STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRIMROSE OF MISHAWAKA	820 FULMER ROAD MISHAWAKA, IN 46544

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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 of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.**	
R 0117 Bldg. 00	410 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 certifiication. (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 deficiency, the facility respectfully requests a desk review in lieu of a post-survey revisit.** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; QMA staff was immediately removed from nursing schedule until further investigation regarding licensure was clarified. 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 by this deficiency an audit was completed on 5/31/24 to ensure that all	06/30/2024

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

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	noeed to obtain her CNA certification in order to remain on the Indiana Aides Registry as a QMA. The second email, dated 5/14/2024 at 1:15 P.M., indicated CNA 2's QMA certification had not been renewed due to the prerequisite requiring a CNA certification. Review of the April and May 2024's schedules indicated CNA 2 had worked on the following days: 4/25, 4/26, 4/29, 4/30/ 5/1, 5/2, 5/3, 5/6, 5/7, 5/8, 5/9, 5/10, 5/13, 5/14, 5/15, 5/16, 5/17, 5/20, 5/22, 5/23, 5/24, 5/28, 5/29 and 5/30/2024 A policy was requested from the Administrator, on 5/30/2024 at 4:30 P.M. but one was not provided prior to the survey exit. During an interview, on 5/30/2024 at 4:28 P.M., the Administrator indicated they follow the state guidelines regarding requirements needed for CNAs and QMAs.		nursing staff licensure is current. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; DON or designee will complete monthly audit of employee licensure to identify licenses for renewal. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place; Dual verification of new hire checklist including verification of current licensure by DON or designee will occur within the on-boarding period to ensure proper licensure. The DON or designee will conduct an audit of new employee files weekly for the first month, monthly for three months, and quarterly thereafter to assure compliance. Result or findings of audit noted above communicated in the monthly QA meeting.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation, record review, and interview, the facility failed to ensure kitchen surfaces for food preparation and storage were maintained in a clean and sanitized manner for 1 of 1 kitchen observed. (Main Kitchen) Finding includes: During an observation on 5/29/2023 at 9:32 A.M.,	R 0154	**Due to the relative low scope and severity of this deficiency, the facility respectfully requests 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**	06/10/2024

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	with the Executive Chef, the following was observed: - Food debris on lower shelf of prep table and steamtable. - Food debris on the plate warmer. - Food debris and grease on holding sheets of liquid accompaniments beside the stovetop/oven. - Thick grease and dust on the cooking ventilation grates. - Food debris under the stove, oven, and fryer area and along the wall. - Food debris on the mixer stand. During an interview on 5/30/2024 at 9:06 P.M., the Executive Chef indicated the facility had a daily cleaning log. He indicated the cooking ventilation grates were professionally cleaned on 10/31/2023, and the maintenance department power washed the grates monthly. He indicated if the staff identified the cooking ventilation grates to be excessively dirty, a work order was to be submitted for "as needed" cleaning. He indicated the cooking ventilation grates were due to be cleaned on 6/2/2024. A review of the Daily Cleaning Log indicated, to sweep and and mop the kitchen floors a minimum of two times per day, more if needed, and sanitize the mixing bowl and table daily. A review of the "Commercial Kitchen Hood Filter Cleaning" log indicated the cooking ventilation grates had been cleaned on 5/5/2023. A policy was provided on 5/30/2024 at 2:17 P.M. by the Executive Director. The policy titled, "Dining Services Training Handbook" indicated, "...Kitchen Sanitation and Safety...7. A schedule for routine and deep cleaning should be maintained and followed. Staff may use the		**practice; No** residents were affected by the deficient practice. **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 to be affected by the deficient practice. On 5/31/2024 the hood ventilation system, shelves, steamtable, plate warmer, stovetop/oven, and food mixer were all immediately cleaned. Under the stove, oven, and fryer was swept and mopped. **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 training handbook was reviewed without change. An in-service was performed by the dietician and the Executive Chef on 6/6/24 to re-educate the dining staff on the Dining services training handbook. The executive Chef or designee will monitor the cleaning schedule 3 times a week for 60 days, then 2 times a week for 30 days and then 1 time a week for 30 days. **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;**	

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	Kitchen Cleaning Schedule to initial tasks that have been completed as scheduled... A policy was provided on 5/30/2024 at 2:17 P.M. by the Executive Director. The policy titled, "Commercial Kitchen Equipment Maintenance and Use", indicated, "...Exhaust Hood: a) Remove and clean filters monthly. They may need to be cleaned more often due to the type of food cooked. They can be 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 grease buildup...." 410 IAC 16.2-5-4(e)(1) Health Services - Offense		Executive Chef or designee will complete audits noted above and communicate findings in monthly QA meetings.	
R 0241 Bldg. 00	Based on record review and interview, the facility failed to provide physician signed orders upon admission to the facility for 1 of 8 resident records reviewed for physician orders. (Resident 9) Finding includes: A record review was conducted on 5/29/2024 at 2:31 P.M for Resident 9. Diagnoses included, but were not limited to, hypertension and aortic regurgitation. A facsimile transmission, initially dated 2/1/2024, requested new admission information, and included an attachment for a document titled, "[Facility Name] Admission Orders and Plan of Care". The facsimile then dated, 2/7/2024, indicated that Resident 9 had been sent to the hospital, and would return to the facility after treatment. During an interview on 5/30/2024 at 2:31 P.M., the	R 0241	**Due to the relative low scope and severity of this deficiency, the facility respectfully requests a desk review in lieu of a post-survey revisit.** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Resident affected by this deficiency no longer resides at Primrose. 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 by this deficiency. DON or designee will ensure all new residents will have physician signed order prior to admission to facility. Immediate audit was completed to ensure all	06/30/2024

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	Director of Nursing (DON) indicated that Resident 9 admitted to the facility from the hospital on 2/1/2024, and on 2/7/2024, she discharged back to the hospital, and she passed away while at the hospital. There were no physician's orders for Resident 9 from 2/1/2024 through 2/7/2024. On 5/30/2024 at 2:40 P.M., the DON indicated she never received the physician signed orders during Resident 9's time at the facility, and Resident 9 should have had signed physician orders.. A policy was provided by the Executive Director on 5/30/2024 at 3:52 P.M. The policy titled, "Admission--Move In", indicated, "...Procedure: 1. A Physician's Plan of Care [or comparable document] should be completed and signed by the primary provider [physician, nurse practitioner, etc.] prior to any move in...."		residents have physician signed admission orders. 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 titled "Admission-Move In" was reviewed without change. DON or designee will ensure "DON Move-In Checklist; Admission Requirements" will be completed upon admission. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place; The DON or designee will conduct an audit of admission orders weekly for the first month, monthly for three months, and quarterly thereafter to assure compliance. Findings or concerns of the audit will be brought to the QA meetings monthly.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on record review and interview, the facility failed to ensure PRN (as needed) medications administered by a QMA (Qualified Medication Aide) were authorized prior to administration by a licensed nurse for 2 of 7 residents reviewed for medications. (Residents 3 & 5) Findings include: 1. A record review was completed on 5/29/2024 at	R 0246	**Due to the relative low scope and severity of this deficiency, the facility respectfully requests a desk review in lieu of a post-survey revisit.** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Staff education regarding QMA administration of PRN medications was completed	06/21/2024

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	11:40 A.M. for Resident 3. Diagnoses included, but were not limited to Parkinson's Disease, dementia, diabetes and anxiety. A Medication Administration Record (MAR), dated May 2024, indicated a PRN (as needed) Acetaminophen an (analgesic) had been administered on 5/3/2024 at 2:59 P.M., by QMA (Qualified Medication Aide) 3 without documentation of a licensed nurse approving the administration of the medication. 2. A record review was completed on 5/30/2024 at 10:27 A.M. for Resident 5. Diagnoses included, but were not limited to deep vein thrombosis and history of alcohol abuse. A MAR, dated May 2024, indicated a PRN Tramadol (narcotic) had been administered on the following dates: -on 5/8 by QMA 4. -on 5/9, 5/18, 5/22, and 5/23 by QMA 5. -on 5/20 by QMA 3. -on 5/28 by QMA 6 During an interview, on 5/30/2024 at 2:25 P.M., the Director of Nursing indicated the QMA should have documented in the record the nurse's approval was received. On 5/30/2024 at 4:23 P.M., the Administrator provided the policy titled "Administration of Medication", dated 1/1/2015, and indicated the policy is the one currently used by the facility. The policy indicated"...15. ...Medication Aides may not administer PRN medications without the prior authorization of the licensed nurse...."		including obtaining prior authorization from a licensed nurse, and specific documentation required. 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 by this deficiency. Daily monitoring of PRN Administration Report in EHR by DON/ADON to review medications administered by QMA and confirm proper documentation every morning. QMA to resolve any missing documentation immediately. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Administration of Medication Policy was reviewed without change. When administering a PRN medication, QMA is required to indicate the 1) purpose of the medication as well as 2) the name of the authorizing licensed nurse before proceeding to record the administration within the eMAR. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place; The DON or designee will conduct an audit of PRN administration and documentation daily for the first month, weekly for	

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			three months, and quarterly thereafter to assure compliance. Any findings will be presented at monthly QA meetings	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to ensure frozen, refrigeratored and non-refidgeratted foods were stored properly and dated when opened for 1 of 1 kitchen reviewed for food storage. This had the potential to affect 34 of 34 residents who consumed food from the kitchen. Finding includes: During an observation on 5/29/2024 at 9:24 A.M., the standup freezer in the dry storage room had opened, unsealed, and unlabeled cookie dough, waffles, jalapeno poppers and biscuits. A main freezer in the kitchen area had a bag of opened, unsealed, and unlabeled breaded meat patties. The refrigerator in the kitchen area had unlabeled fruit bowls and salad, and orange Jello in a full steam table pan, not covered with a bacon box on top, and wrapped slices of cheese on top of wrapped lunch meat not labeled or dated. A spice shelf had the following spices with no open date or use by date on the containers: - garden seasoning - chicken seasoning - ground cayenne - Spanish paprika - ground turmeric - onion powder - cilantro	R 0273	**Due to the relative low scope and severity of this deficiency, the facility respectfully requests 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 practice **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 to be affected by the deficient practice. On 5/31/2024 the kitchen storage areas were checked and all items that were 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	06/10/2024

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	- leaf basil - ground allspice - crushed red pepper - steak seasoning - Jamaican jerk seasoning - ground pepper - granulated garlic - whole oregano leaves - parsley flacks - hot chili powder - ground cinnamon On a shelf beside the rangetop/stove, the following items were not labled with an open date or use by date on the containers: - sriracha sauce - orange extract - green food coloring - blue food coloring The sriracha sauce label indicated it was to be refrigerated after opening. On a lower shelf under the microwave, the following items were not labeled with an open daaate or use by date on the containers: - jug of wine vinegar - jug of worchestershire sauce - jug of marsala wine - jug of soy sauce - sesame oil - jug of soybean oil - jug of liquid butter During an interview on 5/30/2024 at 9:06 A.M., the Executive Chef indicated food could be kept for 3 days after it was prepared if fully cooked and labeled. If the product is unknown and unlabeled the product will be tossed from the freezer or refrigerator. He indicated everything should be labeled when opened. He indicated spices, should		training handbook was reviewed without change. An Inservice was performed by the dietician and the Executive Chef on 6/6/24 to re-educate the dining staff on the Dining services training handbook. Executive Chef or designee will audit the cooler, freezer, and dry storage areas to monitor and look for all items to be properly labeled, sealed, and dated. The Chef or designee will monitor this 3 times a week for 60 days, then 2 times a week for 30 days and then 1 time a week for 30 days. **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 Chef or designee will complete audits noted above and communicate findings in monthly QA meetings.	

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	have an open date, but the staff do not put an expiration date, and some (spices) have been there forever, as the kitchen just does not use the spices. A policy was provided by the Executive Director on 5/30/2024 at 2:17 P.M. The policy titled, "Dining Services Training Handbook" indicated,"...Storage of Refrigerator/Frozen Products..5. Wrap, cover, seal all refrigerator and frozen foods and label them with the preparation date or date received from the primary food vendor. 6. Keep frozen food tightly wrapped in their original packaging or in moisture-proof packaging...Leftover and Prepared Food: All leftover prepared foods must be stored in an appropriate container and covered with an airtight lid or cellophane. You must label the container with the type of food and the date...Safe Food Handling: Reasons & Methods...4. When a food product is opened, make sure that you add the date when it was opened...."			
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency Based on record review and interview, the facility failed to ensure a physician's order for a diet was obtained upon admission to the facility for 1 of 8 resident records reviewed for diet orders. (Resident 9) Finding includes: A record review was conducted on 5/29/2024 at 2:31 P.M. for Resident 9. Diagnoses included, but were not limited to, hypertension and aortic regurgitation. A facsimile transmission, initially dated 2/1/2024,	R 0275	**Due to the relative low scope and severity of this deficiency, the facility respectfully requests a desk review in lieu of a post-survey revisit.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Resident affected by this deficiency no longer resides at Primrose.** How the facility will identify other residents having the potential to	06/05/2024

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	requested new admission information, and included an attachment for a document titled, "[Facility Name] Admission Orders and Plan of Care". Within this document, the physician must sign what diet Resident 9 was to consume while a resident at the facility. The facsimile. dated, 2/7/2024, indicated Resident 9 had been sent to the hospital and would return to the facility after treatment. During an interview on 5/30/2024 at 2:31 P.M., the Director of Nursing (DON) indicated Resident 9 was admitted to the facility from the hospital on 2/1/2024. Resident 9 was sent back to the hospital on 2/7/2024 and she passed away while at the hospital. On 5/30/2024 at 2:40 P.M., the DON indicated she never received the signed diet order during Resident 9's time at the facility, and Resident 9 should have had a diet order upon admission. A policy was provided by the Executive Director on 5/30/2024 at 3:52 P.M. The policy titled, "Admission--Move In", indicated, "...Procedure: 1. A Physician's Plan of Care [or comparable document] should be completed and signed by the primary provider [physician, nurse practitioner, etc.] prior to any move in...."		be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this deficiency. DON or designee will ensure all new residents will have physician signed diet order prior to admission to facility. Immediate audit was completed to ensure that all residents have physician signed diet orders. 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 document titled "Primrose Assisted Living Admission Orders and Plan of Care" reviewed without change. DON or designee will ensure PCP diet order information is included within the plan of care upon admission, quarterly, and as needed. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place; The DON or designee will conduct an audit of admission diet orders weekly for the first month, 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.	

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R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review, observation and interview, the facility failed to ensure an emergency information file was accurate and complete with all required information for 5 of 5 residents reviewed. (Residents 2, 3, 5, 6, & 7) Findings include: On 5/30/2023 2:49 P.M., the Emergency binders were reviewed and indicated the following: -Resident 2- there was no emergency information on the binder. -Resident 3- no hospital preference was listed. -Resident 5- no hospital preference was listed and no picture was located. -Resident 6- no hospital preference was listed. -Resident 7- no hospital preference was listed. During an interview, on 5/30/2024 at 3:18 P.M., the Director of Nursing indicated Resident 2 should have had her emergency information in the binder and the hospital preference should have been listed on the residents sheets. On 5/30/2024 at 3:54 P.M., the Administrator provided the policy titled, "Emergency Plan-Evacuation of Residents", dated 12/21/2021, and indicated the policy was"... the one currently used by the facility. The policy indicated..."4. Use a resident roster to assure that all residents are accounted for...."	R 0356	**Due to the relative low scope and severity of this deficiency, the facility respectfully requests a desk review in lieu of a post-survey revisit.** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Missing resident emergency information was obtained and updated to resident face sheets in emergency binder. 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 was completed on 5/31/2024. Utilization of EHR data to assure all current residents are included in emergency binder. Identified any/all missing resident emergency information. Obtained/updated correct resident information photos and hospital preference. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Move-in Checklist for DON reviewed without change. Dual verification of completion of Move-in Checklist by ED/DON within 72 hours of move in; including check-off of complete	06/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRIMROSE OF MISHAWAKA	820 FULMER ROAD MISHAWAKA, IN 46544

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			Emergency Binder information. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place; The DON or designee will conduct an audit of Emergency Binder weekly for the first month, 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.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to provide a physician's health statement upon admission to the facility for 1 of 8 resident records reviewed for annual health statements. (Resident 9) Finding includes: A record review was conducted on 5/29/2024 at 2:31 P.M for Resident 9. Diagnoses included, but were not limited to, hypertension and aortic regurgitation. A facsimile transmission, initially dated 2/1/2024, requested new admission information, and included an attachment for a document titled, "[Facility Name] Admission Orders and Plan of Care". Within this document, the physician was to sign that Resident 9 was, "free from communicable diseases". The facsimile, dated 2/7/2024, indicated Resident 9 had been sent to the hospital and would return to the facility after treatment.	R 0409	**Due to the relative low scope and severity of this deficiency, the facility respectfully requests a desk review in lieu of a post-survey revisit.** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Resident affected by this deficiency no longer resides at Primrose. 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; Audit conducted by DON/ADON on 6/3/2024 confirming documentation/receipt of annual health statement from PCP for all current residents. What measures will be put into	06/21/2024

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		A. BUILDING 00 B. WING	05/30/2024

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	During an interview on 5/30/2024 at 2:31 P.M., the Director of Nursing (DON) indicated that Resident 9 admitted to the facility from the hospital on 2/1/2024 and on 2/7/2024, she was discharged back to the hospital and she passed away while at the hospital. On 5/30/2024 at 2:40 P.M., the DON indicated she never received the annual health statement during Resident 9's time at the facility, from 2/1/2024 through 2/7/2024 and Resident 9 should have had a health statement upon admission. A policy was provided by the Executive Director on 5/30/2024 at 3:52 P.M. The policy titled, "Admission--Move In", indicated, "...Procedure: 1. A Physician's Plan of Care [or comparable document] should be completed and signed by the primary provider [physician, nurse practitioner, etc.] prior to any move in...."		place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Dual verification by DON or designee of receipt of annual health statement and admission orders from PCP prior to resident move into facility. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place; Audits of new move in admission and plan of care orders will occur weekly for a month, biweekly for a month, then monthly for 2 months. Audits will be reviewed in monthly QA meetings.	