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| CHAPTERS LIVING OF SOUTH BEND | 955 HICKORY ROAD<br>SOUTH BEND, IN 46615 |

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| R 0000<br><br>Bldg. 00 | This visit was for an Initial State Residential Licensure Survey.<br><br>Survey date: August 13, 2024<br><br>Facility number: 016149<br><br>Residential Census: 5<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality Reviewe completed on 8/20/2024 | R 0000 | | |
| R 0117<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(b)<br>Personnel - Deficiency<br><br>Based on record review and interview, the facility failed to ensure at least one staff member had CPR (Cardiopulmonary Resuscitation) and First Aide certification/training on each shift. This had the potential to effect all 5 residents who resided at the facility.<br><br>Finding includes:<br><br>A review of the employee work schedule, dated 8/7/24 through 8/13/24, indicated staff worked 12 hour shifts. There was nn CPR/First Aide certified staff member for the following dates and shifts:<br>- Day shift on 8/7/24, 8/8/24, 8/10/24 and 8/11/24.<br>- Night shift on 8/7/24, 8/8/24, 8/12/24 and 8/13/24.<br><br>On 8/13/24 the Administrator indicated the facility had no policy regarding the need to have at least one staff member to be certified in CPR and First Aide. | R 0117 | 1. All residents have the potential to be affected by deficient practice.<br>2. All residents interviewed, no residents displaying any S/SX of symbological distress.<br>3. The Health Service Director re-educated to ensure State Regulation 0117, Personnel - Deficiency 410 IAC 16.2-5-1.4(b) will be followed and kept in compliance. Under the full understanding of the details listed below.<br>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and | 09/30/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Bobbi Bradford | Director of Health and Wellness | 09/09/2024 |

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| | | | unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates shall be on site at all times.<br>4. Health service director or designee will complete audit and reference to R0017 deficiency, three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on the audit form. Concerns or non-compliance to be documented and discussed in monthly quarter assurance meetings. There is at least one CPR 1st aid staff on each shift. There is a few that need to be certified and will be certified by 9/30/2024 | |
| R 0214<br><br>Bldg. 00 | 410 IAC 16.2-5-2(a)<br>Evaluation - Deficiency<br><br>Based on interview and record review, the facility failed to ensure 4 of 5 residents reviewed, had a pre-admission evaluation, by a nurse, to determine the needs of the resident. (Resident 3, 4, 5 and 6)<br><br>Finding includes: | R 0214 | 1. All residents have the potential to be affected by deficient practice.<br>2. All residents interviewed, no residents displaying any S/SX of symbological distress. | 08/29/2024 |

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| | During the initial tour, on 8/13/24 at 10:40 A.M., the Director of Nursing (DON) indicated Residents 3, 4, 5 and 6 had a diagnosis of dementia. She was unaware if the residents had any other diagnoses.<br><br>On 8/13/24, the Clinical Record Reviews were conducted for Residents 3, 4, 5 and 6 and indicated the there had been no preadmission evaluation for each of the listed residents completed by a licensed nurse.<br><br>The Employee Record form, completed with the Administrator, on 8/13/24, indicated there was only 1 licensed nurse employed by the facility and it was the Director of Nursing (DON) who was a LPN (Licensed Practical Nurse).<br><br>A form titled, "New Resident Checklist For____" indicated a Comprehensive Assessment by facility nurse was to be conducted and documented.<br><br>On 8/13/24 at 3:42 P.M., the DON provided a policy titled, "Admission, Discharge and Transfer Procedure", dated 2/1/23, and indicated the policy was the one currently used by the facility. The policy indicated "...c. On or before admission a licensed nurse will conduct a screening to determine the individual's functional capacity. Needs as identified on the functional capacity screening will be addressed in the service plan and overseen...." | | 3. The Health Service Director re-educated to ensure State Regulation, 0214 Evaluation - Deficiency 410 IAC 16.2-5-2(a) (will be followed and kept in compliance. Under the full understanding of the details listed below.<br>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.<br>4. Health service director or designee will complete audit and reference to R-0214 deficiency, three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on the audit form. Concerns or non-compliance to be documented and discussed in monthly quarter assurance meetings. | |
| R 0216<br><br>Bldg. 00 | 410 IAC 16.2-5-2(c)(1-4)(d)<br>Evaluation - Noncompliance<br><br>Based on interview and record review, the facility failed to ensure an admission weight was | R 0216 | 1. All residents have the potential to be affected by deficient | 08/29/2024 |

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| | documented for 5 of 5 residents the facility had admitted into their facility. (Resident 2, 3, 4, 5 and 6)<br><br>Finding includes:<br><br>On 8/13/24, record reviews were conducted for Residents 2, 3, 4, 5 and 6. There were no admission or post-admission weights documented for these residents.<br><br>A form titled, "New Resident Checklist For____", indicated a Comprehensive Assessment was to be completed by the Nurse, however there was no Pre or Post Admission Assessment, with a weight, documented for any of the reviewed residents.<br><br>On 8/13/24 at 3:42 P.M., the Director of Nursing indicate the facility had no policy regarding when a resident should be weighed.<br><br>An Admission Packet, provided by the Administrator, on 8/13/24, indicated "...Health and Personal Care Services 1. Monitoring. [name of facility], through its 23-hour staff, shall monitor the Resident's health status to identify any changes in the Resident's physical, mental, emotional and social functioning..." | | practice.<br>2. All residents interviewed, no residents displaying any S/SX of symbological distress.<br>3. The Health Service Director re-educated to ensure State Regulation, 0216 Evaluation - Deficiency (a) (will be followed and kept in compliance. Under the full understanding of the details listed below.<br>c) The scope and content of the evaluation shall be delineated in the facility policy<br>manual, but at a minimum the needs assessment shall include an evaluation of the<br>following:<br>(1) The resident ' s physical, cognitive, and mental status.<br>(2) The resident ' s independence in the activities of daily living.<br>(3) The resident ' s weight taken on admission and semiannually thereafter.<br>(4) If applicable, the resident ' s ability to self-administer medications.<br>(d) The evaluation shall be documented in writing and kept in the facility.<br>4. Health service director or designee will complete audit and reference to R-0216 deficiency, three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these | |

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| | | | observations will be documented on the audit form. Concerns or non-compliance to be documented and discussed in monthly quarter assurance meetings. | |
| R 0217<br><br>Bldg. 00 | 410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency<br><br>Based on interview and record review, the facility failed to ensure the resident and/or family member had signed a plan of service for 5 of 5 residents who resided at the facility. (Resident 2, 3, 4, 5 and 6)<br><br>Finding includes:<br><br>During the initial tour, on 8/13/24 at 10:40 A.M., the Director of Nursing (DON) indicated Residents 2, 3, 4, 5 and 6 all had a diagnosis of dementia.<br><br>On 8/13/24, the record reviews for Residents 2, 3, 4, 5 and 6 were completed and there were no signed and dated Service Plans.<br><br>A form titled, "New Resident Checklist For____", did not include information regarding a Service Plan<br><br>On 8/13/24 at 3:42 P.M., the Director of Nursing indicate the facility had no policy regarding Service Plans. | R 0217 | 1. All residents have the potential to be affected by deficient practice.<br>2. All residents interviewed, no residents displaying any S/SX of symbological distress.<br>3. The Health Service Director re-educated to ensure State Regulation, R-0217 Evaluation - Deficiency will be followed and kept in compliance. Under the full understanding of the details listed below.<br>410 IAC 16.2-5-2(e)(1-5)<br>(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:<br>(1) The services offered to the individual resident shall be appropriate to the:<br>(A) scope; (B) frequency; (C) need; and (D) preference of the resident.<br>(2) The services offered shall be reviewed and revised as appropriate and discussed | 08/29/2024 |

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| | | | by the resident and facility as needs or desires change. Either the facility or the residents may request a service plan review.<br>(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.<br>4. Health service director or designee will complete audit and reference to R-0217deficiency, three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on the audit form. Concerns or non-compliance to be documented and discussed in monthly quarter assurance meetings. | |
| R 0274<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(g)(1-3)<br>Food and Nutritional Services - Noncompliance<br>Based on observation and interview, the facility failed to ensure a qualified Dietary Manager and/or Dietician was overseeing the facility provided dietary services. This had the ability to effect all 5 residents who resided at the facility.<br><br>Finding includes:<br><br>During a tour of the kitchen, on 8/13/24 at 11:20 - 11:42 A.M., Cook 5 indicated she and another Cook took care of all the kitchen duties. She was unsure of when or who maintained the facility's | R 0274 | R-0274<br>1. All residents have the potential to be affected by deficient practice.<br>2. All residents interviewed, no residents displaying any S/SX of symbological distress.<br>3. The Executive Director made aware to Management Entity by means of informing the owning entity to ensure State Regulation, 0274 Evaluation - Deficiency (a) | 08/29/2024 |

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| | menus and if any of the residents were on any special diets.<br><br>During an observation of the meal, on 8/13/24 at 12:05 P.M., Cook 5 had not followed the menu and indicated she could not find the sauce needed for Sloppy Joes and had changed the meal to leftover sausage, potatoes and green bean soup, orange slices and a cookie.<br><br>During an interview, on 8/13/24 at 1:19 P.M., the Administrator indicated she had no qualified Dietary Manager working at the facility, however she had hired a Dietary Manager who would be starting on 8/19/24 and she had contracted a Dietician who would be starting on 8/29/24.<br><br>On 8/13/24 at 2:23 P.M., the Administrator indicated there were no policies regarding the need to provide the resident's with a Dietary Manager, with knowledgeable food management. | | (will be followed and kept in compliance. Under the full understanding of the details listed below.<br>(g) There shall be an organized food service department directed by a supervisor<br>competent in food service management and knowledgeable in sanitation standards,<br>food handling, food preparation, and meal service.<br>(1) The supervisor must be one (1) of the following:<br>(A) A dietitian.<br>(B) A graduate or student enrolled in and within one (1) year from completing a<br>division approved, minimum ninety (90) hour classroom instruction course that<br>provides classroom instruction in food service supervision who has a minimum of<br>one (1) year of experience in some aspect of institutional food service management.<br>(C) A graduate of a dietetic technician program approved by the American Dietetic Association.<br>(D) A graduate of an accredited college or university or within one (1) year of<br>graduating from an accredited college or university with a degree in foods and<br>nutrition or food administration with a minimum of one (1) year of experience in | |

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| | | | some aspect of food service management.<br>(E) An individual with training and experience in food service supervision and management.<br>(2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis.<br>(3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.<br>4. Executive Director or designer will complete audit and reference to R-0274deficiency, three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on the audit form. Concerns or non-compliance to be documented and discussed in monthly quarter assurance meetings. | |
| R 0409<br><br>Bldg. 00 | 410 IAC 16.2-5-12(d)<br>Infection Control - Noncompliance<br><br>Based on record review, the facility failed to ensure 5 of 5 residents admitted to the facility had a physician health assessment with a statement indicating there was no evidence of tuberculosis (TB) in the infectious stage. (Resident 2, 3, 4, 5 and 6) | R 0409 | 1. All residents have the potential to be affected by deficient practice.<br>2. All residents interviewed, no residents displaying any S/SX of symbological distress.<br>3. The Health Service Director | 08/29/2024 |

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| | Finding includes:<br><br>On 8/13/24, the record reviews for Residents 2, 3, 4, 5 and 6 were completed and indicated there was no health assessments, completed by the physician, which included the a statement ensuring the resident had no evidence of TB prior to their admission to the facility.<br><br>On 8/13/24 at 3:42 P.M., the Director of Nursing indicated the facility had no policy regarding Health Statements required by the admitting physician. | | re-educated to ensure State Regulation, R-0409 Evaluation - Deficiency (a) (will be followed and kept in compliance. Under the full understanding of the details listed below.<br>(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.<br>4. The Health Service Director or designer will complete audit and reference to R-0409 deficiency, three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on the audit form. Concerns or non-compliance to be documented and discussed in monthly quarter assurance meetings. | |
| R 0410<br><br>Bldg. 00 | 410 IAC 16.2-5-12(e)(f)(g)<br>Infection Control - Noncompliance<br><br>Based on record review and interview, the facility failed to ensure 5 of 5 admitted residents had a negative tuberculin (TB) skin test prior to admission or upon admission. (Resident 2, 3, 4, 5 and 6) | R 0410 | 1. All residents have the potential to be affected by deficient practice.<br>2. All residents interviewed, no residents displaying any S/SX of symbological distress. | 08/29/2024 |

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| | Finding includes:<br><br>On 8/13/24, the Clinical Record reviews for Residents 2, 3, 4, 5 and 6 indicated the facility had not administered or reviewed the medical history of the residents to ensure the residents were not infected with TB prior to or at admission to the facility.<br><br>A form titled, "New Resident Checklist For____", indicated TB test results were included in the required documentation.<br><br>On 8/13/24 at 3:42 P.M., the Director of Nursing indicate the facility had no policy regarding the need for TB testing, for all resident who were admitted to the facility. | | 3. The Health Service Director re-educated to ensure State Regulation, R-0410 Evaluation - Deficiency (a) (will be followed and kept in compliance. Under the full understanding of the details listed below.<br>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.<br>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br>4 The Health Service Director or | |

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| | | | designer will complete audit and reference to R-0410 deficiency, three times per week for four weeks, twice a week for eight weeks, and weekly for four months thereafter or until a pattern of substantial compliance is achieved. The results of these observations will be documented on the audit form. Concerns or non-compliance to be documented and discussed in monthly quarter assurance meetings. | |