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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HOME BY FIR	1410 DEER RUN DRIVE MISHAWAKA, IN 46545

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey date: 1/31/2024 Facility number: 015429 Residential Census: 17 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/5/24.	R 0000		
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leah Bennett	Executive Director	02/16/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HOME BY FIR	1410 DEER RUN DRIVE MISHAWAKA, IN 46545

(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
	(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or their representative, for 1 of 6 residents reviewed for Service Plans. (Resident 2) Finding includes: A record review was completed on 1/31/2024 at 10:45 A.M. Resident 2's diagnoses included, but were not limited to hypertension and chronic obstructive pulmonary disease. A Service Plan, dated 7/14/2023, lacked the resident and facility staff signatures and dates. During an interview, on 1/31/2024 at 2:23 P.M., the Director of Nursing indicated the Service Plan should have been signed. On 1/31/2024, a policy on Service Plans was requested, but one was not provided prior to the survey exit.	R 0217	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 2's service plan was reviewed and signed by the resident/responsible party on 1/31/24. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken:** All resident's service plans were audited to ensure all service plans had responsible party's signatures. All residents had the potential to be affected. No residents experienced any negative outcomes related to this deficient concern. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director educated the Director of Nursing on service plan compliance.	02/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HOME BY FIR	1410 DEER RUN DRIVE MISHAWAKA, IN 46545

(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
			How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place: The Director of Nursing/designee will conduct an audit of all resident's service plans for signatures monthly for six months. If the threshold of 100% is not met, an action plan will be developed. The findings will be submitted to the Executive Director for review and follow-up. **What date the systemic changes will be completed:** Compliance date: 2/13/2024	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food and food preparation and serving areas were maintained in a safe and sanitary manner in the main kitchen. This had the potential to affect all residents residing in the facility. Findings include: 1. During an observation, on 1/31/2024 at 9:57 A.M., the following food items in the freezer and dry storage areas were found opened and/or not dated: frozen broccoli was open and not dated, frozen breaded mushrooms were open and not dated, frozen danish was open and not dated, a	R 0273	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Dietary staff was immediately re-educated about required labeling and kitchen sanitary practices. No residents experienced any negative outcomes related to this deficient concern. **How the facility will identify other residents having the potential to be affected by the**	02/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HOME BY FIR	1410 DEER RUN DRIVE MISHAWAKA, IN 46545

(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
	frozen cake was open and not dated, ice cream was open and not dated, and all spice containers were open and not dated. During an interview, on 1/31/2024 at 10:12 A. M., Cook 2 indicated food should be sealed and dated when opened. 2. During an observation, on 1/31/2024 at 10:15 A.M., the ventilation hood over the stove had grease build up and dust covering it. During an interview, on 1/31/2024 at 10: 18 A.M., Cook 2 indicated the hood was cleaned, but did not have a specific schedule for cleaning. On 1/31/2024 at 3:58 P.M., the Director of Nursing provided a current policy titled, "Proper Food Storage," which indicated, "Label and date all stored food date received, date opened, and use by date ...." On 1/31/2024 at 4:12 P.M., the Director of Nursing provided a current policy titled, "Dietary Sanitation Operations; General Maintenance" which indicated, " ...Nonfood-contact surfaces of equipment used in the operation of food plants should be cleaned as frequently as necessary to protect against contamination of food ...."		**same deficient practice and what corrective actions will be taken:** The Dietary manager completed an audit on 1/31/24 to ensure all opened food was sealed and dated. The ventilation hood over the stove was professionally cleaned on 2/8/23. All residents had the potential to be affected. No residents experienced any negative outcomes related to this deficient concern. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Dietary Manager educated the dietary staff on the required labeling and kitchen sanitary practices. **How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** The Dietary Manager/designee will audit the ventilation hood over the stove is clean and the proper labeling is completed weekly for three months and then monthly for six months. If the threshold of 100% is not met, an action plan will be developed. The findings will be submitted to the Executive Director for review and follow-up. **What date the systemic changes will be completed:** Compliance date: 2/13/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HOME BY FIR	1410 DEER RUN DRIVE MISHAWAKA, IN 46545

(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
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.			
	Based on record review and interview, the facility failed to ensure residents had a signed health statement indicating they were free from tuberculosis in an infectious state at admission and yearly thereafter, for 3 of 7 residents reviewed. (Residents 7, 2 & 5) Findings include: 1. During a closed record review, on 1/31/2024 at 2:15 P.M., Resident 7's record lacked a health statement upon admission indicating he was free from tuberculosis in an infectious state. During an interview, on 1/31/2024 at 4:34 P.M., the Director of Nursing indicated she was unaware that residents should have a health statement upon admission and yearly indicating they are free from tuberculosis in an infectious state. 2. A record review for Resident 2 was completed on 1/31/2024 at 10:45 A.M. Resident 2's diagnoses included, but were not limited to: hypertension and chronic obstructive pulmonary disease. Resident 2 was admitted on 7/14/2023. The resident's record lacked documentation of an annual health statement to indicate Resident 2 was free from tuberculosis in an infectious state upon admission and yearly thereafter. 3. A record review for Resident 5 was completed	R 0409	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 2, 5 & 7's health assessment were reviewed and updated by 2/3/24. No harm was incurred to residents 2, 5, 7 related to this deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken:** All resident's health assessments were immediately reviewed and audited to ensure they included a statement that the resident shows no evidence of tuberculosis in an infectious stage. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director educated the Director of Nursing on resident health assessment compliance. **How the corrective action will**	02/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HOME BY FIR	1410 DEER RUN DRIVE MISHAWAKA, IN 46545

(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 1/31/2024 at 2:10 P.M. Resident 5's diagnoses included, but were not limited to: depression, chronic pain, Parkinson's disease and dysphagia. Resident 5 was admitted on 3/31/2023. The resident's record lacked documentation of an annual health statement to indicate Resident 5 was free from tuberculosis in an infectious state upon admission and yearly thereafter. During an interview, on 1/31/2024 at 2:50 P.M., the Director of Nursing indicated there should have been an annual health statement on the admission orders and on the orders thereafter. On 1/31/2024 at 3:58 P.M., the Director of Nursing provided a policy, titled "Admission Checklist", revised date of 12/29/2023, and indicated the policy was the one currently used by the facility. The policy indicated..." 12. Prior to admission, each resident shall be required to have a health statement, including history of significant past or present infections diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage verified upon admission and yearly thereafter...."		**be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** Director of Nursing/designee will complete an audit to ensure compliance on all resident's health assessments monthly for six months. If a threshold of 100% is not met, an action plan will be developed. The findings will be submitted to the Executive Director for review and follow-up. **What date the systemic changes will be completed** Compliance date: 2/13/2024	