DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 155684 | A. BUILDING 00<br>B. WING | 10/31/2023 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00420013. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00420247.<br><br>Complaint IN00420013 - No deficiencies related to the allegation are cited.<br><br>Complaint IN00420247 - No deficiencies related to the allegations are cited.<br><br>Survey dates: October 23, 24, 25, 26, 27, 30, and 31, 2023<br><br>Facility number: 002662<br>Provider number: 155684<br>AIM number: 200315930<br><br>Census Bed Type:<br>SNF/NF: 41<br>SNF: 12<br>Residential: 43<br>Total: 96<br><br>Census Payor Type:<br>Medicare: 7<br>Medicaid: 25<br>Other: 21<br>Total: 53<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed 11/7/2023. | 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 |
| --- | --- | --- |
| Joseph M. Doran | Administrator | 11/22/2023 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0641<br>SS=D<br>Bldg. 00 | 483.20(g)<br>Accuracy of Assessments<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br><br>Based on record review and interview, the facility failed to ensure a Quarterly MDS (Minimum Data Set) assessment was completed accurately for 1 of 23 reviewed. (Resident 4)<br><br>Finding includes:<br><br>A record review was completed on 9/7/2023 at 2:57 P.M. Diagnoses included, but were not limited to: cancer, heart failure, peripheral vascular disease, and chronic kidney disease.<br><br>A Quarterly MDS (Minimum Data Set) assessment, dated 9/7/2023, indicated Resident 4 required extensive assist of 1 staff for bed mobility, transfers, dressing, and toileting and did not receive a diuretic during the assessment period.<br><br>A current physician order, dated 8/28/2023, indicated Resident 4 had received Torsemide, (a diuretic), 10 mg (milligrams) by mouth every other day, and would had received the diuretic medication 3 times during the assessment period.<br><br>During an interview, on 10/26/2023 at 10:00 A.M., the MDS Coordinator indicated that she should have included the diuretic for 3 days on the Quarterly MDS assessment dated 9/7/2023.<br><br>On 10/31/2023 at 11:11 A.M., the Director of Nursing provided the policy titled,"MDS 3.0 Completion", dated 10/2020, and indicated the policy was the one currently used by the facility. | F 0641 | Resident #4's MDS, Section N, was immediately corrected to include the diuretic.<br><br>All other residents' MDSs, Section N have been audited and found to be accurate.<br><br>To prevent reoccurrence, each MDS that is completed will be audited by the MDS Consultant for the accuracy of Section N, for a minimum of 4 weeks or until 100% accuracy is achieved for 4 consecutive weeks. Once 100% accuracy is obtained, the audits will be completed as needed. An in-service has been provided to the MDS nurse regarding Section N of the MDS. The QAPI Committee will review each of the audit results monthly and assure they are being completed as described and substantial compliance is achieved. Failure to follow the plan of correction will result in disciplinary action up to and including termination. | 11/30/2023 |

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| | The policy indicated "...1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State...." | | | |
| F 0656<br>SS=D<br>Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)- | | | |

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| | (A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed. | | | |
| | Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan for 1 of 24 residents whose care plans were reviewed. (Resident 46)<br><br>Finding includes:<br><br>During an interview, on 10/23/2023 at 11:20 A.M., Resident 46 indicated there could be more activities available and he had requested to use the elliptical machine five days a week but hadn't been able to access the elliptical machine.<br><br>A record review was completed, on 10/25/2023 at 2:00 P.M. Resident 46's diagnoses included, but were not limited to: heart failure, atrial fibrillation, sick sinus syndrome, macular degeneration, and legal blindness.<br><br>A Quarterly MDS (Minimum Data Set), assessment dated 9/6/2023, indicated Resident 46 had moderately impaired cognitive status, and required partial to moderate assistance for | F 0656 | Resident #46's care plan has been revised to include additional interventions.<br><br>All other residents' activity care plans have been audited to assure their interventions are appropriate and meeting the residents' psycho/social needs.<br><br>To prevent reoccurrence, with each care plan developed/reviewed, the interdisciplinary team will review the activity interventions for a minimum of 60 days or until 100% compliance is achieved to assure the resident's psycho/social needs and preferences are being incorporated. An in-service has been provided to the Activity staff. The QAPI Committee will review each of the audit results monthly | 11/30/2023 |

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| | activities of daily living.<br><br>A care plan, dated 6/19/2023, indicated Resident 46 preferred self-selected activities in room, socializing at meals, sunbathing, and running. The care plan listed one intervention: Place current month's large print activity calendar in resident's room for resident and staff reference.<br><br>During an interview, on 10/26/2023 at 10:39 A.M., the Activities Director indicated she was responsible for the activities care plan for Resident 46. The Director of Activities indicated that Resident 46's care plan was not person centered but should have been.<br><br>On 10/26/2023 at 11:30 A.M., the Director of Nursing provided a policy titled, "Comprehensive Care Plans", dated of 5/20/2022, and indicated the policy was the one currently used by the facility. The policy indicated, "..."Person-centered care" means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives...."<br><br>3.1-35(a) | | and assure they are being completed as described and substantial compliance is achieved. Failure to follow the plan of correction will result in disciplinary action up to and including termination. | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident. | | | |

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| | (C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. | | | |
| | Based on interview and record review, the facility failed to update the fall care plan with a new intervention after a fall for 1 of 2 residents reviewed for falls. (Resident 9)<br><br>Finding includes:<br><br>During an interview, on 10/24/23 at 9:16 A.M., Resident 9 indicated she had fallen out of bed about two months ago but couldn't remember the date.<br><br>A record review for Resident 9 was completed, on 10/26/2023 at 3:13 P.M.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 8/25/2023, indicated Resident 9's cognition was moderately impaired. She required extensive assist of 1 staff for bed mobility and transfers. She was always incontinent of bladder but continent of bowel. Active diagnoses | F 0657 | Resident #9's plan of care was reviewed and it contains appropriate interventions to prevent falls.<br><br>The plan of care for all other residents with a history of falls, have been audited to assure appropriate fall interventions are in place.<br><br>To prevent reoccurrence, the interdisciplinary team will review each new fall as it occurs and assure appropriate interventions are in place and any necessary revisions have been added to the plan of care. This will be ongoing as a best practice and not have an end date. An in-service has been provided to the interdisciplinary | 11/30/2023 |

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| | included, but were not limited to: cerebrovascular accident, hemiplegia or hemiparesis, and non-Alzheimer's dementia.<br><br>A care plan, dated 10/5/2023, indicated Resident 9 had potential for falls related to decreased mobility, decreased safety awareness, incontinence, oxygen usage and tubing, medication usage, disease processes and weakness. Diagnoses included, but were not limited to: dementia, history of CVA with right sided hemiplegia and right ankle/hand contractures, weakness, unspecified abnormalities of gait and mobility, and difficulty in walking. Interventions included: Encourage use of a walker with gait belt for ambulation and gait belt for transfers, floors free from spills or clutter, and personal items within reach, including call light.<br><br>A Interdisciplinary Note on 9/20/2023 indicated, "Incident Date: 9/20/2023, Incident Time: 4:40:00, Incident Type: fall, Reason for Incident: CNA reported that she heard [Resident's name] calling for help and found her on her back on the floor left side of her bed., Resident Description: "I was sleeping and then I fell", answered [Resident's name] when asked if she knew what happened., Staff Actions at the time of incident: Assessment done. Assisted x 3 back to bed. No apparent/visible injuries seen. VS taken along with Neuro's and all WNL. No complaints of any pain. She said she was a little dizzy, but after 15 mins, was asked again and the dizziness was gone. [Physician's name] called; no orders made. POA informed of the incident."<br><br>During an interview, on 10/27/23 at 11:15 AM, the Director of Nursing indicated that the care plan for falls should have been updated after the fall on 9/20/2023 and was not. | | team. The QAPI Committee will review each of the audit results monthly and assure they are being completed as described and substantial compliance is achieved. Failure to follow the plan of correction will result in disciplinary action up to and including termination. | |

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| | On 10/27/2023 at 11:35 A.M., the Director of Nursing provided a policy titled, "Fall Prevention", dated 1/30/2023, and indicated the policy as the one currently used by the facility. The policy indicated, " ...9. When a resident experiences a fall, the facility will ... f. Review the resident's care plan and update with new interventions, as indicated ...."<br><br>3.1-35 (c)(1) | | | |
| F 0677<br>SS=D<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; | | | |
| | Based on observation, interview, and record review, the facility failed to provide grooming for a female resident with facial hair for 1 of 2 residents reviewed for activities of daily living. (Resident 206)<br><br>Findings include:<br><br>During an observation and interview, on 10/24/2023 at 10:32 A.M., Resident 206 indicated she had a large amount of chin hairs. She indicated she had a shower the day before and that staff were going to help her shave, but they came back and told her they did not have anything to shave her with.<br><br>A record review was completed, on 10/25/2023 at 11:28 A.M. Resident 206's diagnoses included, but were not limited to atrial fibrillation, congestive heart failure, and type two diabetes. | F 0677 | Resident #206 was assisted by staff to remove the unwanted facial hair.<br><br>All other residents have been checked for unwanted facial hair and provided assistance to remove it if desired. For those residents that do not want their facial hair removed, the resident’s plan of care will reflect their desire.<br><br>To prevent reoccurrence, The Weekly Shower Sheets have been revised to include the removal of unwanted hair. The Director of Nursing or her designee will review the shower sheets and visually inspect the residents at a minimum of once per week for 4 weeks or until 100% compliance | 11/30/2023 |

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| | An Admission MDS (Minimum Data Set) assessment had not been completed due to the resident was just admitted on 10/18/2023.<br><br>A care plan, dated 10/18/2023, indicated Resident 206 needed assistance with bed mobility, toileting, transfers, eating and bathing/hygiene related to weakness with a goal of being well groomed at all times. Interventions included but were not limited to: encouraged to complete activities of daily living for self as able, encourage and assist in maintenance of good grooming and dressing, and shower twice weekly.<br><br>During an observation and interview, on 10/25/2023 at 3:00 P.M., Resident 206 was observed with a large amount of chin hairs present on her chin. She indicated no one came back to help shave her.<br><br>During an observation and interview, on 10/26/2023 at 1:37 P.M., Resident 206 was sitting up in her chair in her room looking in her bedside mirror. She indicated that she would like her chin hairs shaved because they were long, and she was told they would help her after her shower but that did not happen.<br><br>During an interview, on 10/26/2023 at 1:52 P.M., CNA 8 indicated that if chin hairs are visible that staff were supposed to clean up and trim the hairs for both males and females. She indicated that if she saw chin hairs on a woman that she would usually shave them even if it was not a shower day.<br><br>During an interview, on 10/26/2023 at 1:59 P.M., CNA 9 indicated that she did not feel comfortable shaving residents so she would ask another care provider on her team to shave them. She indicated | | is achieved. An in-service has been provided to the nursing staff regarding ADL care. The QAPI Committee will review each of the audit results monthly and assure they are being completed as described and substantial compliance is achieved. Failure to follow the plan of correction will result in disciplinary action up to and including termination. | |

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| | that if she noticed chin hairs on a woman, that she would ask someone else to shave them as she would be afraid of doing this for the resident.<br><br>A policy was provided on, 10/30/2023 at 11:53 A.M., titled "Activities of Daily Living", dated 4/14/2020, and indicated the policy was the one currently used by the facility. The policy indicated " ...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene...."<br><br>3.1-38 (a)(3) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure that physician orders were followed and the physician notified of a missed medication for 1out of 13 reviewed for medication. (Resident 36)<br><br>Finding includes:<br><br>During an initial resident interview on 10/23/2023 at 10:28 A.M., Resident 36 indicated she was upset because the nurse could not find her eye drops for her left eye, they told her they must have lost them in the room, or the nurse stuck | F 0684 | An incident report was completed for resident #36, that included notifying the physician and family regarding the 2 of 4 dose missed that day. The pharmacy refilled the prescription that evening, as ordered by the physician.<br><br>An audit of all other residents' medications has been conducted to assure they are available as ordered by the attending physician. | 11/30/2023 |

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| | them in her pocket. Her eye lid was itchy, tender, swollen, red with bloody drainage and her vision was blurry.<br><br>During an interview and observation on 10/23/2023 at 2:11 P.M., Resident 36 indicated she missed 2 doses of her eye drops and they could not locate them, so they called the pharmacy. She continued to complain of the discomfort. The left eye was red, swollen, tender with a scabbed over area.<br><br>A record review for Resident 36 was completed on 10/25/2023 at 8:55 A.M. Diagnoses included, but not limited to: chronic respiratory failure with hypoxia, chronic diastolic heart failure, atrial fibrillation, and chronic kidney disease.<br><br>A Physician Order, dated 10/18/2023 with an end date of 10/28/2023, indicated "Tobramycin 0.3% eye drops (generic) Type ABT-Antibiotic Order- 2 gtts Left eye Four Times a Day For chalazion left eye."<br><br>During an interview on 10/25/2023 at 10:17 A.M., RN 6 indicated that if a medication was not available, she would call the pharmacy and see why they did not have it and how soon it could be sent out. She would also check to see if it was available in the pyxis, and notify the doctor to see if she wanted to extend if it was an antibiotic.<br><br>During an interview on 10/25/2023 at 10:32 A.M., RN 5 indicated when a resident's medication is not available, she would attempt to get it from the pyxis, then call the pharmacy to see if she could receive it stat (immediately). If the medication was an antibiotic, she would call the doctor to see if they wanted the medication extended. She indicated it happened the past week when a | | To prevent reoccurrence, medication audits will be conducted by nursing personnel at a minimum of once per week for 4 weeks or until 100% compliance is achieved. Licensed nurses and qualified medication aides have been in-serviced on the facility's policy regarding unavailable medications. The QAPI Committee will review each of the audit results monthly and assure they are being completed as described and substantial compliance is achieved. Failure to follow the plan of correction will result in disciplinary action up to and including termination. | |

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| | resident's eye drops went missing and she missed some doses. She thought the night nurse put it in her pocket; she checked the whole cart and the resident's room. She could not find any documentation in the ID (interdisciplinary) note only a note in the MAR indicating the medication was not available. She indicated a note should have been made in the ID. She indicated she would text the doctor when she needed something but was unable to show the doctor had been notified.<br><br>During an interview on 10/25/2023 at 11:15 A.M., the Director of Nursing (DON) indicated she would expect her nurses, if a medication was not available, to notify the pharmacy and Physician. Documentation would be in the ID notes. The nurses notify the doctor by calling a cell phone, fax, or text to call.<br><br>On 10/25 2023 at 12:57 P.M., the DON provided a policy titled, "Unavailable Medications", revised 4/9/2019, and indicated the policy was the one currently used by the facility. The policy indicated "... 5. If a resident misses a scheduled dose of the medications, staff shall follow procedures for medication error, including physician/family notifications, completion of a medication error report, and monitoring the resident for adverse reactions to omissions of the medication...."<br><br>3.1-37 | | | |
| F 0695<br>SS=D<br>Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who | | | |

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| | needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was cleaned per physician orders and humidifer bottles, and tubing was dated and stored adequately for 4 out of 4 reviewed for oxygen. (Resident 5, 37, 11 & 47)<br><br>Findings include:<br><br>1. A record review was completed for Resident 5 on 10/26/2023 at 11:00 A.M. Diagnoses included, but were not limited to: atrial fibrillation, acute on chronic systolic and diastolic heart failure, and hypertension.<br><br>A Physician Order, dated 8/1/2023, indicated albuterol sulfate 2.5 mg (milligram)/3 ml (milliliter) (0.083%) solution for nebulization (generic) - 1 vial inhalation three times a day for reactive airway disease.<br><br>During an observation, on 10/26/2023 at 5:38 A.M., RN 4 went into Resident 5's room and removed the residents nebulizer equipment and place it in the plastic bag.<br><br>During an interview, on 10/26/2023 at 5:43 A.M., RN 4 indicated the procedure was to rinse the mask and medication cup with water, place on a paper towel and cover with one until it dries.<br><br>2. A record review for Resident 37 was completed on 10/26/2023 at 11:00 A.M. Diagnoses included, | F 0695 | Residents #5, 37, 11 and 47's nebulizer equipment and oxygen tubing has been cleaned, stored and labeled in accordance with the facility's policy.<br><br>A review has determined all other residents utilizing oxygen and/or receiving nebulizer treatments, are doing so in conjunction with the facility's policy.<br><br>To prevent reoccurrence, oxygen tubing and the cleaning of respiratory equipment, will be audited by Medical Records for a minimum of once every week for 4 weeks or until 100% compliance is achieved, whichever is longer. All licensed staff have been in-serviced on dating oxygen tubing and the proper storage of nebulizer equipment. The QAPI Committee will review each of the audit results monthly and assure they are being completed as described and substantial compliance is achieved. Failure to follow the plan of correction will result in disciplinary action up to and including termination. | 11/30/2023 |

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but were not limited to: chronic obstructive pulmonary disease and acute and chronic respiratory failure with hypoxia.

A Physician Order, dated 8/15/2023, indicated rinse nebulizer cup and mouthpiece with water after use, shake off excess, allow to air dry, every shift.

A Physician Order, dated 11/9/2022, indicated Ipratropium 0.5 mg-albuterol 3 mg (2.5 mg base) 3 ml nebulization solution, 1 vial inhalation three times a day for chronic obstructive pulmonary disease. Scheduled 6:00 A.M., 11:00 A.M. and 9:00 P.M.

During an observation, on 10/26/2023 at 6:22 A.M., RN 4 entered the Resident 37's room removed his neb mask and placed it in the plastic bag.

During an interview, on 10/26/2023 at 6:23 A.M., RN 4 indicated he should have rinse the mask and medication cup.

During an interview, on 10/26/2023 at 10:21 A.M., the Director of Nursing indicated she would expect her nurses to take the mouth piece/mask off and rinse them and place on a clean paper towel to dry and when dried place back in a clean bag.

On 10/26/2023 at 10:41 A.M., the Director of Nursing provided a policy titled, "Nebulizer", revised 1/30/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...Care of the Equipment: 1. Clean after each use. 2. Wash hands before handling equipment. 3. Disassemble parts after every treatment. 4. Rinse the nebulizer cup and

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| | mouthpiece with sterile or distilled water. 5. Shake off excess water. 6. Air dry on an absorbent towel. 7. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. 8. Change nebulizer tubing weekly per facility policy...."3. During an observation, on 10/23/2023 at 3:02 P.M., Resident 11 had an oxygen bag, dated 10/15/2023. The humidification bottle and oxygen tubing were not dated.<br><br>During an observation, on 10/24/2023 at 10:08 A.M., Resident 11 had an oxygen bag, dated 10/15/2023. The humidification bottle and oxygen tubing were not dated.<br><br>During an observation, on 10/25/2023 at 1:11 P.M., Resident 11 had an oxygen bag, dated 10/15/2023. The humidification bottle and oxygen tubing were not dated.<br><br>During an observation, on 10/26/2023 at 9:22 A.M., Resident 11 had an oxygen bag, dated 10/15/2023. The humidification bottle and oxygen tubing were not dated.<br><br>During an observation, on 10/26/2023 at 1:36 P.M., Resident 11's oxygen bag was dated 10/15/2023, the humidification bottle was now dated 10/26/2023 and the oxygen tubing remained undated.<br><br>During an interview, on 10/26/2023 at 1:37 P.M., RN 6 indicated she just changed the humidification bottle and tubing, and indicated they should have been changed weekly on Sunday nights.<br>4. During an observation, on 10/24/2023 at 10:51 A.M. Resident 5's oxygen tubing and humidification bottle were undated and no oxygen storage bag was present. | | | |

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During an observation, on 10/25/2023 at 10:19 A.M., Resident 5's oxygen tubing and humidification bottle were undated and a no storage bag was present.

During an observation, on 10/26/2023 at 9:00 A.M. the oxygen tubing and humidification bottle for Resident 5 was not dated and no storage bag was present.

A clinical record review was completed, on 10/26/2023 at 10:59 A.M. Resident 5's Physician's Orders included oxygen therapy at 2.5 liters per minute per nasal canula, ordered 10/17/2023.

A Physician's Order, dated 8/1/2023, included: change the oxygen tubing weekly every Sunday on the night shift, change the humidifier bottle as needed, and to change and date the oxygen tubing bag weekly.

The October 2023 treatment record indicated the last documented tubing change was completed on 10/15/2023.

During an interview, on 10/26/2023 at 2:10 P.M., LPN 7 indicated the oxygen tubing is changed once a week on Sunday nights and there should be an orange sticker on the tubing. LPN 7 indicated the sticker was not present and should have been. 5. During an observation on, 10/23/2023 at 3:16 P.M., Resident 47's oxygen tubing was undated.

During an observation on, 10/24/2023 at 9:39 A.M., Resident 47's oxygen tubing was undated.

During an observation on, 10/25/2023 at 8:23 A.M., Resident 47's oxygen tubing was undated.

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During an observation on, 10/26/2023 at 9:12 A.M., Resident 47's oxygen tubing was undated.

A record review was completed on, 10/26/2023 at 11:37 A.M. Resident 47's diagnoses included, but were not limited to: chronic right heart failure, emphysema, pulmonary fibrosis.

A Physician's Order, dated 9/15/2023, indicated Resident 47 had continuous oxygen at two liters nasal cannula.

A Physician's Order, dated 9/15/2023, indicated oxygen tubing should be changed weekly on Sundays on the night shift.

During an interview, on 10/26/2023 at 1:37 P.M., LPN 2 indicated there was no date on the oxygen tubing but there should have been a date.

On 10/26/2023 at 10:41 A.M., the Director of Nursing provided a policy titled, "Nebulizer", revised 1/30/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...Care of the Equipment: 1. Clean after each use. 2. Wash hands before handling equipment. 3. Disassemble parts after every treatment. 4. Rinse the nebulizer cup and mouthpiece with sterile or distilled water. 5. Shake off excess water. 6. Air dry on an absorbent towel. 7. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. 8. Change nebulizer tubing weekly per facility policy...."

On 10/26/2023 at 2:20 P.M., the Director of Nursing provided a policy titled, "Oxygen Administration", dated 1/30/2023, and indicated the policy was the one currently used by the

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| | facility. The policy indicated, " ...5b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. c. Change humidifier bottle when empty, and weekly per facility policy, or as recommended by the manufacturer ...."<br><br>3.1-47 (a)(6) | | | |
| F 0755<br>SS=D<br>Bldg. 00 | 483.45(a)(b)(1)-(3)<br>Pharmacy<br>Srvcs/Procedures/Pharmacist/Records<br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and | | | |

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| | §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>Based on observation, interview and record review, the facility failed to recognize a missed medication as a medication error and notify the pharmacy and physician for 1 out of 14 residents interviewed. (Resident 36)<br><br>Finding includes:<br><br>During an initial resident interview on 10/23/2023 at 10:28 A.M., Resident 36 indicated she is upset because the nurse could not find her eye drops for her left eye, they told her they must have lost them in the room, or the nurse stuck them in her pocket. Her eye lid was itchy, tender. swollen, red with bloody drainage and her vision was blurry.<br><br>During an interview and observation on 10/23/2023 at 2:11 P.M., Resident 36 indicated she missed 2 doses of her eye drops and they could not locate them, so they called the pharmacy. She continued to complain of the discomfort. The left eye was red, swollen, and tender with a scabbed over area.<br><br>A record review for Resident 36 was completed on 10/25/2023 at 8:55 A.M. Diagnoses included, but not limited to: chronic respiratory failure with hypoxia, chronic diastolic heart failure, atrial fibrillation, and chronic kidney disease.<br><br>A Physician Order, dated 10/18/2023 with an end date of 10/28/2023, indicated "Tobramycin 0.3% eye drops (generic) Type ABT-Antibiotic Order- 2 gtts Left eye Four Times a Day For chalazion left eye." | F 0755 | An incident report was completed for resident #36, that included notifying the physician and family regarding the 2 of 4 dose missed that day. The pharmacy refilled the prescription that evening, as ordered by the physician.<br><br>An audit of all other residents' medications has been conducted to assure they are available as ordered by the attending physician.<br><br>To prevent reoccurrence, medication audits will be conducted by nursing personnel at a minimum of once per week for 4 weeks or until 100% compliance is achieved. Licensed nurses and qualified medication aides have been in-serviced on the facility's policy regarding unavailable medications. The QAPI Committee will review each of the audit results monthly and assure they are being completed as described and substantial compliance is achieved. Failure to follow the plan of correction will result in disciplinary action up to and including termination. | 11/30/2023 |

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During an interview on 10/25/2023 at 10:17 A.M., RN 6 indicated that if a medication was not available, she would call the pharmacy and see why they did not have it and how soon it could be sent out. She would also check to see if it was available in the pyxis, and notify the doctor to see if she wanted to extend if it was an antibiotic.

During an interview on 10/25/2023 at 10:32 A.M., RN 5 indicated when a resident's medication is not available, she would attempt to get it from the pyxis, then call the pharmacy to see if she can get it stat (immediately). If the medication was an antibiotic, she would call the doctor to see if she wanted the medication extended. It happened the past week when a resident's eye drops went missing and she missed some doses. She thought the night nurse put it in her pocket; she checked the whole cart and resident's room. She could not find any documentation in the ID notes only a note in the MAR indicating the medication was not available. There should have been a ID note. She would text the doctor when she needed something but was unable to show the doctor was notified.

During an interview on 10/25/2023 at 11:15 A.M., the Director of Nursing (DON) indicated she would expect her nurses if they had a medication error, she would expect them to call the pharmacy and notify the doctor to get further orders. Documentation would be in the ID notes. They do an incident report if the wrong medication is given to another resident but not for a missed or late medication, they do not do a med error report. The nurses would notify the doctor by calling her cell phone, fax, or text for her to call them.

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| | On 10/25 2023 at 12:57 P.M., the DON provided a policy titled, "Unavailable Medications", revised 4/9/2019, and indicated the policy was the one currently used by the facility. The policy indicated "... 5. If a resident misses a scheduled dose of the medications, staff shall follow procedures for medication error, including physician/family notifications, completion of a medication error report, and monitoring the resident for adverse reactions to omissions of the medication...."<br><br>On 10/25/23 at 12:57 P.M., the DON provided a policy titled, "Medication Error Policy", revised 4/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...1. The facility shall ensure medications will be administered as follows: a. According to physician's orders...."<br><br>3.1-25(a) | | | |
| F 0880<br>SS=D<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, | | | |

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| | identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155684 | A. BUILDING 00<br>B. WING | 10/31/2023 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) during an aerosolizing procedure for 1 of 2 residents reviewed for infection control. (Resident 37)<br><br>Finding includes:<br><br>A record review for Resident 37 was completed on 10/26/2023 at 10:00 A.M. Diagnosis included, but were not limited to: chronic obstructive pulmonary disease, peripheral vascular disease, and acute and chronic respiratory failure.<br><br>During an observation, on 10/26/2023 at 6:22 A.M., the Registered Nurse (RN) 4 entered Resident 37 room wearing a N-95, face shield and gown. He removed the nebulizer mask, took his pulse oximeter, auscultated lung sounds and respiratory rate.<br><br>During an interview, on 10/26/2023 at 6:23 A.M., the RN indicated that he did not wear gloves and he should have. | F 0880 | Resident #37 has been receiving his aerosol treatments with the staff wearing the appropriate personal protective equipment (PPE).<br><br>All other residents having the potential to be affected by this practice, are being treated by staff wearing the appropriate personal protective equipment (PPE).<br><br>To prevent reoccurrence, all staff administering aerosol treatments will be monitored for appropriately donning and doffing of PPE at least one time per week per resident for a minimum of 4 weeks or until 100% compliance is achieved. Licensed nurses will be in-serviced on the facility’s policy regarding aerosolizing procedures and PPE. The QAPI Committee will review each of the audit results monthly and assure they are being completed as described and | 11/30/2023 |

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| | During an interview, on 10/26 2023 at 10:24 A.M., the Director of Nursing indicated that when staff are doing an aerosolizing procedure, they are to wear full PPE.<br><br>On 10/26/2023 at 10:41 A.M., the Director of Nursing provided a policy titled, "Aerosolizing Procedure-COVID-19", revised 6/20/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... d. HCP in the room should be in full PPE (N95, eye protection, gown, gloves)...."<br><br>3.1-18 | | substantial compliance is achieved. Failure to follow the plan of correction will result in disciplinary action up to and including termination. | |
| R 0000<br><br>Bldg. 00 | This vist was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00420247. This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00420013.<br><br>Complaint IN00420247- No deficiencies related to the allegation are cited.<br><br>Complaint IN00420013 - No deficiencies related to the allegation are cited.<br><br>Survey dates: October 23, 24, 25, 26, 27, 30, and 31, 2023.<br><br>Facility number: 002662<br><br>Residential census: 43<br><br>This State Residential Finding is cited in accordance with 410 LAC 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. | |

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| | Quality review completed 11/7/2023. | | | |
| R 0092<br>Bldg. 00 | 410 IAC 16.2-5-1.3(i)(1-2)<br>Administration and Management - Noncompliance<br>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:<br>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.<br>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. | | | |
| | Based on record review and interview, the facility failed to ensure documentation of quarterly fire drills were maintained from January 2023 to November 2023. This deficient practice had the potential to affect 43 of 43 residents who reside in the facility.<br><br>Finding includes:<br><br>On 10/30/2023 at 1:15 P.M., the Administrator | R 0092 | An invitation has been extended to the local fire department to participate in our next fire drill.<br><br>In the future, an invitation to participate will be extended at a minimum of every 6 months.<br><br>To prevent reoccurrence, the annual fire drill schedule has been | 11/30/2023 |

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| | provided a Fire Drill binder. The last documented fire drill was dated 12/22/2022.<br><br>During an interview, on 10/30/2023 at 1:30 P.M., the Administrator indicated he could not provide any documentation of Quarterly Fire Drills that had been completed between January 2023 to November 2023 and indicated there should have been documentation of the fire drills being completed.<br><br>On 10/31/2023 at 9:30 A.M., the Administrator provided the policy titled "Fire Drills and Fire Safety Plan", dated 12/27/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...Drills will be held on each shift each quarter. ...b)Have a Fire Drill Report, ready to observe and complete during drill... g) Complete the "Fire Drill Report" immediately after drill, by getting input from staff and having all participants sign...." | | revised to include the dates, not to exceed 6 months, to invite the local fire department to participate in the facility's drills. A new QAPI subcommittee (Environmental Enrichment) has been formed, to provide greater oversight to emergency preparedness and life safety code compliance. This QAPI committee will review the revised annual fire drill schedule and meet each month, for the next six months to assure drills are conducted in accordance with the facility's policy. If 100% compliance is obtained at the end of 6 months, the Environmental Enrich committee will continue to meet quarterly. Additionally, Maintenance staff have been in-serviced on the fire drill policy. Failure to execute the plan of correction will result in disciplinary action up to and including termination. | |