STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155635	A. BUILDING 00 B. WING	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

(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 a State Residential Licensure Survey. Survey dates: March 23, 24, 27, 28, 29, 30 and 31, 2023 Facility number: 000501 Provider number: 155635 AIM number: 100266260 Census Bed Type: SNF/NF: 46 SNF: 4 Residential: 50 Total: 100 Census Payor Type: Medicare: 4 Medicaid: 25 Other: 21 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on 4/20/23.	F 0000	**This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.** /b> /b>	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Kimbrell	CEO	05/05/2023

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

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	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 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-			

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	(iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to have a care plan for an open area for 1 of 3 residents reviewed for skin. (Resident7) Finding includes: During an observation, on 3/23/2023 at 2:37 P.M., Resident 7 was observed to have a red open area to right side of her nose. A record review was completed, on 3/28/2023 at 3:27 P.M. Resident 7's diagnoses included, but were not limited to: osteoporosis, hypothyroidism, depression, insomnia and bolus pemphigoid. A 5 day MDS (Minimum Data Set) Assessment, dated 6/24/2022, indicated Resident 7 had severe cognitive impairment. Current care plans for Resident 7 lacked a person centered care plan for the skin issue to the residents' nose. During an interview, on 3/29/2023 at 1:30 P.M., LPN 3 indicated the resident should have a care plan for the cancer area to her nose. During an interview, on 3/28/2023 at 1:45 P.M., the Director of Nursing indicated the care plan was not person centered. On 3/29/2023 at 2:32 P.M., the Director of Nursing provided the policy titled," Comprehensive Care Plans", dated 7/6/2022. The policy indicated"... f. Resident specific interventions that reflect the resident's needs and preferences... 3.1-35(a)	F 0656	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village requests consideration for a desk review for all citations. ="" b="">" 1. Immediate action(s) taken for the resident(s) found to have been affected include: Care plan for skin of resident 7 was reviewed and updated as indicated. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility's policy and procedure for developing *Comprehensive Care Plans*.	04/26/2023

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			4. How the corrective action(s) will be monitored to ensure the practice will not recur: Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator. All care plans will be updated as indicated. The Director of Nursing ,or designee, will complete random weekly audits of care plans for 12 consecutive weeks, when monthly for 3 months. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
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.			

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	(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (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 observation, interview, and record review, the facility failed to revise care plans for changes in condition for 1 of 23 residents, whose care plans were reviewed. (Residents 44) Finding includes: During an interview, on 3/23/2023 at 2:08 P.M., Resident 44 indicated his left knee was sometimes painful and stiff due to an injury several years ago. A record review, on 3/27/2023 at 9:33 A.M., indicated a Quarterly MDS (Minimum Data Set) Assessment, dated 2/23/2023, included, cognition was intact, Resident 44 required extensive assistance of 1 staff person for bed mobility, dressing, and toileting. He required extensive assistance of 2 staff persons for transfers. He had no falls or other health conditions. Diagnoses for Resident 44 included, but were not limited to: acute kidney failure, other pulmonary embolism, acute deep vein thrombosis, and osteoarthritis.	F 0657	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village requests consideration for a desk review for all citations. ="" b=""> 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 3/27/2023, Resident 44s care plan was updated to include leg brace per recommendations. 2. Identification of other residents having the potential to	04/26/2023

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	The Physician orders for Resident 44 included, on 2/3/2023 left knee brace as needed for osteoarthritis. Resident 44's care plan dated 2/2/2023 lacked care plan interventions for use of the brace for his left leg. During an interview, on 3/27/2023 at 1:42 P.M., the MDS coordinator indicated that she does most of the care plans but was not aware of the brace for Resident 44. She indicated that it should have been on the care plan. 3.1-35(c)(1)		be affected was accomplished by: All residents of the facility have the potential to be affected by this practice. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All interdisciplinary care plan team members responsible for coordinating care plan conferences will be re-educated on the facility's policy and procedure: *Care Planning – Resident Participation.* **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The MDS nurse or designee will conduct a weekly random audit of six residents for a period of 12 consecutive weeks and then 6 residents monthly for 3 months to ensure that the residents who have had changes have had updated interventions that are appropriate to their plan of care. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	
F 0677 SS=E 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;			

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

FORM APPROVED
OMB NO. 0938-039

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	Based on record review, observation and interview, the facility failed to ensure nail care was provided and ensure residents who required staff assistance for toileting were toileted timely to prevent further incontinence for 4 of 20 residents reviewed for ADL (Activities of Daily Living) care. (Resident 19,12, 24 and 29) Finding includes: 1.During a meal observation, on 3/23/2023 at 11:45 A.M., Resident 19 was observed using her fingers to feed herself. During an observation, on 3/23/2023 at 1:53 P.M., Resident 19 was observed with a dark substance under her finger nails. During an observation, on 3/27/2023 at 11:56 A.M., Resident 19 was observed with a dark substance underneath her fingernails. During an interview, on 3/27/2023 at 12:03 P.M., CNA 4 indicated the residents fingernails should have been cleaned. A record review was completed on, 3/27/2023 at 3:00 P.M. Resident 19's diagnoses included, but were not limited to: Alzheimer's disease, chronic kidney disease, heart failure, diabetes, and dementia. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/22/2023, indicated severe cognitive impairment. She had no rejection of care behaviors, required extensive assist of 1 staff for personal hygiene and total assist for bathing. A current care plan, dated 1/8/2022, indicated the resident had impaired functional status and	F 0677	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village requests consideration for a desk review for all citations. ="" b=""> 1. Immediate action(s) taken for the resident(s) found to have been affected include: Nail care was provided for resident(s) # 19 on 3/28/2023. The Director of Nursing Services and the treatment nurse completed an assessment of each residents nails on 3/28/2023. Residents requiring specialized nail care due to high risk conditions will be referred to a podiatrist for appropriate care and treatment. Residents 12 and 24 set up for toileting schedule based off of most common times of incontinence and interviews with residents. Evaluation of toileting schedule is ongoing. Resident 29 deceased. 2. Identification of other residents having the potential to be affected was accomplished by:	05/01/2023

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	required assistance with ADL's and care related to, Alzheimer's disease,dementia and weakness. Interventions included grooming and hygiene extensive staff assist of 1. Resident 19's nail care documentation dated 3/1/2023 to 3/27/203, indicated the resident received nail care fourteen (14) days out of 26 days from 3/1/2023 to 3/26/2023. On 3/29/2023 at 8:45 A.M., the Director of Nursing provided the policy titled,"Nail Care, dated 6/7/2022. The policy indicated "... 6. Procedure a. Perform hand hygiene and don gloves. b. Gently clean underneath nails with nail stick if resident is able to tolerate and allows. 2. During an interview, on 3/23/2023 at 2:54 P.M., Resident 12 indicated," I can't hold my pee". A clinical record review was completed on 3/27/2023 at 1:43 P.M. Resident 12's current diagnoses's included, but were not limited to: hypertension, dementia, over active bladder, edema and blind. Current physician orders included: Detral (bladder relaxant) 1 mg (milligram) daily for urinary frequency, and Furosemide (diuretic) 20 mg daily for edema. A Significant Change MDS (Minimum Data Set) Assessment, dated 1/30/2023, indicated Resident 12 was occasionally incontinent of bladder and bowels. She was not on a scheduled toileting program. A Significant Change MDS (Minimum Data Set) Assessment, dated 2/9/2023 indicated the resident had intact cognition. She required extensive assist		The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** An in-service education program was conducted by the Director of Nursing Services and the treatment nurse with all direct care staff addressing ADL care including resident preferences and high risk conditions. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The treatment nurse will review nail care for residents with high risk conditions. The Director of Nursing Services, or designee, will conduct a random audit of at least five (5) residents per week for 12 weeks then monthly for an additional 12 weeks. for nail care until substantial compliance is achieved or as otherwise determined by the Risk Management/Quality Assurance Committee. The Director of Nursing Services, or designee, will set up residents based on MDS calendar each month for toileting schedule and assess outcome to see if adjustments are appropriate at that time based on facility policy. Random audits for toileting needs	

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	of 1 staff for bed mobility, transfers, dressing, and toilet use. She was not on a toileting schedule and was frequently incontinent of bladder and bowel. Restorative programs included: walking and dressing/grooming. A current care plan, dated, 2/2/2023, indicated the resident had functional incontinence related to diagnoses of cognitive deficit, over active bladder, frequency of micturition (urinating). She had the potential for adverse effects related to incontinence and use of incontinence products. Interventions included, use of incontinent pads, administer medications per order, ask is she would like to be toileted before meals and bed time, check for incontinence q (every) 2 hours and provide incontinent care. Resident 12's incontinence documentation, dated 3/1/2023 to 3/29/2023, indicated Resident 12 was not checked every 2 hours for incontinence and had numerous incontinent episodes. Resident 12 had been incontinent 14 times at 7:00A.M., 9 times at 7:00 P.M., 7 times at 1:00 A.M., and 5:00 P.M., and lacked the documentation on the daily charting sheets 102 times to show that the checking for incontinence every 2 hours had been completed. During an interview, on 3/29/2023 at 1:43 P.M., the Director of Nursing indicated the resident was not on a scheduled toileting plan and she would evaluate the resident for a toileting program. 3. During an interview, on 3/23/2023 at 2:11 P.M., Resident 24 indicated she has accidents prior to getting to the bathroom. A record review was completed, on 3/27/2023 at 8:52 A.M. Resident 24's diagnoses included, but		will be completed on 6 residents each week for 12 weeks then 6 residents monthly for an additional 12 weeks. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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were not limited to: Huntington's disease, overactive bladder, and diabetes.

A Quarterly MDS (Minimum Data Set) Assessment, dated 2/13/2023, indicated the resident required extensive assist of 1 staff for bed mobility, transfers, dressing, and toilet use, was frequently incontinent of bladder and occasionally of bowels.

A current care plan, dated 2/14/2022, indicated the resident had functional incontinence issues of bowel and bladder related to disease process, overactive bladder, and UTI's. She had potential for adverse effects related to medication usage and disease process. Interventions included, but were not limited to: Resident uses incontinent products: briefs. Check and change at least every 2 hours, providing incontinence care each episode.

A current care plan, dated 3/9/2023, indicated the resident was to be checked and changed every 2 hours.

During an interview, on 3/29/2023 at 9:38 A.M.,CNA 2 indicated the resident will turn on the light to go to the bathroom. She will get into her wheel chair and they supervise her in the bathroom. CNA 2 indicated the resident had been wet on occasion and she does not walk her to the bathroom, she "had never done that before".

During an interview, on 3/28/2023 1:45 P.M., the Director of Nursing indicated the resident was not being checked/toileted per schedule.

4. During an interview, on 3/24/2023 at 9:21 A.M., Resident 29 indicated she had accidents in the mornings.

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A clinical record review was completed on 3/28/2023 at 9:32 A.M. Resident 29 was admitted on 2/27/2023. Her diagnoses included, but were not limited to: renal insufficiency, hypertension, anxiety, and heart failure.

An Admission MDS (Minimum Data Set) Assessment, dated 3/5/2023 indicated Resident 29 had moderate cognitive impairment, required extensive assist of 1 staff for bed mobility, toilet use, transfers, and 2 staff for dressing and was occasionally incontinent of bladder and bowels.

A current care plan, dated 2/27/2023, indicated the resident had functional bladder and bowel continence issues related to end of life status, reoccurring urinary tract infections, and disease process. Interventions included, the resident used incontinent products- pull-ups. Staff to assist resident with toileting as needed. Staff to provide peri care after incontinence episodes. Staff to check and change at least every 2 hours and PRN (as needed) to promote skin integrity.

The Daily Charting for incontinence checks, dated 3/16/2023 through 3/28/2023, indicated Resident 29 was not checked and or toileted per care plan. Resident had incontinence episodes on: 3/18/23 3 times 3/21/23 2 times, 3/22/23 3 times and 3/26/23 of 4 times. The Daily Charting sheets lacked the documentation 42 times to show that the checking for incontinence every 2 hours had been completed.

During an interview,on 3/28/2023 at 1:45 P.M., the Director of Nursing indicated she will evaluate the resident for scheduled toileting to see if it's appropriate.

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	During an interview,on 3/29/2023 at 9:37 A.M.,CNA 2 indicated Resident 29 will turn on her light to go to the bathroom. She will assist her in to the wheelchair and then when she's done she will turn on the light and I will wipe her and assist with getting her pants pulled up. 3.1-38(a)(3)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			
	Based on observation, interview and record review, the facility failed to ensure a tube feeding solution was dated when hung, and a water flush bag was changed timely for 1 of 1 residents reviewed for tube feedings. (Resident 7)	F 0693	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault	04/26/2023

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	Finding includes: During an observation, on 3/29/2023 at 10:56 A.M., Resident 7's feeding bag was undated when it had been hung to administer, no orders of the flow amount were documented on the bag, there were no resident identifiers, the water bag had a sticky label with the date 3/27/2023 with 200 ml (milliter) flush. There was 750 ml of water remaining in the bag. Current physician orders for Resident 7 included: Nestle 1.2 via g-tube at 60 ml and hour continuously. Change feeding bag and water bag when empty- feeding is able to hang up to 49 hours. Flush g-tube with 200 ml every 6 hours. During an interview, on 3/29/2023 at 10:58 A.M., LPN 3 indicated the bags are to be replaced at the same time and water had been added to the bag that was dated 3/27/2023 instead of replacing the bag. On 3/29/2023 at 1:10 P.M., the Director of Nursing provided the policy titled,"Care and Treatment of Feeding Tubes", dated 11/28/2022. The policy indicated "...1. Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and it's caloric value, volume, duration, mechanism of administration, and frequency of flush... The resident's plan of care will address the uses of feeding tube, including strategies to prevent complications...." On 3/29/2023 at 2:15 P.M., the Director of Nursing provided the policy titled,"Flushing a Feeding Tube", dated 10/7/2022. The policy indicated"...13. If resident has water flushes that are hung in a feeding bag and programmed by pump, follow manufactures recommendations for changing out		by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village requests consideration for a desk review for all citations. ="" b=""> 1. Immediate action(s) taken for the resident(s) found to have been affected include: Water bag for resident 7 was replaced on 3/29/2023. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with tube feedings have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Nursing staff members will be responsible for ensuring that supplies for residents with enteral feedings are changed out and dated per policy. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing ,or designee, will complete weekly audits of feeding supplies for 12 consecutive weeks, when monthly for 3 months on all residents with tube feedings.	

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	155635	A. BUILDING 00 B. WING	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

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	bags...." 3.1-44(a)(1)		Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 0812 SS=D 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. (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 food items in the freezer were sealed securely after opening, failed to ensure refrigerators were clean in 1 of 1 kitchens and 2 of 2 pantries. (main pantry and rehab pantry) Findings include:	F 0812	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who	05/02/2023

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	1. During an observation with the dietary manager in the main kitchen, on 3/23/2023 at 10:25 A.M., the following was observed: There was a buildup of ice along the left side of the air condenser. Opened bags of cod, breaded shrimp, and diced turkey were not sealed tightly. An opened box of corn with noted freezer burn, was not sealed tightly. The floors were dirty with debris under the racks. During an interview, on 3/23/2023 at 10:29 A.M., the Dietary Manager indicated the ice should be gone, the bags should have been sealed tightly, the floor should be cleaned 2. During an observation of the main pantry, with CNA 2 on 3/29/2023 at 9:43 A.M., the following was observed: the microwave had burnt areas to the inside of the door and on the back edge along the floor of the oven. The refrigerator was dirty inside and along the base and had a black substance along the seal of the front door. A container of ice cream was observed with no name on it. During an interview, on 3/29/2023 at 9:46 A.M., LPN 7 indicated she was aware and would have housekeeping look at the fridge. 3. During an observation of the rehab panty, with QMA 6 the following was observed: the refrigerator had black along the seal of the freezer, a dead fly was lying on a shelf, crumbs and a purple stain were on the base of the refrigerator. On the counter was an opened/undated/unnamed bag of potato chips not sealed completely. On 3/29/2023 at 1:10 P.M., the Director of Nursing provided the policy titled," Food and Supply		draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village requests consideration for a desk review for all citations. **Corrective Action for Affected:** *(List all resident codes as identified in IL 2567 report and action performed)* 1. During an observation with the dietary manager in the main kitchen, on 3/23/23 at 10:25 am the following was observed:There was a buildup of ice along left side of the air condenser. Opened bags of cod, breaded shrimp and diced turkey were not sealed tightly. An open box of corn with noted freezer burn was not sealed tightly. The floors were dirty with debris under the racks. Corrective Action:· Build of ice was immediately removed.· Open packages were sealed up bags and put into containers with a tight-fitting lid.· Corn was disposed of· Debris under racks were cleaned. 2. During an observation of main pantry, with CAN on 3/29/23 at 9:43 am the following was observed: the microwave had burnt areas to the inside of the door and on the back edge along the floor of the oven. The refrigerator was dirty inside and along base and had a black	

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	Storage", dated 1/2023. The policy indicated "... All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination too maintain the safety and wholesomeness of the food for human consumption...Cover, label and date unused portions and open packages... Frozen Storage. Store bulk materials in NSF approved containers that have tight fitting lids. Label both the bin and the lid. Use food grade plastic bags for food storage...Wrap food tightly to prevent cross contamination...." On 3/29/2023 at 1:10 P.M., the Director of Nursing provided the policy titled, "Unit Pantry Stock", dated 1/2023. "...Food and Nutrition Services -Label, date and discard outdated items per the food policy...Nursing and/or Food and Nutrition Services Designee -Ensure all items are covered, labeled and dated. Procedures and responsibilities for cleaning and care area must be assigned. The responsible department(s) will maintain equipment temperature and cleaning logs per record retention policy. Cleaning and sanitizing of refrigerator/pantry: Nursing. Defrosting freezer and cleaning and sanitizing ice machine: Plan operation. Cleaning floors and counters , removal of trash, ect.: Housekeeping...." 3.1-21(3)		substance along the seal of the front door. A container of ice cream was observed with no name on it.Corrective Action:· A new microwave was purchased for the area.· Refrigerator was cleaned.· Ice cream was labeled with resident's name and dated. 3. During an observation of the rehab pantry, with QMA 6 the following was observed: the refrigerator had black along the seal of the freezer, a dead fly was lying on shelf, crumbs and purple stains were on the base of the refrigerator. On the counter was an opened/unnamed bag of chips no sealed completely.Corrective Action:· Refrigerator was cleaned· Chips were disposed of. **Other Residents Will Continue to Be Identified:** Upon hire, dining staff receive education and training with the use of an orientation checklist on dating, labeling and storage of food. Training includes 24/5 on Food Storage Practices Dining Manager assists in training and completes regular observation rounding in pantries on to assure sanitation on microwave and refrigerator and checks for dates and labels on resident's food. Department managers participate in compliance rounds in freezer to audit, which includes dating	

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			labeling, sealing up open product and sanitation. Any negative observation addressed at the time of observation audit tool will be corrected and results reviewed for trends. **System Revision:** Housekeeping will be responsible cleaning of refrigerators and microwaves weekly. Reeducation and reminder to dining staff to Food Storage Practices. Implement audit tool for Dining manager or designee to complete random observations on *Pantries and Freezer Storage/Sanitation*. Forward audits to the facility Administrator. **How Facility Will Monitor System:** Dining Manager to review audits and address negative observations one to one with identified staff. Report findings to the QAPI Committee for review and resolution.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 23, 24, 27, 28, 29, 30 and 31, 2023	R 0000	**This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law**	

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	Facility number: 000501 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on 4/20/23.		**and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.** /b> /b>	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure as needed medications administered by a Qualified Medication Aide (QMA) had a licensed nurses documented authorization for 1 of 1 residents reviewed. (Resident 4) Finding includes: During a record review, for Resident 4 on 3/30/2023 at 1:37 P.M., physician orders included, but were not limited to: on 12/21/2022 acetaminophen 325 mg (milligrams) 2 by mouth	R 0246	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	05/01/2023

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Summary Statement of Deficiencies:

every 4 hours as needed for pain/fever and meclizine 25 mg 1 by mouth 3 times daily as needed for dizziness.

Medication administration records included, but were not limited to: meclizine, administered by a QMA (Qualified Medication Aide), on 3/1, 3/2. 3/6, 3/7, 3/10, 3/11, 3/12, 3/13, 3/14, 3/15, 3/16, 3/17, 3/18, 3/21, 3/22, 3/24, and 3/30/2023, did not have licensed nurse authorization documented.
Tylenol, administered by a QMA, on 3/1, 3/2, 3/7, 3/8, 3/10, 3/16, 3/18, 3/21, 3/22, and 3/24/23, did not have licensed nurse authorization documented.

During an interview, on 3/31/2023 at 3:27 P.M., the Director of Nursing indicated that the nurse receives a pop up on the computer to complete prn documentation.

During an interview, on 3/31/2023 at 4:30 P.M., the Assistant Director of Nursing indicated that the nurse should be giving authorization for a QMA to administer any prn medication and it should be documented. Medication administration records and physician orders for March 2023 were requested. Medication administration records were provided but physician orders were not provided.

A policy provided by the Executive Director, on 3/31/2023 at 3:45 P.M., titled, "PRN Medications" and dated 7/9/2022, did not include guidelines for medications administered by a QMA and a policy that included such information was not provided.

Provider's Plan of Correction:

Grace Village requests consideration for a desk review for all citations.
="" span="">
="" span="">
="" b="">
1. Immediate action(s) taken for the resident(s) found to have been affected include:
Ensured that resident 4s physician was aware of the PRNs given and that they follow orders.

2. Identification of other residents having the potential to be affected was accomplished by:
The facility has determined that all residents have the potential to be affected.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
All QMAs and nurses were in-serviced regarding the facility policy for medication administration and the requirements of a QMA.

Policy updated to reflect that a QMA will have nurse approval prior to administration of a PRN.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
The Director of nursing, or designee, will complete random weekly audits of 6 residents for 12 consecutive weeks of PRNs

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			administered by QMAs then monthly for 12 weeks. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
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, interview and record review, the facility failed to ensure food items in the freezer were sealed securely after opening in 1 of 1 kitchens. (Main Kitchen) Findings include: During an observation with the dietary manager in the main kitchen, on 3/23/2023 at 10:25 A.M., the following were observed: There was a buildup of ice along the left side of the air condenser. Opened bags of cod, breaded shrimp, and diced turkey not sealed tightly. An opened box of corn with noted freezer burn, not sealed tightly. The floors were dirty with debris under the racks. During an interview, on 3/23/2023 at 10:29 A.M., the Dietary Manager indicated the ice should be gone, the bags should have been sealed tightly, the floor should be cleaned On 3/29/2023 at 1:10 P.M., the Director of Nursing	R 0273	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Grace Village requests consideration for a desk review for all citations. *Corrective Action for Affected: (List all resident codes as identified in IL 2567 report and action performed)* 1. During an observation with the dietary manager in the main	05/02/2023

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	provided the policy titled," Food and Supply Storage", dated 1/2023. The policy indicated "... All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination too maintain the safety and wholesomeness of the food for human consumption...Cover, label and date unused portions and open packages... Frozen Storage. Store bulk materials in NSF approved containers that have tight fitting lids. Label both the bin and the lid. Use food grade plastic bags for food storage... Wrap food tightly to prevent cross contamination...."		kitchen, on 3/23/23 at 10:25 am the following was observed:There was a buildup of ice along left side of the air condenser. Opened bags of cod, breaded shrimp and diced turkey were not sealed tightly. An open box of corn with noted freezer burn was not sealed tightly. The floors were dirty with debris under the racks. Corrective Action:· Build of ice was immediately removed.· Open packages were sealed up bags and put into containers with a tight-fitting lid.· Corn was disposed of· Debris under racks were cleaned. **Other Residents Will Continue to Be Identified:** Upon hire, dining staff receive education and training with the use of an orientation checklist on dating, labeling and storage of food. Training includes 24/5 on Food Storage Practices Department managers participate in compliance rounds in freezer to audit, which includes dating labeling, sealing up open product and sanitation. Any negative observation addressed at the time of observation audit tool will be corrected and results reviewed for trends. **System Revision:** Reeducation and reminder to dining staff to Food Storage	

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			Practices. Implement audit tool for Dining manager or designee to complete random observations on *Freezer Storage/Sanitation*. Forward audits to the facility Administrator. **How Facility Will Monitor System:** Dining Manager to review audits and address negative observations one to one with identified staff. Report findings to the QAPI Committee for review and resolution.	