STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00372712. Complaint IN00372712 - Unsubstantiated due to lack of evidence. No deficiencies related to the allegations were cited. Survey dates: February 14, 15, 16, 17, 18, and 21, 2022 Facility number: 000048 Provider number: 155115 AIM number: 100275330 Census Bed Type: 75 SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 5 Medicaid: 57 Other: 13 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/3/22.	F 0000	**F 000** **It is the intention of the facility to request a Face to Face IDR for survey findings F 679, F 758 and F 602** **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 on or after 3/26/22.**	
F 0567 SS=D Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.			
	Based on record review and interview, the facility failed to ensure residents were able to withdrawal their money on weekends and evenings for 1 of 1 residents reviewed for personal funds. (Resident	F 0567	**F 567 – Protection/Management of Personal Funds** It is the practice of this facility to ensure residents have the right to	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	27) Finding includes: During an interview, on 2/14/22 at 12:40 P.M., Resident 27 indicated she was only able to get money out of her account at 1:00 P.M., and not every day. During an interview, on 2/18/22 at 3:09 P.M., CNA 18 in (Certified Nursing Assistant) indicated the residents could not get money out of their account at 8:00 P.M. During an interview, on 2/18/22 at 3:15 P.M., QMA (Qualified Medication Aide) 19 indicated he did not know when the residents were able to obtain money out of their accounts now, but before the pandemic the residents could get money at any time because they had a bag locked in the medication cart. During an interview, on 2/18/22 at 3:17 P.M., LPN (Licensed Practical Nurse) 20 indicated the residents could not get money out of their accounts at any time. On 2/18/22 at 2:25 P.M., Corporate Nurse Consultant provided the policy titled," Resident Trust Overview", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Funds should be available to residents 24 hours a day and 7 days a week. A method for distributing funds after hours and on weekends must be established...." 3.1-6(f)(1)		manage his or her financial affairs and have access to their funds 24 hours per day, 7 days per week. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 27 has been provided information on how to access funds 24 hours per day, 7 days per week. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. The facility has posted information to inform on how and where to access funds. Resident Council will be educated on process for accessing funds 24 hours per day, 7 days per week. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Posting has been placed in Resident common area advising of how and where to access funds. All staff will be in serviced on procedure on or before 3/25/22. **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:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
			Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool "Residents Rights" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on record review and interview, the facility failed to prevent misappropriation of resident property in 1 of 1 allegations of misappropriation of resident property reviewed. (Resident 61) Finding includes: During a telephone interview, on 2/15/22 at 10:43 A.M., Resident 61's daughter had indicated	F 0602	We are requesting a Face to Face IDR for this citation, as we disagree with the scope and severity assigned. **F 602 – Free from Misappropriation/Exploitation** What Corrective action(s) will be accomplished for those residents	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	Resident 61 had been hospitalized during a COVID lock down and during this hospitalization, the resident's belongings had been removed from his room at the facility. The daughter indicated a grievance form had been submitted to the facility on 4/10/21. During an interview on, 2/21/22 at 9:50 A.M., Regional Executive 15 indicated that three items had been found and the remaining items value had been reimbursed to daughter. Regional Executive 15 indicated that since items had been found and returned there was no theft and that is why it was not reported to the state. A clinical record review completed on 2/21/22 at 9:50 A.M., lacked the documentation regarding the missing items. On 2/14/22 at 2:00 P.M., the facility provided a policy titled," Abuse Prohibition, Reporting and Investigation", with a revision date February 2020, and indicated it was the policy currently used by the facility. The policy indicated " ...It is the policy of [name of company] to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation. Misappropriation of Resident Funds or Property- Deliberate misplacement, exploitation, wrongful, temporary or permanent use of a resident's property or money without the resident's consent ...." 3.1-28(a)		found to have been affected by the deficient practice: It is the practice of this facility to ensure all residents are free from Misappropriation/Exploitation. Items reported missing by Resident 61 were located and returned to the resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. All other residents were interviewed and no other have reported missing items. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Residents' personal belongings will be listed on their Personal Inventory Sheets. Residents to be educated during Resident Council on reporting of missing items. Any item determined to be misappropriation of property will be reported to ISDH through the gateway reporting system. **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:** Ongoing compliance with this corrective action will be monitored	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
			through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Grievance Resolution” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on record review, observation and interview, the facility failed to ensure a significant change in condition MDS (Minimum Data Set) assessment was completed following a decline in ADL's (activity of daily living) skills and	F 0637	**F 637 – Comprehensive Assessment After Significant Change** What Corrective action(s) will be accomplished for those residents	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	incontinence status for 1 of 24 residents whose MDS assessments were reviewed. (Resident 49) Finding includes: A clinical record review was completed on 2/16/22 at 10:37 A.M., indicating Resident 49's diagnoses included, but were not limited to: obesity, hypertension, depression, lymphedema and schizophrenia. An Admission MDS assessment, dated 9/28/2021, indicated Resident 49 required extensive assist of 1 staff for bed mobility, transfers, dressing, toilet use, limited assist of 1 staff for eating and was frequently incontinent of bladder and bowels. A Nurse's Note, dated 12/20/21, indicated Resident 49 had been transferred to the hospital. A Nurse's Note, dated 12/25/21, indicated Resident 49 returned to the facility. A Quarterly MDS, dated 12/31/21, indicated Resident 49 required extensive assist of 2 staff for bed mobility, transfers, dressing, and toilet use and extensive assist of 1 staff for eating. Always incontinent of bladder and bowels. During an interview, on 2/21/22 at 10:25 A.M., the MDS nurse indicated there should have been a significant change MDS completed upon return from the hospital. On 2/21/22 at 10:29 A.M., a policy was requested. During an interview, on 2/21/22 at 10:30 A.M., MDS staff indicated they use the RAI (Resident Assessment Instrument) manual.		found to have been affected by the deficient practice: Resident 49 experienced a significant change and hospitalization. Comprehensive assessments have been completed for Resident 49. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. All residents who returned from the hospital within the last 14 days will be reviewed for a significant change. A significant change MDS will be initiated if criteria is met per RAI manual. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses will be provided education related to Comprehensive Assessments following a Significant Change in Condition on or before 3/25/22. Nurse Management team will complete IDT Clinical review on all residents who return from the hospital to determine if Change of Condition assessment is needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	3.1-31(d)(1)		**assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Comprehensive Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §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 - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	psychosocial well-being as required under §483.24, §483.25 or §483.40; and (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). (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview and record review, the facility failed to develop and implement a personalized plan of care for 1 of 1 residents reviewed for activities. (Resident 57) Finding includes: A clinical record review was completed on 2/16/22, at 1:15 P.M., and indicated Resident 57's diagnoses included but were not limited to: rheumatoid arthritis, atrial fibrillation, major depressive disorder, morbid (severe) obesity due	F 0656	**F 656 – Develop/Implement Comprehensive Care Plan** What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of the facility to ensure all residents have a comprehensive person-centered care plan consistent with the residents' goals and preferences.	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	to excess calories, history of malignant neoplasm of other parts of uterus, personal history of COVID-19, essential (primary) hypertension. During an interview on 2/18/22 at 9:13 A.M., the Activity Director indicated that Resident 57 does not have a care plan for activities, and she should have had one. On 2/17/22 at 9:25 A.M., the MDS Nurse provided a policy titled, "IDT Comprehensive Care Plan Policy", dated 10/2019 and indicated it is the one currently used by the facility. " ...It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial needs ...." 3.1-35(a)		The care plan for Resident 57 has been reviewed and updated to include a care plan for activities. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. An audit of all residents Comprehensive Care Plans related to Activities will be completed and updated appropriately. Comprehensive Care Plan meetings will be held to ensure care plans are consistent with the residents' goals and preferences. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Comprehensive Care Plan reviews for individualized activities will be completed for all residents upon Admissions and quarterly thereafter. Social Enrichment Consultant/Designee will in-service Social Enrichment Director on Comprehensive Care Plans for individualized activities on or before 3/25/22. **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:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
			Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Comprehensive Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review, observation and interview, the facility failed to ensure care plans were updated for falls for 1 of 24 residents whose care plans were reviewed. (Resident 32) Finding includes: On 2/14/22 at 10:59 A.M., Resident 32 was observed in bed with a pressure bed alarm at the end of the bed and a folded blue fall mat leaning up against the wall. On 2/15/22 at 9:25 A.M., Resident 32 was observed to transfer herself to the bed. The fall mat was leaning up against the wall. On 2/16/22 at 11:00 A.M., Resident 32 was observed lying in bed with her legs hanging over the side of the bed. The fall mat was leaning up against the wall. The wheelchair had no dycem on the seat. On 2/17/22 at 9:22 A.M., Resident 32 was observed in bed. The fall mat was leaning up against the wall. The wheelchair had no dycem on the seat. On 2/17/22 at 12:55 P.M. observed Resident 32 in bed. The fall mat was leaning up against the wall	F 0657	**F 657 – Care Plan Timing and Revision** **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of the facility to ensure that all resident care plans are reviewed and updated timely. The care plan for Resident 32 has been reviewed and updated appropriately. An audit of fall interventions was completed to ensure placement. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. A Comprehensive review of all resident fall care plans will be completed on or before 3/25/22 to ensure accurate. An audit of fall interventions will be completed to validate placement and to ensure care plans reflect the fall	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	and the wheelchair had no dycem on the seat. A clinical record review was completed on 2/17/22 at 12:24 P.M., and indicated Resident 32's diagnoses included: Parkinson's disease, dementia, anxiety, end stage heart failure, psychosis and falls. A Nurse's Progress note, dated 1/31/22 at 12:22 P.M., indicated the IDT (interdisplinary team) reviewed the fall that had occurred on 1/30/2022 at 10:06 P.M. The resident had been in the wheelchair prior to the fall and was found sitting on her buttocks in front of the dresser. Resident 32 indicated she had slipped out of her chair. Current interventions include, fall mat next to bed, drop seat to wheelchair, dycem to wheelchair, and a soft touch call light. During an interview, on 2/18/22 at 1:50 P.M., CNA 22 indicated she was unsure if the resident used a cushion to her wheel chair and did not know if she had dycem to the wheelchair. During an interview, on 2/21/22 at 10:10 A.M., LPN 3 indicated the care plan had not been updated for fall interventions. LPN 3 indicated the dycem order was discontinued on 2/9/2022 and was not taken off the care plan until 2/20/22. On 2/17/22 at 9:25 A.M., LPN 3 provided the policy titled, "IDT Comprehensive Care Plan Policy", dated 10/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input...." 3.1-35(d)(2)(B)		interventions. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Comprehensive Care Plan reviews will be completed for all residents who are at risk for falls upon admission and quarterly thereafter. DNS/Designee to in service all nursing staff on updating comprehensive care plans for fall interventions upon admission and upon any changes related to falls on or before 3/25/22. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Comprehensive Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
			Compliance Date: 3/25/22	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §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 assistance with showers and for removal of facial hair for 3 of 3 residents reviewed. (Resident 43, 32 & 57) Findings include: 1. A clinical record review was completed, on 2/16/22 at 1:15 P.M., and indicated that Resident 57's diagnoses included, but were not limited to: rheumatoid arthritis, atrial fibrillation, major depressive disorder, morbid (severe) obesity due to excess calories, history of malignant neoplasm of other parts of uterus, personal history of COVID-19, and essential (primary) hypertension. During an observation and interview on 2/14/22 at 3:34 P.M., resident 57 was observed to have hair on her chin and indicated she does not get her showers. During an observation and interview on 2/17/22 at 8:55 A.M., resident 57 was observed to have hair on her chin and she indicated she has not had a shower. A Quarterly MDS (Minimum Data Set) assessment, dated 1/12/22, indicated Resident 57's BIMS (Brief Interview for Mental Status) indicated severely impaired cognition and total dependence	F 0677	**F 677 – ADL Care Provided for Dependent Residents** **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this facility to ensure residents receive treatment and care in accordance with professional standards, comprehensive plan of care, and residents' choices. It is the practice of the facility to ensure all residents receive assistance with Activities of Daily Living. Resident 57 has been provided assist with removal of facial hair and shower assistance per preference. Resident 32 was provided assistance with nail care and shower assistance per preference. Resident 43 was provided shower assistance per preference. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	for bathing. A review of Resident 57's (ADL's) activity of daily living care plan, indicated she requires assistance and offer showers two times a week, partial bath in between. A review of Resident 57's shower bath report indicated she did not have any documented showers from 1/1/22 thru 2/17/22. During an interview and review of the shower documentation on 2/17/22 at 9:48 A.M., the Director of Nursing indicated she should have been given showers and facial hair shaved. 2. A clinical record review was completed on 2/17/22 at 12:24 P.M., indicating Resident 32's diagnoses included, but were not limited to: Parkinson's disease, dementia, anxiety, end stage heart failure, psychosis and falls. On 2/17/2022 at 1:20 P.M., Resident 32 was observed in the hallway with long dirty nails. A Significant Change MDS (Minimum Data Set) assessment, dated 6/23/21, indicated it was very important to the resident to choose bath/showers. A Quarterly MDS (Minimum Data Set) assessment, dated 12/15/21, indicated Resident 32 required extensive assist of 1 staff for personal hygiene and was totally dependant for bathing/showers. A current care plan, dated 7/11/19, indicated Resident 32 required assistance with ADL's (activities of daily living). Interventions included, but were not limited to: assist with bathing as needed or resident preference. Offer showers two times per week and partial bath in between.		All residents have the potential to be impacted by this deficient practice. An audit of shower preferences and frequency will be completed on or before 3/25/22. Any resident who was identified as not receiving shower pre preference was provided a shower. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will ensure Shower schedules are established. The DNS/Designee will review Shower Sheets daily to ensure showers are provided per resident preference. DNS/designee to provide in service education to all nursing staff related to Shower preferences and shower schedules on or before 3/25/22. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Accommodation of Needs” weekly for 4 weeks, monthly for 6 months and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	A current care plan, dated 7/11/19, indicated the resident was receiving hospice services. Interventions included, but were not limited to: accommodate for fluctuations in residents choices and preferences and hospice aide visits per hospice plan of care. A shower schedule indicated Resident 32 was to receive showers on Wednesday and Saturdays on the day shift. The Aide Hospice Visit Note Reports, for Resident 32, indicated the following: 1/4/22 --refused shower- partial sponge bath given. 1/13/22--shower received. 1/28/22 --shower received. 2/3/22 --refused shower- bed bath given. 2/7/22 --refused shower. The facility bathing documentation, dated 1/19/22 through 2/17/22, indicated the resident had refused bathing on 1/19/22, 2/6/22 and 2/13/22, and had only received partial bed baths 1/20/22 through 2/17/22. During an interview, on 2/17/22 at 1:12 P.M., CNA (Certified Nursing Assistant) 21 indicated the residents are to have a shower twice a week. If they refuse, we go back and ask them again, then go to the nurse then and write it up as a refusal. CNA 21 indicated the nails are done when the showers are given, and sometimes activity staff will do nails in an activity. During an interview, on 2/18/22 at 10:20 A.M., LPN (Licensed Practical Nurse) 3 indicated the residents should be offered a shower 2 times a week and hospice is above and beyond what we		quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	are to do for the resident.3. During an observation on 2/14/22 at 2:20 P.M., Resident 43 had an appearance of greasy hair and cloudy, dirty glasses. During another observation on 2/15/22 at 10:01 A.M., Resident 43's hair continues to be greasy in appearance and glasses are cloudy and dirty. During an interview on 2/15/22 at 10:01 A.M., Resident 43 indicated he does not receive his showers. On 2/16/22 at 2:02 P.M., Resident 43 indicated he would like a shower. During an interview on 2/17/22 at 3:20 P.M., CNA 13 indicated, residents tell you what they want for their bathing and a "cheat sheet" was available for resident shower days. During an interview on 2/17/21 at 3:27 P.M., CNA 14 indicated a Shower Report is completed with each shower and provided to the nurse for review and signature. The Shower Report is then placed in a binder. CNA 14 and the surveyor reviewed the Shower Report binder, and only one Shower Report could be found for Resident 43 dated 12/25/21. CNA 14 provided a shower schedule that indicated Resident 43's showers were scheduled for Tuesdays and Fridays in the evening. A record review of Resident 43 was completed on 2/18/22 at 9:47 A.M. Diagnosis included, but were not limited to: vascular dementia with behavioral disturbances, schizophrenia, and Parkinson's disease. A Quarterly MDS (Minimum Data Set) assessment, dated 12/28//21, indicated Resident 43 had a BIMS (Brief Interview Mental Status) score indicating no cognitive impairment. He was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	dependent with the assistance of one staff member for bathing. A Significant Change MDS assessment dated 8/12/21, indicated Resident 43's ability to choose between a tub bath, shower, bed bath or sponge bath was very important to him A Care Plan dated 3/10/17, indicated, "...Resident preferences while in the facility: ... choose between a shower, bed bath, sponge bath, or tub bath, choose to take a shower 2x weekly in the PM ...." Another Care Plan indicated, "Resident needs assistance with ADLs ...Prefers showers ....". An intervention of this Care Plan dated 4/5/22, indicated, "Offer shower three times per week, partial bath inbetween...." A review of the CNA's Point of Care (CNA documentation) history, indicated Resident 43 received from 12/16/21-2/18/22, 48 partial baths, 3 other baths and 2 showers that were given on 12/19/21 and 2/8/22. On 2/17/22 at 12:34 P.M., the MDS nurse provided a policy titled, "Preferences for Daily Routine", dated 12/15, and indicated the policy was the one currently used by the facility. The policy indicated "...To identify and develop a plan of care that reflects a resident's past and current daily customary routines. The Preferences for Daily Customary Routines is a tool that can be used to gather information about a resident and incorporate this into the interdisciplinary plan of care...." 3.1-38(2)(A)(3)(D)			
F 0679 SS=D	483.24(c)(1) Activities Meet Interest/Needs Each Resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
Bldg. 00	§483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record review, the facility failed to provide meaningful activities for a cognitively impaired resident who could not self-initiate activities for 1 of 1 resident reviewed for activities. (Resident 57) Finding includes: A clinical record review was completed on 2/16/22, at 1:15 P.M., and indicated Resident 57's diagnoses included. but were not limited to: rheumatoid arthritis, atrial fibrillation, major depressive disorder, morbid (severe) obesity due to excess calories, history of malignant neoplasm of other parts of uterus, personal history of COVID-19, essential (primary) hypertension. A Quarterly MDS (Minimum Data Set) assessment, dated 1/12/22, indicated Resident 57's BIMS (Brief Interview for Mental Status) score of 9, moderately impaired cognition. During an observation and interview on 2/14/22 at 3:26 P.M., resident indicated they bring her a paper, but no activities to do. There was no music, newspapers, books, or magazines in the room.	F 0679	**We are requesting a Face to Face IDR for this citation, as we disagree with the scope and severity assigned.** **F 679 – Activities Meet Interest/Needs Each Resident** What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of the facility to ensure all residents are provided meaningful activities. Resident 57 has preference for books, newspapers and magazines to read. Resident 57 enjoys listening to music. Resident 57 has been provided activities per preference. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficit practice. An audit of all residents' activity preferences will be	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	During an observation, on 2/17/22 at 11 A.M., she was lying in bed with the TV on, no activity provided books, magazines, newspapers or music noted in the room. During an observation, on 2/18/22 at 09:30 A.M., resident is lying in bed, no activity materials provided. An Admission MDS (Minimum Data Set) assessment, dated 10/18/21, indicated Section F interview for activity preferences indicated that books, newspapers, and magazines to read, listen to music, being around animals such as pets, keeping up with the news, is important to her. During an interview on 2/18/22 at 9:01 A.M., the Activities Director indicated she colors, listens to music, he gives her snacks, hands her the Daily Chronicle and chats with her. During an interview on 2/18/22, 9:40 A.M., activity aide 8 indicated she hands her a daily chronicle and hot coco (chocolate). She indicated she does not come out and attend any activities. The Daily Chronicle was a piece of paper with "on this date"; quote of the day; happy birthday to a famous person; "did you know", current date, attached is a list of today's activities and a coloring page. During an interview on 2/18/22 10:00 A.M., provided her activity documentation from 1/1/22 thru 2/18/22, he indicated it shows a lot of coffee cart and chronicles. He indicated that there is no charting of books, newspaper or magazines, or music being offered per her activity preference. On 2/18/22 at 2:25 P.M., the Regional Nurse		completed on or before 3/25/22 to ensure the residents have access to activities and supplies per preference. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Activity Director/Designee will monitor activities daily to ensure ongoing activities are provided to meet the needs/preferences of the residents by conducting Facility Rounds daily to ensure activities are facilitated per Activity Calendar. The Activity Director/Designee to ensure activity supplies are provided to meet needs/preferences of residents by daily rounds validating activity supplies in resident rooms. Social Enrichment Consultant/designee will provide in service education to Social Enrichment Director and Activity Staff related to daily activity calendars and resident preferences. Social Enrichment Consultant to provide education related to having activity supplies readily available for staff to offer to residents for independent use. **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:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	provided a policy titled, "Activities", dated 1/06, and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of this facility to provide for an ongoing program of activities designed to meet the interest and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment...." 3.1-33(a)(8)(c)		Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Social Wellness and Enrichment Program” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 3/25/22	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care 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 record review and interview, the facility failed to have hospice documentation readily available for a resident receiving hospice services for 1 of 1 residents reviewed for hospice services and failed to ensure a physician order was obtained for resident in transmission-based precautions (TBP) and bilevel positive airway pressure (BIPAP). (Resident 32 & 225)	F 0684	**F684- Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this facility to ensure residents receive treatment	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	Findings includes: 1. On 2/17/22 at 12:24 P.M., a clinical record review was completed and indicated Resident 32's diagnoses included, but were not limited to: Parkinson's disease, dementia, anxiety, end stage heart failure, psychosis and falls. A Quarterly MDS (Minimum Data Set) assessment, dated 12/15/21, indicated the resident required extensive assist of 1 staff for personal hygiene, totally dependant for bathing and was receiving hospice services. Current physician orders for Resident 32's indicated she had been receiving hospice services since 12/20/19. During an interview, on 2/18/22 at 10:30 A.M., LPN (Licensed Practical Nurse) 3 indicated Resident 32 had a hospice binder with the care plan, progress notes and other hospice information. Resident 32's hospice binder lacked hospice communication/progress notes for 2021/22, nurse/aide visit schedules, care plans, and current medications. During an interview, on 2/18/22 at 10:03 A.M., LPN 3 indicated the binder should have had the care plans, progress notes, nurse/aide visiting schedules and medication list. During an interview, on 2/18/22 at 1:27 P.M., CNA 22 she did not know who was on hospice services. 2. A clinical record review was completed, on 2/16/22 at 1:40 PM., and indicated the Resident 225's		and care in accordance with professional standards, comprehensive plan of care, and residents' choices. A physician order was received for use of BIPAP for Resident 225. Hospice binder was updated for Resident 32. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident receiving Hospice services and using BIPAP/CPAP have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents receiving Hospice Services. All residents identified in this audit will be reviewed and ensure hospice documentation is readily available. DNS/Designee will ensure all residents using BIPAP/CPAP will have physician order and Transmission Based Precautions. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DNS/designee will in-service the nursing staff on or before 3/25/22 on Hospice services and documentation for residents receiving Hospice Services. The DNS/designee will in-service nursing staff on or before 3/25/22 on physician's orders and Infection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	diagnoses included but were not limited to: COVID, pulmonary edema, atrial fibrillation, morbid obesity, chronic kidney disease stage 3, chronic obstructive pulmonary disease. The record indicated the resident was admitted on 2/8/22. An Admission MDS (Minimum Data Set) assessment, dated 2/14/22, indicated Resident 225's had a BIMS (Brief Interview for Mental Status) score of 14, intact cognition. During an interview on 2/15/22 at 11:15 A.M., the Director of Nursing (DON), indicated the BIPAP came in on the 9th or the 10th per the resident and she was going to get the order for the BIPAP. During an interview on 2/18/22 at 10:30 A.M., Regional Nurse indicated the resident should have had an order for the TBP. She indicated the order for the BIPAP was not obtained until 2/15/22 and the physician should have been notified when the BIPAP entered the building. On 2/21022 at 1:25 P.M., LPN 3 provided the policy titled," Hospice Policy", dated 8/2019, and indicated the policy was the one currently used by the facility. The policy indicated"... 2. The plan of care will include: a. Resident choices/preferences. b. Pain/discomfort management. c. Care and services (including medications and supplies) that the facility and hospice will provide in order to be responsive to the resident's need and desire for hospice care. d. A revision of other care plans to ensure consistency with the hospice plan of care and individual's need and preferences. 3. b. Contact information will be present on the chart for the hospice company. ...e. Hospice documentation available at the facility. 5. The		Control/TBP during use of BIPAP/CPAP. DNS/Designee will review Hospice Binder to ensure documentation is present. DNS/Designee will review physician orders to ensure any new admission/ resident with a change in condition, who receive BIPAP/CPAP services have a physician order for the services. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Hospice” and “Infection Control Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	Social Service Director or designee will act as the Hospice Coordinator which will be responsible for the following functions: a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for those residents receiving these services. d. ...Obtaining the following information from the hospice: i. The most recent hospice plan of care specific to each patient. ...iv. Names and contact information for hospice personnel involved in hospice care of each patient. ...vi. Hospice medication information specific to each patient...." A policy was requested for obtaining physician orders, but one was not provided. 3.1-37			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation and interview, the facility failed to ensure fall interventions were implemented and used for 2 of 4 residents reviewed for falls. (Resident 32 & 63) Findings include: 1. On 2/14/22 at 10:59 A.M., Resident 32 was observed in bed with a pressure bed alarm at the	F 0689	**F689 Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this facility to ensure that the resident	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	end of the bed and a folded blue fall mat leaning up against the wall. On 2/15/22 at 9:25 A.M., Resident 32 was observed to transfer herself to the bed. The fall mat was leaning up against the wall. On 2/16/22 at 11:00 A.M., Resident 32 was observed lying in bed with her legs hanging over the side of the bed. The fall mat was leaning up against the wall. The wheelchair had no dycem on the seat. On 2/17/22 at 9:22 A.M., Resident 32 was observed in bed. The fall mat was leaning up against the wall. The wheelchair had no dycem on the seat. On 2/17/22 at 12:55 P.M. observed Resident 32 in bed. The fall mat was leaning up against the wall and the wheelchair had no dycem on the seat. A clinical record review was completed on 2/17/22 at 12:24 P.M., and indicated Resident 32's diagnoses included: Parkinson's disease, dementia, anxiety, end stage heart failure, psychosis and falls. A current care plan, dated 7/11/19, indicated Resident 32 was at high risk for falls due to previous falls, requires assist for mobility and transfers and has unsteady gait. Interventions included, but were not limited to: fall mat next to bed. A Nurse's Progress note, dated 1/31/22 at 12:22 P.M., indicated the IDT (interdisplinary team) reviewed the fall that had occurred on 1/3022 at 10:06 P.M. The resident had been in the wheelchair prior to the fall and was found sitting		environment remains free from hazards and has supervision and devices to prevent accidents. The Fall Care Plan and interventions/devices for Resident 32 and Resident 63 have been reviewed and updated appropriately. An audit of fall interventions and devices was completed to ensure placement. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit of Intervention/Equipment/Devices will be completed by DNS/designee on or before 3/25/22 to ensure proper equipment for the care and treatment of residents. This audit will include fall interventions, mechanical lifts and slings and wheelchair sizing. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service Nursing department on fall interventions and devices on or before 3/25/22. DNS/designee will conduct daily rounds to ensure fall interventions/devices are in place per plan of care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	on her buttocks in front of the dresser. Resident 32 indicated she had slipped out of her chair. The resident was unable to be re-educated due to dementia diagnosis. Current interventions include, fall mat next to bed, drop seat to wheelchair, dycem to wheelchair, and soft touch call light. During an interview, on 2/18/22 at 1:29 P.M., QMA 21 indicated the floor mat should have been by the bed. During an interview, on 2/18/22 at 1:50 P.M., CNA 22 indicated the floor mat should be by the bed but the resident gets up by herself and yells to get it out of here. She was unsure if the resident used a cushion to her wheel chair and did not know if she was supposed to have dycem to the wheelchair. A TAR (Treatment Administration Record) dated, February 2022, indicated the dycem and the floor mat had been initialed as being administered from 2/1/22 through 2/20/22. 2. During the initial tour of the facility, conducted on 2/14/22 from 10:00 A.M. - 10:40 A.M., Resident 63 was observed in his room, sitting of the side of his bed. Resident 63 was noted to be holding a bed spread around his front. There were bath towels, blankets and sheets observed wrapped around the resident feet. The resident was not wearing any pants or incontinence briefs. The room smelled strongly of urine and the towels on the floor were noticeable wet. On 2/16/22 at 9:35 A.M., Resident 63 was observed lying in his bed. There were no sheets on his bed, a large white colored mechanical lift pad was noted underneath the resident. The resident was not wearing any pants or		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: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Accommodation of Needs” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up By what date the systemic changes will be completed: Compliance Date: 3/25/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	incontinence briefs. During an interview with the resident, he indicated he had fallen and the fire department had been in to get him up off the floor because the facility did not have a big enough mechanical lift pad available. The resident indicated the white mechanical lift sling underneath him was from the fire department. A maintenance staff member was observed putting side rails/assist bars on the resident's bed. During an interview with LPN 2, on 2/16/22 at 9:40 A.M., she confirmed the resident had been seated on the edge of his bed and slipped off the side of the bed to his knees and when she tried to instruct him to get himself back up onto the bed, the resident twisted himself and sat on his buttocks on the floor. LPN 2 indicated several staff tried to assist the resident to get up off the floor and there was no appropriately sized mechanical lift pad available from the laundry. During an interview with the Regional Nurse Consultant, on 2/18/22 at 2:20 P.M., she indicated the facility had two size extra-large mechanical lift transfer slings. The Regional Nurse Consultant was unaware of the weight limitation for the size extra-large slings. She indicated there was at least one other resident who required extra-large mechanical lift slings. She was also unaware as to why the appropriate sized sling was not available when Resident 63 fell on 2/15/22. On 2/17/22 at 9:32 A.M., Resident 63 was observed seated in a wheelchair. The wheelchair was too small for the resident due to the resident's large girth. The resident's abdomen hung over the sides of the wheelchair, and he was seated towards the front edge of the wheelchair, even though his back was against the w/c back rest. There was a large puddle of urine on the floor and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	multiple blankets and sheets wrapped around the resident's feet and wheelchair pedals. The resident was utilizing his lap top computer and indicated he had transferred himself into his wheelchair. He indicated it was difficult for him to transfer himself because the wheelchair was too small. During an interview with LPN 2, on 2/17/22 at 9:40 A.M., she indicated she had previously spoken with therapy about getting resident 63 a new wheelchair but she thought it would have to be special ordered. She indicated therapy was screening him today due to his recent fall. The clinical record for Resident 63 was reviewed on 2/16/22 at 11:30 A.M. Resident 63 was admitted to the facility on 6/01/21 with diagnoses including, but not limited to: schizophrenia, difficulty walking, unsteadiness, muscle weakness, chronic atrial fibrillation, heart failure, morbid obesity, diabetes mellitus and glaucoma. Review of the most recent falls for Resident 63 indicated he had a witnessed fall, on 2/16/22 from the side of his bed onto his knees and then onto his buttocks. On 2/08/22 at 11:30 AM., Resident 63 slipped off the front edge of his wheelchair when attempting to transfer himself from his bed into the wheelchair. On 12/23/21 the resident was found on the floor beside his bed after he fell while attempting to transfer himself form his bed to his wheelchair. The most recent MDS (Minimum Data Set) assessment, completed for Resident 63 as a quarterly review on 1/19/2022, indicated the resident required limited assistance of one staff for bed mobility, toileting, and personal hygiene needs. The resident required supervision for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	transfer needs and did not ambulate and had experienced one fall since admission. The current care plans included a plan to address the resident's risk for falls. The fall care plan was initiated on 6/11/21 with interventions to review coping mechanisms for frustration, follow the toileting program, signage in room to remind resident to ask for help, ensure wheelchair is accessible, nonskid strips next to bed, call light in reach, frequent reminders to ask for assistance with transfers, non skid footwear. The plan was updated on 2/16/22 to include quarterside rails x2 to promote independent bed mobility, bariatric bed and therapy screen. During an interview with PCA 10, on 2/17/22 at 9:40 A.M., she indicated they did not have pull ups that fit Resident 63 so they kind of just pulled them up under the resident's groin area in hopes of keeping the resident from urinating all over the front of him. LPN 2 and PCA 10 were noted to go into Resident 63's room and obtained a size XL pull up incontinence brief for Resident 63. Resident 63 had transferred himself back to bed and the resident's floor between his wheelchair and bed were still wet with urine and there were still blankets and sheets wrapped around the resident's feet and wheelchair pedals. During an interview with the supply clerk, Employee 11, on 2/17/22 at 9:50 A.M., she indicated incontinence products were kept in a locked room on the second floor. She indicated she personally, delivered products to each residents' room. She indicated the facility did supply bariatric briefs that fit up to 120-inch waists but Resident 63 did not like the briefs so she did not stock his room with bariatric briefs. She indicated the facility did have over 10 cases			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	of the bariatric briefs available. She indicated the facility had size XXL pull ups for bariatric patients. The size XXL pull ups indicated they fit 80-inch waists. Employee 11 was unsure if there were any larger sized pull up briefs. There were only 3 individual size XXL pull up briefs left in the supply room. Employee 11 indicated she needed to order more of those briefs. On 2/21/22 at 1:25 P.M., LPN 3 provided the policy titled,"Fall Management Policy", dated 11/2017, and indicated the policy was the one currently used by the facility. The policy indicated"...It is the policy of [name of company] to ensure residents residing in the facility receive adequate supervision and or assistance to prevent injury related to falls. Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls... 6. The resident specific care requirements will be communicated to the assigned caregiver utilizing resident profile or CNA assignment sheet...." 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who 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, record review and	F 0695	**F695 Respiratory/Tracheostomy**	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	interview, the facility failed to dispense oxygen therapy according to the physician's order for 1 of 3 residents reviewed for respiratory care. (Resident 31) Finding includes: During an observation on 2/15/22 at 10:26 A.M., Resident 31 was sitting in her wheelchair in her room. The nasal cannula attached to the oxygen concentrator to provide oxygen administration is observed to be on the floor under the wheelchair. Resident 31 has no complaints of shortness of breath. On 2/16/22 at 9:46 A.M., the nasal cannula tubing was not attached to the portable oxygen tank and hanging on the wheelchair handles and the nasal cannula to the portable oxygen was on the floor. The nasal cannula attached to the oxygen concentrator is noted to be on the floor. Resident 31 indicated she felt it is difficult to breath. At 2/16/22 at 9:49 A.M., LPN (Licensed Practical Nurse) 12 was informed of Resident 31 not receiving ordered oxygen therapy and the complaint of difficulty breathing. LPN 12 took Resident 31's oxygen saturation. The oximeter registered 91%. During an interview in 2/16/22 at 10:21 A.M., LPN 12 indicated Resident 31 should have her oxygen on at all times. A record review of Resident 31 was completed on 2/16/22 at 11:03 A.M. Diagnosis included, but were not limited to: vascular dementia with behavioral disturbance, COPD (Chronic Obstructive Pulmonary Disease), and generalized anxiety disorder.		**Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this facility to ensure residents receive respiratory care in accordance with professional standards, comprehensive plan of care, and residents' preferences. Resident 31 had oxygen administered per physician order. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident receiving oxygen has the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents that require oxygen. All residents identified in this audit will be reviewed and ensure administration of oxygen per physician order. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on oxygen administration on or before 3/25/22. Any resident requiring oxygen will be reviewed each shift by the DNS/designee to ensure administration of oxygen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	A Quarterly MDS (Minimum Data Set) assessment, dated 12/15//21, indicated the Resident 31 had a BIMS (Brief Interview Mental Status) score indicating no cognitive impairment. A Physician's Order,, dated 7/21/21, indicated oxygen at 2.5 liters per nasal cannula, and keep saturations greater than 92%. A Care Plan, dated 2/7/2019, indicated, "...Resident is at risk for shortness of breath while lying flat and with exertion and impaired gas exchange related to: COPD, resp [respiratory]failure...." Interventions of the Care Plan indicated, administer oxygen as ordered. On 2/18/22 at 2:25 P.M., the Regional Nurse Consultant, provided the policy, "Oxygen Therapy and Devices". The policy indicated, " ...some people with certain health conditions whose lung functions is impaired, the amount of oxygen that is obtained through normal breathing is not enough. Therefore, they require supplemental amounts to maintain normal body function ...." 3.1-47(a)(6)		per physician order. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Oxygen Therapy” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review and interview, the facility failed to ensure there was	F 0698	**F 698 - Dialysis** **What Corrective action(s) will**	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	documentation of ongoing communication between the dialysis center and facility for 3 of 3 residents receiving dialysis at certified dialysis centers. (Resident 11, 41 and 44) Findings include: 1. Review of the Resident Matrix, completed by the facility on 02/14/22 at 11:30 A.M., Residents 11, 41 and 44 were identified as receiving dialysis treatments at a certified dialysis center. The clinical record for Resident 11 was reviewed on 02/15/22 at 11:00 A.M. Resident 11 was admitted to the facility on 05/01/21 with diagnoses included, but not limited to: end stage renal disease. The current Physician Orders for Resident 11, included orders for the resident to receive hemodialysis treatments at a local dialysis center three times a week, on Tuesdays, Thursdays and Saturdays. During an interview with LPN (Licensed Practical Nurse) 2, on 2/16/22 at 10:30 A.M., she indicated the facility had "dialysis binders" for all dialysis residents. She looked around the nurse's station and indicated she did not know where the dialysis binder was for Resident 11. She indicated the resident often hid his binder and they would find it in his room after he had left for his dialysis treatment, even though they had handed it to him before he left the building. On 2/17/22 at 8:55 A.M., a Thursday morning, LPN 2 was queried as the whereabouts of Resident 11. She indicated she thought he had already left for his dialysis treatment. She indicated the resident should be up "by the birds" in the front lounge.		**be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of the facility to ensure residents requiring dialysis receive such services consistent with professional standards of practice including ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Residents 11, 41 and 44 receive dialysis services. Each resident has a dialysis binder that is reviewed by facility and dialysis center to improve communication and collaboration. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents receiving dialysis services have the potential to be impacted by this deficient practice. The DNS/designed will ensure all residents receiving dialysis services have an updated communication binder in place on or before 3/25/22. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/designee will in service Nurses on or before 3/25/22 on Dialysis communication and collaboration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	After a moment, LPN 2 opened the resident's room door and Resident 11 was noted to be in his room in his wheelchair, wearing his coat and a baseball cap. He indicated he had been in the bathroom. The resident was then observed to propel his wheelchair towards the front of the building and was noted on 2/17/22 at 8:57 A.M., in the front lobby, seated in his wheelchair, waiting on the facility transportation to take him to his dialysis treatment center. The resident was not noted to have a "dialysis binder" on his person or anywhere on his wheelchair. On 2/17/22 at 9:00 A.M., a blue colored binder, labeled "Dialysis binder" was observed on top of the resident's dresser/nightstand, in his room. The binder contained one completed form, dated 1/29/2022 and several blank forms. LPN 2 made no attempt to look for the binder and/or send any documentation with resident to the dialysis center. On 2/17/22 at 9:05 A.M., the resident was loaded into the facility transportation bus. Interview with the Activity Director who was driving the bus, at that time, indicated the receptionist had handed him a sack lunch for the resident. There was no dialysis binder given to the Activity Director. Review of the "Events" portion of the electronic resident chart indicated only 8 of the 14 opportunities to document pre and post dialysis assessments had been completed for Resident 11. 2. The clinical record for Resident 44 was reviewed on 2/15/22 at 10:30 A.M. Resident 44 was admitted to the facility on 09/22/21 with diagnoses including, but not limited to: end stage renal disease.		DNS/designee will ensure the residents who go to dialysis will have the communication binder by verifying upon transfer. If resident refuses to take the binder the IDT will call dialysis center for verbal communication and collaboration. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Dialysis” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow u **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	The current Physician's Orders included an order for the resident to receive hemodialysis treatments three times a week, on Tuesday, Thursdays and Saturdays. On 2/15/22 at 9:05 A.M., Resident 44 was observed seated in his wheelchair in the front lobby waiting for his transportation ride to the dialysis center. Resident 44 was noted to be holding a folded blanket and had an insulated lunch box around his neck. There was no dialysis paperwork or binder noted on the resident's person or attached to his wheelchair. During an interview with LPN 2, on 2/16/22 at 10:30 A.M., she indicated the facility did utilize "binders" for dialysis residents. LPN 2 was observed to look around the nurse's station and located a three-ring binder with the resident's name and "Dialysis Binder" on the outside. There was one completed form, dated 1/29/2022 and several blank forms in the binder. There was no reason given, by LPN 2, as to why the assessments and communication forms had not been completed since 1/29/22. Review of the "Event" form, for pre and post dialysis documentation, indicated only 8 of the 14 opportunities were documented for Resident 44. 3. On 02/16/22 at 11:00 A.M., Resident 41 was observed seated in his wheelchair by the center hall nurse's station. He was wearing his winter coat and indicated he was getting ready to go to dialysis. During an interview with LPN 4, on 2/16/22 at 2:39 P.M., he confirmed Resident 41 was out of the building at the dialysis center. When queried as to what communication the facility usually sent			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	with dialysis residents, LPN 4 indicated there were dialysis binders for each resident. LPN 4 located a dialysis binder for Resident 41 at the center hall nurse's station. The binder contained one completed form, dated 11/23/21 and several blank forms. LPN 4 indicated he was not taking care of Resident 41 today and did not know why the dialysis binder had not been completed and sent with Resident 41. Review of the facility policy and procedure, titled, "Dialysis Care", dated 11/2017, indicated the following: " ...The facility will assure that each resident receives care and services for the provision of hemodialysis ...consistent with professional standards of practice including: Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services ...2. For those residents receiving dialysis at a certified dialysis facility, assess and document vital signs (including blood pressure in the arm where the access site is not located), weights if ordered and communicate with the dialysis facility prior to and post dialysis ...an assessment of the resident will be completed upon return from each dialysis visit to include vital signs and assessment of the site including bruit and thrill (if applicable), drainage and general condition ...3. A dialysis event will be initiated in EMR to include time of transfer and completed on return to the unit. 4. The nurse in charge at the time of transfer to dialysis will provide the resident with all appropriate paperwork as required by the Dialysis Center. 5. The nurse in charge at the time of return will review paperwork for new orders and/or notes accompanying the resident. 6. The facility will employ a method communication between the facility and the dialysis center to relay changes in condition and response to treatment ...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	3.1-37(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure a residents psychotropic medication was not increased without adequate indication/documentation in 1 of 5 residents reviewed for unnecessary medications.(Resident 32) Finding includes: A clinical record review was completed on, 2/17/22 at 12:24 P.M., and indicated Resident 32's diagnoses included: Parkinson's disease, dementia, anxiety, end stage heart failure, psychosis and falls. A Quarterly MDS (Minimum Data Set) assessment, dated 12/15/21, indicated Resident 32 had received antipsychotic and antianxiety medications routinely during the assessment period. A current medication order, dated 2/22, indicated Resident 32 was receiving Haldol (antipsychotic) medication of 0.5 mg (milligrams) twice a day. A Psychiatry Progress Note, dated 11/10/21, indicated the resident was seen by the physician	F 0758	We are requesting a Face to Face IDR for this citation, as we disagree with the scope and severity assigned. **F758 Free from Unnecessary Medication** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of this facility to provide the resident an environment free of unnecessary psychotropic medication. Resident 32 had current medication regimen reviewed by attending physician/Hospice provider. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	for a follow up assessment due to the resident was involved in a resident to resident verbal altercation. The resident had no recollection of the altercation, and staff reported no other mood or behavior concerns. Resident 32's medications included Haldol (antipsychotic) 0.5 mg (milligrams) twice a day for psychosis. A Visit Note Report, dated 11/15/21, indicated a subsequent hospice visit. The facility staff nurse reported the resident had been increasingly agitated, had been changing her own briefs and throwing the dirty ones in the closet and had been refusing assistance with adl's (activities of daily living). Dr. [name of doctor] notified of changes and new order to increase Haldol to 1 mg twice a day was received. During an interview, on 2/18/22 at 2:15 P.M., Social Service staff indicated she had only been here a short time and that the medication was ordered by the doctor. A Behavior Summary form, dated 12/2/21, indicated Resident 32 was being monitored for 3 behaviors: Behavior 1- becomes anxious about money. Experienced 10 times in November 2021. Behavior 2- rapid changes in mood. Experienced 24 times in November 2021. Behavior 3- displays paranoid delusions regarding other peoples feelings toward her. Experienced 13 times in November 2021. The behavior monitoring lacked the documentation of the new behaviors. On 2/21/22 at 12:05 P.M., Social Service staff indicated she was unaware of what delusions the resident had and gave no response if the medication increase was unnecessary. She indicated she was not a doctor and could not		facility audit will be completed by DNS/designee for all residents receiving an increase in dosage of psychotropic medications to ensure supportive documentation is present to support the increase dosage of the psychotropic medication. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service social services on unnecessary medications on or before 3/25/22. Social Services and Hospice provider to collaborate prior to change in psychotropic medication to ensure compliance. Social services will ensure the rationale and documentation for the increased dosage is present in the medical record. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Unnecessary Medications” weekly for 4 weeks, monthly for 6 months and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	make that determination of the medication increase. On 2/21/22 a policy was requested for Unnecessary Medications, but one was not provided. 3.1-48(b)(2)		quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility	F 0761	**F761 Label/Storage Drugs and**	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	failed to ensure medications were properly labeled, dated and stored for 1 of 3 medication carts reviewed for medication storage on the East Two hall. Finding includes: On 2/17/22 at 1:10 P.M., a random observation of the medication cart and medication room on East Two was completed. In the top left drawer of the medication cart, an insulin pen, a bottle of moxifloxacin 0.5% eye drops, a bottle of timolol maleate 0.5% eye drops, and a bottle of ketorolac 0.5% eye drops were observed to not have a date opened written on pen or bottles. A random bottle of Linzess (oral constipation medication) had no identifying patient information on it. The second left drawer of the medication cart had Nystatin oral solution and nicotine patches stored together in the same cubicle of the drawer. The right first drawer had two lispro insulin pens, an uncapped glargine insulin pen, an aspart insulin pen, and four basaglar insulin pens were observed with no open dated written on the pens. In addition, two of the basaglar insulin pens had no resident identification information and one basaglar insulin pen had an identifier of "Bobby" written on it. The second right drawer had fluticasone (a nasal spray) mixed with oral pills stored together in the same cubicle. The third right drawer had powered medications, liquid medications and inhalation medications stored together in the same cubicle of the drawer. A multi-use bottle of liquid protein had no open date written on the bottle. The medication storage room had an open bottle of distilled water with no open date written on the bottle. During an interview on, 2/17/22 at 1:11 P.M., LPN (Licensed Practical Nurse)12 indicated she was		**Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this facility to label drugs and biologicals used in the facility in accordance with currently accepted professional principles. All incorrectly labeled, dated, expired medications were disposed of in accordance with the pharmacy policies. All medications stored appropriately in accordance with the pharmacy policies. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all medication storage areas to ensure all medications are stored, labeled, and dated correctly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on Medication Storage on or before 3/25/22. DNS/designee will conduct daily rounds to ensure medications are labeled and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	not aware of what the distilled water was used for on the East Two hallway and the bottle of distilled water should have an open date written on the bottle. On 2/17/22 at 1:33 P.M., LPN 12 indicated insulin pens and multiuse bottle medications should have a date placed on the pens and bottles, medications should have resident identifiers, and medications should be stored according to medication type (i.e., liquids together, inhalation meds together). On 2/18/22 at 2:25 P.M., the Regional Nurse Consultant, provided the policy, "Storage and Expiration of Medications, Biologicals, Syringes and Needles", with the most recent revision date of 10/31/16. The policy indicated, " ...5. Facility staff should record the date opened on the medication container when the medication when the medication has a shortened expiration date once opened. 6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels or cautionary instructions. 17. Facility personnel should inspect nursing station storage areas for proper storage compliance on regularly scheduled basis ...." 3.1-25(j)		stored correctly. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Medication Storage” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure ungloved hands did not touch prepared foods prior to serving, failed to ensure serving scoops were inverted for drying, failed to ensure the plate warmer, food processor, coolers, pans, skillet were clean. Failed to ensure pantry refrigerators were clean. Failed to ensure items in the freezer were dated/labeled and enclosed after opening to prevent freezer burn in 1 of 1 kitchens. (Main Kitchen) This had the potential to affect 73 of 75 residents who received meals out of this kitchen. Findings include: 1. During a kitchen observation, on 2/14/22 from 9:52 A.M. to 10:39 A.M., the following were observed: a refrigerator floor bottom and racks were dirty with dried food substances. A stand up cooler had a large container of ice tea, undated and with no covering. Two fresh roses sitting on the shelf. A closed bag of parsley with a large hole in the bag; an open bag of lettuce; 3 hard boiled eggs in a plastic bag not sealed or dated; a	F 0812	**F812 Food Procurement, Storage/Prepare/Serve-Sanitar y** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this facility to ensure food is prepared and stored in compliance with currently accepted professional standards. All refrigerators and small appliances will be cleaned and sanitized. All incorrectly labeled, dated, or expired foods were disposed of. Food service rendered per Infection control standards. Refrigerator in pantry and nurses' station were cleaned. Cook was educated on food handling. **How other residents having the**	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	cucumber cut off on both ends not covered or dated; a 1/2 onion in a plastic bag not dated; an open and undated bag of cole slaw, and an open bag of meat balls undated. The freezer had a large bag of peas not dated; 6 polish sausages in plastic wrap undated; small pieces of cut corn on the cob undated; a container of cherries undated; 2 pans with pancakes with stickers indicating used by dates of 11/5/21 and 12/14/21. During an interview on 2/14/22 at 10:44 A.M., the Dietary Manager indicated the food items should be dated, the roses should not be in the cooler and the foods should have been sealed. On 2/14/22 at 11:15 A.M., Cook 23 was observed taking food temperatures. Cook 23, with ungloved hands placed the thermometer in the pan of the potato soup. She removed her hand, and a small area of soup was noted on her hand. Cook 23 cleaned the thermometer and placed it in a submarine sandwich. The temperature was 45 degrees. She then moved a couple of the sandwiches with her ungloved hands to get another temperature. During an interview, on 2/14/22 at 11:28 A.M., Cook 23 indicated she should have worn gloves and not touched the sandwich's without gloves. 2. On 2/15/22 at 11:00 A.M., during an observation of the kitchen the following was observed: the microwave had crumbs in it; cooking utensil spoons had dried food substances; 3 square cooking pans had dried food substances; a large skillet had a black build up around the edges extending down the sides; the plate warmer had dried food substance along the edges where the		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A kitchen and Pantry audit will be completed by RD/designee for kitchen sanitation and any findings will be immediately corrected. Meal service will be monitored to ensure proper food handling. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The CDM/designee will in-service culinary staff on food handling, food storage and kitchen/pantry sanitation on or before 3/25/22. CDM/designee will conduct/complete daily am check list to ensure proper food handling, food storage and kitchen/sanitation in kitchen and pantry. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	plates are set and on the bottom of the warmer; the puree mixer had dried food substances on the bottom of the container; During an interview, on 2/15/22 at 11:26 A.M., the dietary manager indicated the microwave, the cooking utensils, pans, skillet, plate warmer and the puree mixer all should have been cleaned. 3. On 2/15/22 at 11:33 A.M., the panty on the east hall was observed with LPN (Licensed Practical Nurse) 24. The following was observed: the freezer had a container of frozen sorbet undated and no name; a bottle of water was stuck to the freezer floor and had a yellow sticky substance along the edge of the back of the freezer and on the shelf. The refrigerator had a dried white substance on the top shelf along the right side; broken bottom drawer and a dried orange colored substance along the back edge of the bottom of the fridge. During an interview, on 2/15/22 at 11:36 A.M. LPN 24 indicated the areas should have been cleaned and the food items should have a date on them. 4. On 2/15/22 at 11:49 A.M., an observation of a nursing nutrition pantry on East 2 hall was completed with QMA (Qualified Medication Aide) 25 the following was observed: an opened /undated bottle of soda with no name; a small bottle of go ginger juice with no name or date; the bottom of the refrigerator had dried yellow substance under the crisper drawer. A refrigerator in a small dining room across from the nurses station had a purple substance on the bottom of the door and on both crisper drawers. During an interview, on 2/15/22 at 11:52 A.M., QMA 25 indicated those things should not be it		QAPI Audit tool "Food Safety & Sanitation" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	there, needed a date and a name on them and the refrigerator should be cleaned. On 2/17/22 at 2:34 P.M., the Dietary Manager provided the policy titled," Cleaning Food Preparation Appliances", dated 7/2015, and indicated the policy was the one currently used by the facility. The policy indicated"...Small appliances and food appliances such as mixers and food processors will be cleaned and sanitized after each use...." On 2/17/22 at 2:35 P.M., the Dietary Manager provided the policy titled"...Food Storage", dated 6/2021, and indicated the policy was the one currently used by the facility. The policy indicated"... 10. Leftover prepared foods are to be stored in covered containers or wrapped securely. The food must be clearly labeled with the name of the product, the date it was prepared, and marked to indicate the date by which the food shall be consumed or discarded. Left over foods can be held at 41 degrees F. or less for no more than 3 days. 11. Refrigerated ready to eat, potentially hazardous food purchased from approved vendors shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded. This opened food can be held at 41 degrees or less for no more than 7 days and the date marked may not exceed the manufactures use-by-date. ...f. All foods shall be covered or wrapped tightly, labeled and dated...." 3.1-21(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, 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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. 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 infection control practices were followed for 2 of 3 observations of care. A nasal cannula on the floor, two uncapped insulin pens and resident using BIPAP (bilevel positive airway pressure) not placed in transmission-based precaution (TBP). (Resident 31 & 225) Findings include: 1. During an observation and an interview, on	F 0880	**F 880 Infection Prevention & Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this facility to ensure that residents are provided a safe, sanitary and comfortable environment and to help prevent the development and transmission	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	2/15/22 at 9:48 A.M., the nursing scheduler indicated she was told by the Director of Nursing (DON) to place the resident in transmission-based precautions (TBP) because she uses a BIPAP so the nurses need to gown up. The signage indicated that a gown, gloves, face mask and shield was required to enter. During an interview on 2/15/22 at 11:15 A.M., the Director of Nursing, indicated she should have been put her in TBP when the BIPAP arrived, which was the 9th or 10th. During an observation and interview, on 2/16/22 at 9:24 A.M., the resident was observed in a different room, Resident 57, indicated they moved her after dinner because you cannot have a roommate with a BIPAP and the door needs to be shut. She indicated that her son brought in the BIPAP the day after she came in. The 2/15/22 at 4:01 P.M., [Recorded as Late Entry on 02/16/22 11:04 AM] Progress Note entry indicated, "...spoke with the resident about her usage of bipap , and policy of the government in r/t covid and because she uses over 24 hours. The need to move her to a different room policy explained. Ok with room move...." A clinical record review was completed, on 2/16/22 at 1:40 PM., and indicated the Resident 225's diagnoses included but were not limited to: COVID, pulmonary edema, atrial fibrillation, encephalopathy, morbid obesity, anemia, chronic kidney disease stage 3, chronic obstructive pulmonary disease, impaired mobility. The record indicated the resident was admitted on 2/8/2022. An Admission MDS (Minimum Data Set) assessment, dated 2/14/22, indicated Resident 14		of communicable diseases and infections. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The facility will ensure the following: IP/Designee will ensure all residents with aerosol generating procedures are placed in TBP in accordance with guidance. IP/Designee to ensure all residents utilizing oxygen have nasal cannula properly stored. IP/Designee to ensure proper storage of insulin pens. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A Root Cause Analysis will be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause. The facility LTC Infection Control Self-Assessment will be reviewed with the consultant IP to determine accuracy. Staff will be educated on Infection control standards.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	BIMS (Brief Interview for Mental Status) score of 14, intact cognition.During an observation on 2/14/22 at 11:20 A.M. and 2:25 P.M., Resident 31's nasal cannula connected to the oxygen concentrator was on the floor. (Resident 31) 2. On 02/15/22 at 10:26 A.M., Resident 31 was observed sitting in her wheelchair with a portable oxygen tank hanging from the back of the wheelchair. The nasal cannula was on the floor under the wheelchair. The nasal cannula for the oxygen concentrator was on the floor by the bed. It was observed no dates were on either of the nasal cannulas. On 02/16/22 9:46 A.M., the nasal cannula attached to the oxygen concentrator is on the floor by the bed. The nasal cannula to the portable oxygen tank was on the floor. Resident 31 indicated it was difficult to breath. 3. On 2/16/22 at 9:49 A.M., LPN 2 was informed of Resident 31 not receiving ordered oxygen therapy and the complaint of difficulty breathing. LPN 12 took Resident 31's oxygen saturation. The oximeter registered 91%. LPN 12 placed the nasal cannula that was on the floor into the resident's nares. During an interview in 2/16/22 at 10:21 A.M., LPN 12 indicated nasal cannulas should not be on the floor. On 2/17/22 at 1:01 P.M., LPN 12 observed the nasal cannulas and indicated there was no date on the cannulas and a date should be on the cannulas indicated the date they were changed. A record review of Resident 31 was completed on 2/16/22 at 11:03 A.M. Diagnosis included, but		Daily observational rounds will be conducted on all shifts for 6 weeks until compliance is maintained by the IP/designee using the "Infection Control" audit tool to observe for proper infection control practices per facility policy and CDC guidance. The consultant IP will provide ongoing training, oversight, resources and competencies as needed based on the Observation Rounds Audit and QA tools identifying on-going areas of concern or not meeting threshold. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The IP/DNS/Designee will monitor each solution/systemic change identified in the RCA daily or more often as necessary for 6 weeks and until compliance is maintained. Infection Control QA tool will be completed daily by IP/designee x6 weeks and until compliance is maintained. The IP/designee will be responsible for the completion of the Infection Control QA Tool weekly x 6, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	were not limited to: vascular dementia with behavioral disturbance, COPD (Chronic Obstructive Pulmonary Disease), and generalized anxiety disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 12/15//21, indicated the Resident 31 had a BIMS (Brief Interview Mental Status) score indicating no cognitive impairment. Physician's Orders, dated 7/21/21, indicated, oxygen at 2.5 liters per nasal cannula, and keep saturations greater than 92% and change oxygen tubing and humidity weekly on Sundays. A Care Plan, dated 2/7/2019, indicated, "Resident is at risk for shortness of breath while lying flat and with exertion and impaired gas exchange related to: COPD (Chronic Obstructive Pulmonary Disease), resp [respiratory]failure." Interventions of the Care Plan indicated, administer oxygen as ordered. On 2/18/22 at 2:25 P.M., Regional Nurse 7, provided the policy, "Oxygen Therapy and Devices". The policy indicated, " ...Oxygen Devices 1) Nasal cannula ...e. Change out weekly and PRN, f. Place in a labeled bag when not in use ...." 3.1-18(a)		Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update and make changes to the DPOC as needed with input and oversight from the Consultant Infection Preventionist for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed:** **Compliance Date:** 3/25/22	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on observation, interview and record review, the facility failed to ensure residents received their immunizations after the consent was signed for 2 of 5 residents reviewed. (Resident 44 & 72) Findings include: 1. A clinical record review was completed, on 2/18/22 at 10:56 A.M., and indicated Resident 72's diagnoses included, but were not limited to: dementia without behavioral disturbance, Type 2 diabetes mellitus, anemia, 2019-nCoV acute respiratory disease. The Resident was admitted on 11/9/21. Resident 72 signed for an influenza consent was signed on 11/11/21 and it was not administered. 2. A clinical record review was completed on 2/21/22 at 9:18 A.M., and indicated Resident 44's diagnoses included, but were not limited to: atrial fibrillation, hypertension, benign prostatic hyperplasia, diabetes mellitus, thyroid disorder. He was admitted on 9/22/22. Resident 44 signed for a pneumococcal vaccination on 9/24/21 and it was not administered.	F 0883	**F 883 – Influenza and Pneumococcal Immunization** What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of the facility to ensure residents are provided education and administration of immunizations per preference. Residents 44 consented to administration of pneumococcal vaccination however has refused administration to date. Resident 72 consented for administration of flu vaccine. Resident 72 has discharged from facility with return not anticipated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. IP/Designee will audit all Residents Preventative Health records to ensure immunization education and authorization and administration on or before	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	During an interview on 2/18/22 at 1:47 P.M., the Regional Nurse, indicated that Resident 44 did not receive her flu vaccination, and Resident 72 his pneumococcal vaccination. On 2/18/22 at 1:48 P.M., Regional Nurse indicated they should have received the vaccination. On 2/18/22 at 2:25 P.M., the Regional Nurse provided a policy titled, "Influenza Vaccination (Resident)," reviewed on 8/2021, and indicated the policy was the one currently used by the facility. The policy indicated " ...It is the policy of this facility that resident(s) will be offered influenza vaccination to help prevent the development and transmission of influenza ...." And provided a policy titled, "Pneumococcal Vaccination", reviewed on 4/2019, and indicated the policy was the one currently used by the facility. The policy indicated " ...It is the policy of this facility that resident(s) will be offered pneumococcal vaccination (if appropriate) to help prevent the development and transmission of pneumonia ...."		3/25/22. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/Designee to audit education and consent for immunizations during New Admission review. DNS/Designee will provide in service education to all Nurses related to reviewing immunization consents and administration. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Resident Immunizations” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	Based on observation, interview and record review, the facility failed to ensure a safe, clean and comfortable environment was maintained, related to a broken electrical box, a wall with a visible crack, wall and peeling paint on the ceiling, unpainted spackled areas, base board heaters with gouged/ bent metal and chipped paint, a fire door with bent door metal, and an unlocked housekeeping closet dirty with floor care mats and swivel stools. Finding includes: During an environmental tour, on 2/21/22 from 11:30 A.M. to 11:46 A.M., with the Maintenance staff, the following was observed: Room 115 had an electrical box not attached to the wall above a residents head board. A wall with a crack extending from the ceiling, half way down the wall. An area of peeling paint on the ceiling starting at the top of the crack. A baseboard heater in the hallway by Room 119 had missing paint and had areas of bent and distressed metal. A baseboard heater in the hallway by Room 130 had missing paint, bent metal pieces and gouged areas. The fire door on East Two unit had a piece of the metal bent along the left door where the door closes to extend over the right door extending from the floor up 24 inches. The walls on the East Two unit and the small dining room had areas of patch work that were unpainted. A dirty housekeeping closet, unlocked with swivel stools, dirty floor buffing pads and a pipe extending from the floor to the ceiling with padding torn off at the bottom of the pipe. On 2/18/22 at 11:48 A.M., Maintenance staff indicated he did not have a painting schedule, the heaters should be repaired, the door should have been repaired. He indicated he didn't know what	F 0921	**F 921 – Safe Functional Sanitary Environment** **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of the facility to ensure a safe, functional, sanitary and comfortable environment. Facility repairs completed. Facility repairs for electrical box, crack in wall, peeling paint in the ceiling, unpainted spackled areas, base bord heaters fire door have been completed. Housekeeping closet door is locked. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. Maintenance Director/Designee will complete a facility wide audit to ensure safe, functional, sanitary and comfortable environment. Any items in disrepair will be repaired or replaced on or before 3/25/22. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff to be in serviced on completion of Work Orders when repairs needed on or before	03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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
	the closet was used for. On 2/21/22 at 12:22 P.M., the Maintenance staff provided the policy titled," Painted/Stained Surface", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...Frequency: Monthly- Check painted and stained surfaces monthly for scuffing, deterioration, and peeling. Repaint, re-stain, or touch up as needed...." A policy was requested for preventative maintenance and environmental rounds, but one was not provided. 3.1-19(f)		3/25/22. Maintenance Director /Designee will conduct walkthroughs weekly to ensure facility is in good repair, and to ensure work orders are completed as necessary. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Preventative Maintenance” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/25/22	