STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155684	A. BUILDING 00 B. WING	11/16/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00393530. Complaint IN00393530 - Substantiated. Federal/state deficiencies related to the allegations are cited at F658. Unrelated deficiency is cited. Survey dates: November 14, 15, and 16, 2022 Facility number: 002662 Provider number: 155684 AIM number: 200315930 Census Bed Type: SNF/NF: 41 SNF: 12 Total: 53 Census Payor Type: Medicare: 8 Medicaid: 26 Other: 19 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 11/29/22.	F 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joseph M. Doran	Administrator	12/15/2022

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

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	care plan, must- (i) Meet professional standards of quality. Based on record review and interview, the facility failed to ensure physician ordered dressing changes and wound care were administered per order for 1 of 2 residents reviewed for dressing changes. (Resident C). Finding includes: On 11/15/22 at 10:00 A.M., the clinical records for Resident C were reviewed. Review of the resident's most recent comprehensive Minimum Data Set (MDS), an admission assessment dated 10/13/22, indicated Resident C had been admitted to the facility on 10/6/22 from a local hospital following a surgical repair for an abdominal hernia. Resident C was cognitively intact with a Brief Interview for Mental of 15, required extensive assistance for toilet use and personal hygiene and supervision for transfers to and from the toilet. Resident C's diagnoses included, but were not limited to; kidney disease requiring dialysis, aftercare for abdominal hernia repair, and diabetes. Skin conditions indicated the resident had a surgical wound that required surgical wound care. Review of the resident's Patient Transfer Assessment Form from the local hospital, dated 10/6/22, indicated an order for wound care for abdominal incision from surgery and JP drains (closed suction device used to collect fluids). Physician order instructed for midline incision care to keep the incision covered with a 4" x 4" gauze and tape, to be changed three times daily. Review of Resident C's Treatment Record date	F 0658	The dressing for resident C was changed. The physician and family were notified. The staff member was educated. All residents with orders for dressing changes have the potential to be affected. The Wound Treatment policy was updated and the nursing staff was educated on following physician treatment orders by the DON/designee. An audit will be completed by the wound nurse/designee to ensure dressings are changed per the physician's order. Audits will be conducted twice per week for 4 weeks and once per week for 4 weeks. The results of the audit will be reported to and reviewed by the QAPI committee monthly and the audits will continue until substantial compliance is maintained.	12/19/2022

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	from 10/6/22 to 10/31/22 indicated there were no dressing changes to the midline abdominal incision from 10/6/22 to 10/14/22. On 11/15/22 at 10:27 A.M., an interview with the Director of Nursing indicated when the resident was admitted to the facility follow an abdominal hernia repair on 10/6/22, she had an order for dressing changes to the surgical area that were entered into the electronic medical record incorrectly under ancillary treatments, where it should have been entered under daily treatments. The Director of Nursing indicated the resident should have had daily dressing changes as ordered, but did not have daily dressing changes. On 11/16/22 at 10:51 A.M., a document titled Wound Treatment Policy dated 12/11/19, was provided by the Assistant Director of Nursing who indicated it was the current policy. The policy indicated, "Wound treatment will be provided in accordance with physician orders, including the cleaning method, type of dressing and frequency of dressing change..." This Federal tag relates to Complaint IN00393530. 3.1-35(g)(1)			
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			

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	to prevent accidents. Based on interview and record review, the facility failed to ensure a resident with severe cognitive impairment was adequately supervised for 1 of 1 residents reviewed for elopement, (Resident G). Finding includes: On 11/15/22 at 12:00 P.M., the clinical records for Resident G were reviewed. Resident G's Admission Record indicated the resident was admitted to the facility on 1/29/21. Review of the resident's most recent Minimum Data Set (MDS), a quarterly assessment dated 9/13/22, indicated the Resident G had a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. Diagnoses included, but were not limited to; age related debility, sleep disorder, and cerebral atherosclerosis (thickening and hardening of the walls of the arteries in the brain).The resident required supervision for activities of daily living and utilized a wheelchair for locomotion. Review of the Resident G's Care Plans included, but were not limited to;Assistance with Daily Living, dated 7/1/22, which directed that the resident required assistance with bed mobility, toileting, and transfers. Cognitive Loss/Dementia, dated 4/21/22, that indicated impaired ability to comprehend communication and impaired memory related to cognitive impairment and disease processes. A care plan for wandering was implemented on 7/6/22 and resolved on 9/26/22. Review of a Elopement Risk Assessment dated 9/26/22 at 12:18 P.M., indicated the resident had a	F 0689	Resident G was assessed and found to have no injuries or distress. The physician and family were notified. A new elopement assessment was completed, care plan updated, and Wander Guard placed. All residents who are cognitively impaired have the potential to be affected. Residents with cognitive impairment have been assessed for elopement risk within the last quarter. The Accidents and Supervision policy was updated, and Nursing was educated on hazards and supervision by the DON/designee. Elopement risk assessments will be completed for all residents each quarter. An audit will be completed by the DON/designee to ensure supervision of cognitively impaired residents is adequate. The audit will be conducted twice a week for 4 weeks and then once a week for 4 weeks. The results of the audit will be reported to and reviewed by the QAPI committee monthly and the audits will continue until substantial compliance is maintained.	12/19/2022

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	diagnosis of dementia, and moved about the unit independently, which indicated she was at low risk for elopement. On 11/14/22 at 12:20 P.M., the Administrator provided Incident Number 184, dated 10/12/22 at 9:15 A.M., which indicated on 10/11/22 Resident G was found at 6:30 A.M. sitting in her wheelchair, in the foyer, fully dressed with coat. When asked if she needed help, she replied she was waiting for friends to pick her up. Resident was assisted back to the unit to discover she had the incorrect time. she was supposed to be picked up at 10:00 A.M., and on 10/12/22 upon further investigation, it was discovered the resident did exit the building on Monday at 2:30 A.M., and waited in the foyer until she was found at 6:30 A.M. No injuries were incurred. On 11/15/22 at 11:07 A.M., an interview with the Director of Nursing, indicated nursing staff check on residents during "Rounding" at 2:00 A.M., and 6:00 A.M. The Director of Nursing indicated Resident G liked to be left alone at night so nursing staff would not typically check on her after she goes to bed at night. The Director of Nursing indicated the facility did not have a specific policy related to checking residents during the night unless they were an elopement risk. The Director of Nursing indicated Resident G had a recent Elopement Risk Assessment that indicated the resident was not an elopement risk and that the resident did not have wondering tendencies. On 11/15/22 at 2:00 P.M., an interview with the Administrator indicated Resident G had exited the building by the lobby side door on 10/11/22 at 2:30 A.M., then walked to the front lobby door and came into the foyer to wait for her ride. She			

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	was confused about the time and was to be picked up at 10:00 A.M. The receptionist came to work on 10/11/22 at 6:30 A.M. to find the resident sitting in the foyer. Through staff interviews, the Director of Nursing determined staff were unaware Resident G was out of her room. A policy regarding supervision was requested, none was provided. An interview with the Director of Nursing on 11/16/22 at 9:30 A.M. indicated the facility did not have a policy regarding supervision. 3.1-45(a)(2)			