUPPLIER SE OF MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP COD  820 FULMER ROAD  MISHAWAKA, IN 46544		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey.  Survey dates: May 29 & 30, 2024  Facility number: 013439  Residential Census: 34  These State Residential Findings are cited in accordance with 410 IAC 16.2-5.  Quality Review completed on 6/10/2024.	R 0000	The creation and submission this plan of correction does constitute an admission by the provider of any conclusions forth in the statement of deficiencies, or of any violate of regulation.  Due to the relative low scope and severity of this survey, the facility respectfully requests desk review in lieu of a post-survey revisit.	not chis set ion
R 0117 Bldg. 00	A10 IAC 16.2-5-1.4(b) Personnel - Deficiency  Based on record review and interview, the facility failed to ensure 1 of 5 employees reviewed, had not worked with an expired certification. (CNA/QMA 2).  Finding includes:  A review of CNA 2's file was completed on 5/29/2024 at 3:45 P.M., and indicated her Certified Nursing Certificate had expired on 4/25/2024. CNA 2 was also a Qualified Medication Aide (QMA). Her QMA licenses had expired on 4/25/2024.  During an interview, on 5/30/2024 at 2:03 P.M., the Director of Nursing provided 2 emails, one dated 5/14/2024 at 1:09 P.M., which indicated CNA 2 did not have training as a CNA and would need to take the nurse aide training and competency examination to become a certified nurse aide (CNA). The note also indicated CNA 2 would	R 0117	Due to the relative low scope and severity of this deficient the facility respectfully reque a desk review in lieu of a post-survey revisit.  What corrective actions will be accomplished for those reside found to have been affected be deficient practice; QMA staff vimmediately removed from nuschedule until further investigate regarding licensure was clariff. How the facility will identify off residents having the potential be affected by the same deficient practice and what corrective a will be taken; All residents have the potential to be affected by deficiency an audit was compliant of the potential to be affected by deficiency an audit was compliant.	e ents by the evas ursing ention ed. her to ient ection ec

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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.

State Form Event ID: RYGI11 Facility ID: 013439 If continuation sheet Page 1 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
			B. W	ING _		05/30/	/2024
		1	1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			LMER ROAD		
PRIMRO	SE OF MISHAWAK	(A			WAKA, IN 46544		
	T		<u> </u>		,		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		CNA certification in order to			nursing staff licensure is curre		
	remain on the India	na Aides Registry as a QMA.			What measures will be put into		
	The second amail	detect 5/14/2024 et 1.15 D.M			place or what systemic change		
		dated 5/14/2024 at 1:15 P.M., QMA certification had not			the facility will make to ensure		
		o the prerequisite requiring a			that the deficient practice does recur; DON or designee will	5 HUL	
	CNA certification.	o the prerequisite requiring a			complete monthly audit of		
	Civi confidencial.				employee licensure to identify		
	Review of the Apri	l and May 2024's schedules			licenses for renewal.		
	_	ad worked on the following			How the corrective action will	he	
	days: 4/25, 4/26, 4/29, 4/30/ 5/1, 5/2, 5/3, 5/6, 5/7,				monitored to ensure the defici		
	5/8, 5/9, 5/10, 5/13, 5/14, 5/15, 5/16, 5/17, 5/20, 5/22,				practice will not recur; what qu		
	5/23, 5/24, 5/28, 5/29 and 5/30/2024				assurance program will be put	•	
	3/23, 3/21, 3/20, 3/23 and 3/30/2021				place; Dual verification of new		
	A policy was reque	sted from the Administrator,			checklist including verification		
		0 P.M. but one was not		current licensure by DON or			
	provided prior to th	e survey exit.		designee will occur within the			
					on-boarding period to ensure		
	_	y, on 5/30/2024 at 4:28 P.M., the			proper licensure. The DON or		
		ated they follow the state			designee will conduct an audit	of	
		g requirements needed for			new employee files weekly for	the	
	CNAs and QMAs.				first month, monthly for three		
					months, and quarterly thereaft	ter to	
					assure compliance. Result or		
					findings of audit noted above		
					communicated in the monthly	QA	
					meeting.		
D 0154	440 400 400 5 4	E/I.)					
R 0154	410 IAC 16.2-5-1.	• •					
Bldg. 00	Sanitation and Sa	fety Standards - Deficiency					
Blug. 00	Raced on observation	on, record review, and	D A	154	Due to the relative law seems		06/10/2024
		ty failed to ensure kitchen	R 0	134	Due to the relative low scope and severity of this deficient		06/10/2024
		reparation and storage were			the facility respectfully reque	_	
	_	an and sanitized manner for 1 of			a desk review in lieu of a	,313	
	1 kitchen observed.				post-survey revisit.		
	I Kitchen observed.	(			What corrective action(s) wil	ı	
	Finding includes:				be accomplished for those	•	
					residents found to have been	1	
	During an observati	ion on 5/29/2023 at 9:32 A.M.,			affected by the deficient	-	

State Form Event ID: RYGI11 Facility ID: 013439 If continuation sheet Page 2 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
			B. W	B. WING			05/30/2024	
					-			
NAME OF I	PROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP COD					
5511450	05 05 1400 1404				LMER ROAD			
PRIMRO	SE OF MISHAWAK	KA .		MISHAWAKA, IN 46544				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDER'S DLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		16	DATE	
	with the Executive	Chef, the following was			practice; No residents were			
	observed:	,			affected by the deficient practi	ce.		
		wer shelf of prep table and			How the facility will identify			
	steamtable.	1 1			other residents having the			
	- Food debris on the	e plate warmer.			potential to be affected by th	e		
		rease on holding sheets of			same deficient practice and			
	_	ents beside the stovetop/oven.			what corrective action will be	<u>.</u>		
		dust on the cooking ventilation			taken; All residents had the			
	grates.	9			potential to be affected by the			
	~	the stove, oven, and fryer			deficient practice. On 5/31/20	24		
	area and along the	<del>-</del>			the hood ventilation system,			
	- Food debris on the				shelves, steamtable, plate			
T cod decide on the minor stands.				warmer, stovetop/oven, and fo	od			
	During an interview on 5/30/2024 at 9:06 P.M., the				mixer were all immediately			
	_	icated the facility had a daily			cleaned. Under the stove, over	en.		
		dicated the cooking ventilation		and fryer was swept and mopped.				
		ionally cleaned on 10/31/2023,		What measures will be put				
		e department power washed			into place or what systemic			
		He indicated if the staff			changes the facility will make	•		
	identified the cooki	ng ventilation grates to be			to ensure that the deficient			
	excessively dirty, a	work order was to be			practice does not recur;			
	submitted for "as no	eeded" cleaning. He indicated			Primrose policy Dining service	s		
	the cooking ventila	tion grates were due to be			training handbook was reviewe	ed		
	cleaned on 6/2/2024	4.			without change. An in-service	was		
				performed by the dietician and the				
	A review of the Da	ily Cleaning Log indicated, to			Executive Chef on 6/6/24 to			
	sweep and and mop	the kitchen floors a minimum			re-educate the dining staff on	the		
	of two times per da	y, more if needed, and sanitize			Dining services training			
	the mixing bowl an	d table daily.			handbook. The executive Che	ef or		
					designee will monitor the clear	ning		
	A review of the "Co	ommercial Kitchen Hood Filter			schedule 3 times a week for 6	0		
	Cleaning" log indic	ated the cooking ventilation			days, then 2 times a week for	30		
	grates had been clea	aned on 5/5/2023.			days and then 1 time a week f	or		
					30 days.			
		ded on 5/30/2024 at 2:17 P.M.			How the corrective action(s)			
	1 -	irector. The policy titled,			will be monitored to ensure t	he		
	"Dining Services Training Handbook" indicated,		deficient practice will not					
		on and Safety7. A schedule			recur, i.e., what quality			
		p cleaning should be			assurance program will be p	ut		
	maintained and foll	owed. Staff may use the			into place;			

State Form Event ID: RYGI11 Facility ID: 013439 If continuation sheet Page 3 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		05/30/2024	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	Ь	
NAME OF P	PROVIDER OR SUPPLIEF	2					
PRIMRO	SE OF MISHAWAK	Δ	820 FULMER ROAD MISHAWAKA, IN 46544				
1 IXIIVIIXO	OL OF WIIOTIAWAN			WIIOTIA	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΙΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	chedule to initial tasks that			Executive Chef or designee w		
	have been complete	ed as scheduled			complete audits noted above		
	A policy was provided on 5/30/2024 at 2:17 P.M.				communicate findings in mont	nıy	
		irector. The policy titled,			QA meetings.		
	-	en Equipment Maintenance and					
		Exhaust Hood: a) Remove and					
		y. They may need to be					
		due to the type of food					
		e rinsed and wiped down by					
	hand. They need to be professionally cleaned every 6-12 months, According to state code. b) Empty drip pans. c) Wipe down the hood to						
	remove excessive g	rease buildup"					
						ļ	
R 0241	410 IAC 16.2-5-4(						
	Health Services -	Offense					
Bldg. 00							
		view and interview, the facility	R 0	241	Due to the relative low scope		06/30/2024
		ysician signed orders upon			and severity of this deficience		
		cility for 1 of 8 resident records			the facility respectfully reque	ests	
	reviewed for physic	eian orders. (Resident 9)			a desk review in lieu of a		
	Finding includes:				post-survey revisit.	_	
	Finding includes.				What corrective actions will be accomplished for those reside		
	Δ record review wa	as conducted on 5/29/2024 at			found to have been affected b		
		ent 9. Diagnoses included, but			deficient practice; Resident	y ti ie	
		, hypertension and aortic			affected by this deficiency no		
	regurgitation.	, ny portonaran'i ana aorito			longer resides at Primrose.		
	8 8				How the facility will identify oth	ner	
	A facsimile transmi	ission, initially dated 2/1/2024,			residents having the potential		
		ission information, and			be affected by the same defici		
	included an attachn	nent for a document titled,			practice and what corrective a		
	"[Facility Name] A	dmission Orders and Plan of			will be taken; All residents have	/e	
	Care". The facsimil	e then dated, 2/7/2024,			the potential to be affected by	this	
		lent 9 had been sent to the			deficiency. DON or designee	will	
	hospital, and would	return to the facility after			ensure all new residents will h		
	treatment.				physician signed order prior to		
					admission to facility. Immediat		
	During an interview	on 5/30/2024 at 2:31 P.M., the			audit was completed to ensure	e all	

State Form Event ID: RYGI11 Facility ID: 013439 If continuation sheet Page 4 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
			B. W	ING		05/30/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			LMER ROAD		
DRIMBO	SE OF MISHAWAK	۲۸			WAKA, IN 46544		
T TAINWAGO OF WHOLINAWAY			IVIIOLIA	WARA, IN 40044			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	Director of Nursing	g (DON) indicated that Resident			residents have physician sign	ed	
	9 admitted to the fa	cility from the hospital on			admission orders.		
	2/1/2024, and on 2/	7/2024, she discharged back to			What measures will be put into	0	
	the hospital, and sh	e passed away while at the			place or what systemic change	es	
	hospital. There we	re no physician's orders for			the facility will make to ensure	;	
	Resident 9 from 2/1	1/2024 through 2/7/2024.			that the deficient practice does	s not	
					recur; Primrose policy titled		
	On 5/30/2024 at 2:4	40 P.M., the DON indicated she			"Admission-Move In" was revi	ewed	
		physician signed orders during			without change. DON or desig		
	Resident 9's time at	the facility, and Resident 9			will ensure "DON Move-In		
		gned physician orders			Checklist; Admission		
					Requirements" will be complete	ted	
	A policy was provided by the Executive Director				upon admission.		
	on 5/30/2024 at 3:52 P.M. The policy titled,				How the corrective action will	be	
		In", indicated, "Procedure:			monitored to ensure the defici		
		an of Care [or comparable			practice will not recur; what qu		
	-	be completed and signed by			assurance program will be put		
	the primary provide				place; The DON or designee v		
		rior to any move in"			conduct an audit of admission		
	, , ,	,			orders weekly for the first mor		
					monthly for three months, and		
					quarterly thereafter to assure		
					compliance. Findings or conc	erns	
					of the audit will be brought to		
					QA meetings monthly.		
					S. Chicoungs monuny.		
R 0246	410 IAC 16.2-5-4(	(e)(6)					
	Health Services -						
Bldg. 00	11001111 00111000	Delicioney					
g. 00	Based on record rev	view and interview, the facility	$R_0$	246	Due to the relative low scope	د	06/21/2024
		N (as needed) medications	I K U	2 <del>4</del> 0	and severity of this deficience		00/21/2024
		QMA (Qualified Medication			the facility respectfully reque	-	
		zed prior to administration by a			a desk review in lieu of a	,313	
	· ·	2 of 7 residents reviewed for			post-survey revisit.		
	medications.	. 61 , Tesidellis Teviewed 101			What corrective actions will be	۵.	
	(Residents 3 & 5)				accomplished for those reside		
	(Residents 5 & 5)				found to have been affected b		
	Findings include:					-	
	i manigs include:				deficient practice; Staff education		
	1 A magainst marris	was completed on 5/20/2024 of			regarding QMA administration		
	1. A record review	was completed on 5/29/2024 at	ı		PRN medications was comple	lea	1

State Form Event ID: RYGI11 Facility ID: 013439 If continuation sheet Page 5 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  05/30/2024	
NAME OF P	ROVIDER OR SUPPLIER	<b>R</b>		ADDRESS, CITY, STATE, ZIP COD	
				ULMER ROAD	
PRIMRO	SE OF MISHAWAK	KA .	MISHA	AWAKA, IN 46544	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ident 3. Diagnoses included,		including obtaining prior	
		d to Parkinson's Disease,		authorization from a licensed	
	dementia, diabetes	and anxiety.		nurse, and specific documer	ntation
	A Medication Adm	inistration Record (MAR),		required.  How the facility will identify of	athor
		dicated a PRN (as needed)		residents having the potentia	
	Acetaminophen an	dicated a Fig. (as needed)		be affected by the same defi	
	_	n administered on 5/3/2024 at		practice and what corrective	
	` ~	A (Qualified Medication Aide) 3		will be taken; All residents ha	
		tion of a licensed nurse		the potential to be affected b	
	approving the admi	nistration of the medication.		deficiency. Daily monitoring	-
				PRN Administration Report i	
2. A record review was completed on 5/30/2024 at				EHR by DON/ADON to revie	ew
	10:27 A.M. for Res	ident 5. Diagnoses included,		medications administered by	/ QMA
		d to deep vein thrombosis and		and confirm proper documer	ntation
	history of alcohol a	buse.		every morning. QMA to reso	lve
				any missing documentation	
	-	y 2024, indicated a PRN		immediately.	
		) had been administered on the		What measures will be put in	
	following dates:			place or what systemic chan	-
	-on 5/8 by QMA 4.			the facility will make to ensu	
		and 5/23 by QMA 5.		that the deficient practice do	es not
	-on 5/20 by QMA 3 -on 5/28 by QMA 6			recur; Administration of	
	-011 3/28 by QMA (	,		Medication Policy was review	wed
	During an interview	v, on 5/30/2024 at 2:25 P.M., the		without change. When administering a PRN medica	ation
	_	g indicated the QMA should		QMA is required to indicate	
	_	n the record the nurse's		purpose of the medication as	· · · · · · · · · · · · · · · · · · ·
	approval was receiv			as 2) the name of the author	
	**			licensed nurse before proce	-
	On 5/30/2024 at 4:2	23 P.M., the Administrator		to record the administration	
	provided the policy	titled "Administration of		the eMAR.	
		1/1/2015, and indicated the		How the corrective action wi	
		rrently used by the facility.		monitored to ensure the defi	
		d"15Medication Aides		practice will not recur; what	
	-	PRN medications without the		assurance program will be p	
	prior authorization	of the licensed nurse"		place; The DON or designed	e will
				conduct an audit of PRN	
				administration and documen	
			1	daily for the first month, wee	kly for

State Form Event ID: RYGI11 Facility ID: 013439 If continuation sheet Page 6 of 13

PRINTED: 09/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  05/30/2024			
PRIMRO	PROVIDER OR SUPPLIER	Α	STREET ADDRESS, CITY, STATE, ZIP COD  820 FULMER ROAD  MISHAWAKA, IN 46544				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				three months, and quarterly thereafter to assure compliant Any findings will be presented monthly QA meetings			
R 0273	410 IAC 16.2-5-5. Food and Nutrition	1(f) nal Services - Deficiency					
Bldg. 00	failed to ensure froz non-refidgeratted for dated when opened food storage. This has a standard includes: During an observation of the standard freezer opened, unsealed, a waffles, jalapeno por freezer in the kitched unsealed, and unlab. The refrigerator in the fruit bowls and salar steam table pan, not top, and wrapped slavapped lunch mea	on and interview, the facility ten, refrigeratored and toods were stored properly and for 1 of 1 kitchen reviewed for that the potential to affect 34 of the insumed food from the kitchen.  Son on 5/29/2024 at 9:24 A.M., in the dry storage room had and unlabeled cookie dough, the popers and biscuits. A main the area had a bag of opened, the led breaded meat patties. The kitchen area had unlabeled d, and orange Jello in a full at covered with a bacon box on the increase of cheese on top of the thorough the following spices with no date on the containers:	R 0273	Due to the relative low scope and severity of this deficient the facility respectfully reque a desk review in lieu of a post-survey revisit.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the deficient practit. 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 had the potential be affected by the deficient practice. On 5/31/2024 the kitchen storage areas were checked and all items that we not labeled or covered were discarded.  What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Primrose policy Dining services	ests  I  ce  e  to		

State Form Event ID: RYGI11 Facility ID: 013439 If continuation sheet Page 7 of 13

PRINTED: 09/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY  COMPLETED  05/30/2024		
NAME OF F	PROVIDER OR SUPPLIER	₹		Γ ADDRESS, CITY, STATE, ZIP COD		
	SE OF MISHAWAK		820 FULMER ROAD MISHAWAKA, IN 46544			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	- leaf basil			training handbook was review		
	- ground allspice			without change. An Inservice		
	- crushed red peppe	er		performed by the dietician an	id the	
	- steak seasoning			Executive Chef on 6/6/24 to		
	<ul><li>Jamaican jerk seas</li><li>ground pepper</li></ul>	soning		re-educate the dining staff or	i the	
	- ground pepper - granulated garlic			Dining services training handbook. Executive Chef o		
	- whole oregano lea	aves		designee will audit the cooler		
	- parsley flacks			freezer, and dry storage area		
	- hot chili powder			monitor and look for all items		
	- ground cinnamon			properly labeled, sealed, and		
	8			dated. The Chef or designed		
On a shelf beside the rangetop/stove, the				monitor this 3 times a week for		
		re not labled with an open date		days, then 2 times a week for		
	or use by date on the containers:			days and then 1 time a week for		
	- sriracha sauce			30 days.		
	- orange extract			How the corrective action(s)		
	- green food colorir	ng		will be monitored to ensure the		
	- blue food coloring	-		deficient practice will not		
		label indicated it was to be		recur, i.e., what quality		
	refrigerated after op	pening.		assurance program will be prog	put	
	On a lower shelf un	nder the microwave, the		Executive Chef or designee v	vill	
	following items we	re not labeled with an open		complete audits noted above		
	daaate or use by da	te on the containers:		communicate findings in mor	nthly	
	- jug of wine vinega			QA meetings.		
	- jug of worchesters					
	- jug of marsala wii	ne				
	- jug of soy sauce					
	- sesame oil					
	- jug of soybean oil					
	- jug of liquid butte	r				
	During an interview	v on 5/30/2024 at 9:06 A.M., the				
	Executive Chef ind	icated food could be kept for 3				
	days after it was pro	epared if fully cooked and				
	labeled. If the produ	uct is unknown and unlabeled				
		tossed from the freezer or				
		icated everything should be				
labeled when opened. He indicated spices, should						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/30/2024			
	PROVIDER OR SUPPLIER SE OF MISHAWAK		STREET ADDRESS, CITY, STATE, ZIP COD  820 FULMER ROAD  MISHAWAKA, IN 46544				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)		(X5) COMPLETION DATE		
	expiration date, and forever, as the kitch spices.  A policy was provided	sout the staff do not put an some (spices) have been there en just does not use the ded by the Executive Director 7 P.M. The policy titled,					
	Products5. Wrap, of frozen foods and late or date received vendor. 6. Keep from their original packagingLeftover leftover prepared for appropriate contained lid or cellophane. You with the type of food Handling: Reasons	e of Refrigerator/Frozen cover, seal all refrigerator and bel them with the preparation d from the primary food zen food tightly wrapped in ging or in moisture-proof er and Prepared Food: All ods must be stored in an er and covered with an airtight ou must label the container od and the dateSafe Food & Methods4. When a food make sure that you add the					
R 0275	410 IAC 16.2-5-5. Food and Nutritio	1(h) nal Services - Deficiency					
Bldg. 00	failed to ensure a plot obtained upon admires ident records rev (Resident 9)  Finding includes:  A record review wa 2:31 P.M. for Resid were not limited to regurgitation.	riew and interview, the facility hysician's order for a diet was ssion to the facility for 1 of 8 iewed for diet orders.  s conducted on 5/29/2024 at ent 9. Diagnoses included, but hypertension and aortic	R 0275	Due to the relative low scop and severity of this deficient the facility respectfully requ a desk review in lieu of a post-survey revisit.  What corrective actions will accomplished for those residents found to have bee affected by the deficient practice; Resident affected this deficiency no longer resides at Primrose.  How the facility will identify of residents having the potential	cy, ests  be n by		
	failed to ensure a plot obtained upon admires ident records rev (Resident 9)  Finding includes:  A record review wa 2:31 P.M. for Resid were not limited to regurgitation.	nysician's order for a diet was ssion to the facility for 1 of 8 iewed for diet orders.  s conducted on 5/29/2024 at ent 9. Diagnoses included, but	1. 02/3	and severity of this deficient the facility respectfully requal a desk review in lieu of a post-survey revisit.  What corrective actions will accomplished for those residents found to have bee affected by the deficient practice; Resident affected this deficiency no longer resides at Primrose.	cy, ests  be n by		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  05/30/2024			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD  820 FULMER ROAD  MISHAWAKA, IN 46544				
	SE OF MISHAWAR  SUMMARY (EACH DEFICIEN REGULATORY OF requested new admincluded an attachn "[Facility Name] A Care". Within this of sign what diet Resi resident at the facil 2/7/2024, indicated the hospital and we treatment.  During an interview Director of Nursing was admitted to the 2/1/2024. Resident on 2/7/2024 and sh hospital.  On 5/30/2024 at 2: never received the se Resident 9's time at should have had a co A policy was provi on 5/30/2024 at 3:5 "AdmissionMove 1. A Physician's Pla document] should be the primary provide				pricient e action have by this ee will ill have prior to diate sure sician into anges ure loes not titled in of ange. re PCP cluded in as will be efficient to quality put into ee will ion diet month, and are		
				concerns from audit to the monthly QA meetings.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLET			ETED
			B. W	NG		05/30/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
DDIMBO	SE OF MISHAWAK	۲۸		820 FULMER ROAD MISHAWAKA, IN 46544			
1 I KIIWII KO		V-1		MIGHA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0356	410 IAC 16.2-5-8.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	Clinical Records - Noncompliance						
Bldg. 00							
		view, observation and	R 0	356	Due to the relative low scope		06/06/2024
		ty failed to ensure an			and severity of this deficient	-	
		tion file was accurate and			the facility respectfully reque	ests	
	_	equired information for 5 of 5			a desk review in lieu of a		
	residents reviewed.	(Residents 2, 3, 5, 6, & 7)			post-survey revisit.		
					What corrective actions will be		
	Findings include:				accomplished for those reside		
					found to have been affected b	y the	
	On 5/30/2023 2:49 P.M., the Emergency binders were reviewed and indicated the following:				deficient practice; Missing		
					resident emergency information	n	
		was no emergency information			was obtained and updated to		
	on the binder.				resident face sheets in emerge	ency	
		spital preference was listed.			binder.		
		spital preference was listed and			How the facility will identify oth		
	no picture was loca				residents having the potential		
		spital preference was listed.			be affected by the same defici		
	-Resident /- no hos	spital preference was listed.			practice and what corrective a	ction	
	D	5/20/2024 4.2.10 D.M. d			will be taken; An audit was		
		v, on 5/30/2024 at 3:18 P.M., the			completed on 5/31/2024.		
		g indicated Resident 2 should gency information in the binder			Utilization of EHR data to assu		
		eference should have been			all current residents are includ		
	listed on the resider				in emergency binder. Identified	J	
	listed on the resider	its sheets.			any/all missing resident emergency information.		
	On 5/30/2024 at 3:4	54 P.M., the Administrator			Obtained/updated correct resi	dont	
		titled, "Emergency Plan-			information photos and hospita		
		dents", dated 12/21/2021, and			preference.	וג	
		was" the one currently used			What measures will be put into	,	
		policy indicated"4. Use a			place or what systemic change		
		ssure that all residents are			the facility will make to ensure		
	accounted for"	said that an residents are			that the deficient practice does		
	accounted for				recur; Move-in Checklist for D		
					reviewed without change. Dua		
					verification of completion of		
					Move-in Checklist by ED/DON		
					within 72 hours of move in;		
					including check-off of complete	e	
	I		1		I marading official of complete	-	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00  B. WING		COMPLETED 05/30/2024			
	ROVIDER OR SUPPLIER SE OF MISHAWAK		STREET ADDRESS, CITY, STATE, ZIP COD  820 FULMER ROAD  MISHAWAKA, IN 46544				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
				Emergency Binder information How the corrective action will I monitored to ensure the deficie practice will not recur; what quassurance program will be put place; The DON or designee v conduct an audit of Emergence Binder weekly for the first mon monthly for three months, and quarterly thereafter to assure compliance. The DON or designee will bring findings or concerns from audit to the monthly QA meetings.	be ent ality into vill y th,		
R 0409 Bldg. 00	410 IAC 16.2-5-12 Infection Control -	• •					
	failed to provide a p upon admission to the records reviewed for (Resident 9)  Finding includes:  A record review was 2:31 P.M for Reside were not limited to, regurgitation.  A facsimile transmis requested new admi included an attachm "[Facility Name] Ac Care". Within this d sign that Resident 9 diseases". The facsin Resident 9 had been	iew and interview, the facility hysician's health statement he facility for 1 of 8 resident r annual health statements.  Is conducted on 5/29/2024 at ent 9. Diagnoses included, but hypertension and aortic ssion, initially dated 2/1/2024, ssion information, and ent for a document titled, dmission Orders and Plan of ocument, the physician was to was, "free from communicable mile, dated 2/7/2024, indicated a sent to the hospital and facility after treatment.	R 0409	Due to the relative low scope and severity of this deficiency the facility respectfully reque a desk review in lieu of a post-survey revisit.  What corrective actions will be accomplished for those reside found to have been affected by deficient practice; Resident affected by this deficiency no longer resides at Primrose. How the facility will identify oth residents having the potential be affected by the same defici practice and what corrective a will be taken; Audit conducted DON/ADON on 6/3/2024 confirming documentation/record annual health statement fro PCP for all current residents. What measures will be put into	ests ents y the er to ent ction by eipt m		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCT		UCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		<u>00</u> COMPL		LETED	
		B. WING	B. WING		05/30/2024			
NAME OF PROVIDER OR SUPPLIER PRIMROSE OF MISHAWAKA			820	STREET ADDRESS, CITY, STATE, ZIP COD 820 FULMER ROAD MISHAWAKA, IN 46544				
(X4) ID PREFIX TAG			ID PREFIX TAG	place the that recurrence hear order moves assistant will biswer more than the recurrence hear order moves assistant will biswer more than the recurrence hear order moves assistant will be recurrence as a single content of the recurrence assistant will be recurrence as a single content or the re	PROVIDER'S PLAN OF CORRECTION SHOULD COSS-REFERENCED TO THE APPROPRIES. THE ACTION SHOULD COSS-REFERENCED TO THE APPROPRIES.  THE ACTION SHOULD COSS-REFERENCED TO THE AC	nges ure poes not  al esion sident  fill be ficient quality put into in orders th,	(X5) COMPLETION DATE	

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