	PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES						ORM APPROVED MB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219		UILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/25/2017	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
SIGNAT	URE HEALTHCAR	E OF SOUTH BEND			N IRONWOOD RD I BEND, IN 46635		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETIO DATE
= 0000		,					
Bldg. 00	This visit was for the Investigation of Complaints IN00229396 and IN00237622.		F 0	000			
	-	0229396 - Substantiated. related to allegations are					
	Federal/State de	0237622- Substantiated. eficiencies are cited at 282, F 309 and F323.					
	Survey dates: A 2017.	august 23, 24, and 25,					
	Facility number Provider number AIM number: 1	er: 155219					
	Census Bed Tyj SNF/NF: 58 Total: 58	pe:					
	Census Payor T Medicare: 6 Medicaid: 47 Other: 5 Total: 58	`ype:					
		vies reflect State Findings ance with 410 IAC					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

PRINTED:

09/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155219	B. WING	00	08/25/2017		
NAME OF I	NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP C	ODE		
SIGNAT	JRE HEALTHCAR	E OF SOUTH BEND		N IRONWOOD RD I BEND, IN 46635			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE	
	16.2-3.1						
	Quality Review September 1, 20	was completed on 017.					
⁻ 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHA (INJURY/DECLII (g)(14) Notification	NE/ROOM, ETC)					
	resident; consult physician; and no	immediately inform the with the resident's otify, consistent with his or resident representative(s)					
		nvolving the resident which nd has the potential for an intervention;					
	physical, mental, is, a deterioration psychosocial sta	change in the resident's or psychosocial status (that n in health, mental, or tus in either life-threatening ical complications);					
	(that is, a need to form of treatment	er treatment significantly o discontinue an existing t due to adverse or to commence a new form					
		transfer or discharge the facility as specified in					
		notification under)(i) of this section, the					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155219	A. BUILDING B. WING	00	COMPLETED 08/25/2017	
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD		
SIGNAT	URE HEALTHCAF	RE OF SOUTH BEND		H BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETIC	
TAG		OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	DATE	
	information spec	ure that all pertinent ified in §483.15(c)(2) is ovided upon request to the				
		nust also promptly notify the resident representative, if is-				
		room or roommate pecified in §483.10(e)(6); or				
	Federal or State	resident rights under law or regulations as graph (e)(10) of this section.				
	Based on recor	d review and interview,	F 0157	F 157 – D: NOTIFICATION OF	09/20/20	
	the facility faile	ed to ensure a physician		CHANGES		
	was notified tir	nely for a diabetic resident				
	who developed	a wound to his left 5th				
	toe for 1 of 3 re	esidents reviewed for		It is the intent of the facility to		
	wounds. (Resi	dent L)		ensure that all Physicians, residents and appropriate family members and		
	Finding include	es:		updated with complete and accura information in a timely manner.	te	
	The clinical rec	cord for Resident L was		1. What corrective action(s)		
	reviewed on 8/	24/17 at 10:00 A.M		will be accomplished for those		
	Resident L was	admitted to the facility on		residents found to have been		
		agnoses including, but not		affected by the deficient practice:		
		stage renal disease,		No provident idea (19		
		us, cva (cerebrovascular		No resident identifier given due to		
		left side weakness and		anonymous complaint		
	· · · · ·	(methicillan resistant				
	-	aureus) bacteremia from				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS FOD MEDICADE & MEDICAID SEDVICES

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155219	B. WING		08/25/2017	
AME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	-	
			52654			
SIGNAT	URE HEALTHCAR	E OF SOUTH BEND	SOUT	H BEND, IN 46635		
K4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
REFIX		NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		PRIATE	
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE	
	-	al dialysis catheter, and		2. How other residents have	U	
	history of mrsa-	-urine.		the potential to be affected by the	ne	
				same deficient practice will be identified and what corrective a	rtion	
	A nursing prog	ress note, dated 7/19/17 at		will be taken:		
	11:00 A.M., inc	licated " Late entry		win be taken.		
	7/18/17 Res [re	sident] reported to this		Event reports have been reviewe	ed	
	-	be was noted with scant		for the past 30 days to ensure th	at	
		hower, after inspecting		Physician has been notified of an	ιy	
		se removed res left shoe		skin issues and orders obtained	for	
		ben area to the surface of	timely treatment.			
	-	with scant bleeding and				
		•		3. What measures will be	out	
		ing 5 x [by] 3 cm		into place or what systematic changes will be made to ensure	that	
		rea cleaned and bacitracin		the deficient practice will not	liidl	
		l with a dry drsg.		reoccur:		
		asked what happened to				
	toe, res stated th	hat he noted some loose		Systematic changes will include:		
	skin and peeled	it resulting in open area				
	and bleeding to	left 5th toe, res c/o		Licensed nurses have been		
	[complained of	pain to area sensitivity to		re-educated on Facility Policy an		
	touch re and wi	th prn [as needed] tylenol		Procedure as it relates to Physici		
		f met. res told to keep		Notification/Change of Condition	1	
		ear sock/non skid socks to		4. How the corrective action	an(s)	
		while up in wheelchair"		will be monitored to ensure the	51(3)	
				deficient practice will not reoccu	ır:	
	A event nursing	g assessment, dated				
	-	P.M., indicated		Event reports will be reviewed		
		and Orders: Doctor:		Monday through Friday as part of	of	
				daily clinical meeting to ensure		
		cian] 7/19/17 at 7:00		Physician notification and treatn orders if needed. Event reportin		
		treatment information:		a standing agenda item at month		
	AREA CLEANSED AND			QAPI meeting and reports will be		
		[a ointment applied to the		tracked and trended for complia		
	-	nt infection] AND DRY		with Physician notification and		
	DRSG APPLIE	۵D"		treatment orders.		
			1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3LNI11

Facility ID: 000124

If continuation sheet

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	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			CON	(X3) DATE SURVEY COMPLETED 08/25/2017	
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH BEND			STREET A 52654 I SOUTH	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
	A.M., the DON from a sister fac physician should wound is discov order should be A " Skin Assess policy that was current by the fa the Administrate A.M The polic Physician and fa made with all ne in resident skin in the medical re- identifying the re-	iew, on 8/24/17 at 10:40 (Director of Nursing) ility indicated the d be notified when a ered and a treatment obtained at that time. sments and Evaluations" undated but deemed cility, was provided by or on 8/25/17 at 10:00 ey, indicated "11. unily notification must be ewly identified alterations integrity and documented ecord by the nurse ew skin alteration" is related to Complaint						
⁻ 0279 SS=D Bldg. 00	PLANS 483.20 (d) Use. A facility assessments com	b)(1) REHENSIVE CARE must maintain all resident upleted within the previous resident's active record						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	CO1	(X3) DATE SURVEY COMPLETED 08/25/2017	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP	CODE		
SIGNAT	URE HEALTHCAR	E OF SOUTH BEND		N IRONWOOD RD H BEND, IN 46635			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
		Its of the assessments to and revise the resident's are plan.					
	483.21 (b) Comprehensi	ve Care Plans					
	a comprehensive for each resident resident rights se §483.10(c)(3), th objectives and tin resident's medica psychosocial nee comprehensive a	ust develop and implement e person-centered care plan , consistent with the et forth at §483.10(c)(2) and at includes measurable meframes to meet a al, nursing, and mental and eds that are identified in the assessment. The care plan must describe the					
	attain or maintair practicable physi psychosocial we	hat are to be furnished to n the resident's highest cal, mental, and I-being as required under 5 or §483.40; and					
	required under § but are not provid exercise of rights	that would otherwise be 483.24, §483.25 or §483.40 ded due to the resident's a under §483.10, including treatment under					
	rehabilitative ser provide as a resu recommendation the findings of th	ed services or specialized vices the nursing facility will ult of PASARR s. If a facility disagrees with e PASARR, it must indicate e resident's medical record.					
	(iv)In consultation resident's repres	n with the resident and the entative (s)-					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155219	A. BUILDING B. WING	00	COMPLETED 08/25/2017	
				ADDRESS, CITY, STATE, ZIP CODE	00/23/2011	
NAME OF	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH BEND			N IRONWOOD RD		
SIGNAT				H BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION	COMPLET	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	(A) The resident' desired outcome	s goals for admission and s.				
	for future dischard document wheth return to the com any referrals to k	s preference and potential ge. Facilities must er the resident's desire to munity was assessed and ocal contact agencies ropriate entities, for this				
	care plan, as app with the requiren (c) of this section	d review and interview,	F 0279	F 279 – D: COMPREHENSIVE CARE PLANS	09/20/20	
	comprehensive timely for a res wound to his le	care plan was developed ident who had developed a ft 5th toe for 1 of 3 ved for wounds. (Resident		It is the intent of the facility to ensure that all residents have a completed comprehensive care plan that reflects their current status	1	
	reviewed on 8/2 Resident L was 5/27/15 with di limited to, end	es: ord for Resident L was 24/17 at 10:00 A.M. admitted to the facility on agnoses including, but not stage renal disease, us, cva (cerebrovascular		 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No resident identifier given due to anonymous complaint 		
	history of mrsa staphylococcus	eft side weakness and (methicillan resistant aureus) bacteriemia from al dialysis catheter, and -urine.		2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING CEREET ADDRESS. CUTV. STATE ZID CODE		(X3) DATE SURVEY COMPLETED 08/25/2017
NAME OF PROVIDER OR SUPPLIER			52654	ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD 1 BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRC DEFICIENCY)	BE COMPLETIO
	A nursing progra 11:00 A.M., ind 7/18/17 Res [rea nurse that left to bleeding after s further this nurse and noted an op res left 5th toe v skin off measur [centimeters]. a applied covered [dressing] where toe, res stated th skin and peeled and bleeding to [complained of touch re and wi relief met. res to wear sock/non se even while up in A event nursing 7/18/17 at 4:30 "Notification [name of physic A.MFirst aid/ AREA CLEAN BACITRACIN wound to preve DRSG. APPLIF	ess note, dated 7/19/17 at licated " Late entry sident] reported to this be was noted with scant nower, after inspecting e removed res left shoe en area to the surface of with scant bleeding and ing 5 x [by] 3 cm rea cleaned and bacitracin with a dry drsg. asked what happened to hat he noted some loose it resulting in open area left 5th toe, res c/o pain to area sensitivity to th prn tylenol with some old to keep shoe off and skid socks to left foot, n wheelchair"		All residents have had their comprehensive care plans revie and updated to reflect their cur status to include wounds 3. What measures will be into place or what systematic changes will be made to ensure the deficient practice will not reoccur: Systematic changes will include Licensed nurses have been re-educated on Facility Policy an Procedure as it relates to Comprehensive Care Plans, and updating Care Plans when resid has a change of condition 4. How the corrective act will be monitored to ensure the deficient practice will not reocc A PI tool has been developed th will monitor compliance with updating residents comprehens care plans with any changes in resident status. DON/Designee complete PI tool weekly for one month then monthly for three months with results being forwarded to QAPI committee f any further follow up and/or resolution.	ewed rrent put put that i tha

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	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			CO	(X3) DATE SURVEY COMPLETED 08/25/2017	
	PROVIDER OR SUPPLIE	E OF SOUTH BEND		52654 N	ADDRESS, CITY, STATE, ZIP CO N IRONWOOD RD I BEND, IN 46635	CODE		
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
	5TH TOE WOU SOAPY WATE BETADINE, A THIN COAT C SITECOVER KERLIX DAIL A physician's p 7/31/17 at 9:51 He has got a tra are going to put gentleman, and his insulin by c need to check h at bedtimeTh We will put a P watch that toe. will talk to Ren anticoagulation me. I will orde maintain this go a 12 lead electr he is in sinus rh anticoagulation A comprehensi "7/31/15 Prot for developing extensive/total mobilityGoal skin, free of rec	rogress note, dated A.M., indicated " Plan: ash to the fifth digit. We t a Prevelon boot on this we are going to address hecking his sugars. We is sugars before meals and e trash foot is concerning. revelon boot on and It may self -amputate. I al about his need for . It looks like trash foot to r certain studies to entleman to see. I will get ocardiogram to make sure bythm and discuss " ve care plan, indicated blem: Resident is at risk skin breakdown. Needs assist with bed : Resident will have intact lness, blisters, or ver a bony prominence						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155219 B. WING 08/25/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD SIGNATURE HEALTHCARE OF SOUTH BEND SOUTH BEND. IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG 3/22/17...Approach: Report changes in skin status to physician...Provide diet as ordered and monitor nutritional status and dietary needs, consult dietician prn [as needed]...Provide pressure relieving or reduction mattress...Avoid prolonged skin to skin contact...Minimize pressure over bony prominence's...Complete Weekly Skin Check...Complete Braden Scale Risk Assessment quarterly and prn... Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during daily care...Skin protective ointment for excoriation areas as ordered " During an interview, on 8/25/17 at 2:00 P.M., the Corporate Nurse indicated it did not appear as though a care plan had been developed for the wound on Resident L's left 5th toe. A "Skin Assessments and Evaluations" policy that was undated but deemed current by the facility, provided by the Administrator on 8/25/17 at 10:00 A.M. and reviewed at 2:10 P.M., indicated "...15. At the time a new alteration in resident skin integrity is identified, the resident's Care Plan should be revised and/or updated...." This Federal tag is related to Complaint FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3LNI11 Facility ID: 000124 If continuation sheet Page 10 of 22

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/25/2017	
	PROVIDER OR SUPPLIE	R E OF SOUTH BEND	ę	street address 52654 N IRON SOUTH BEND			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PR	ID (EAC CROSS ΓAG	PROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIA DEFICIENCY)	те	(X5) COMPLETIO DATE
= 0282 SS=D Bidg. 00	CARE PLAN (b)(3) Comprehe The services pro- facility, as outline care plan, must- (ii) Be provided b accordance with of care. Based on record the facility faile plan of care for treatment and d an amputation f	vided or arranged by the d by the comprehensive y qualified persons in each resident's written plan d review and interview, d to follow the physicians a resident who required a aily dressing change after for 1 of 3 residents eatments. (Resident K)	F 0282	QUALIF It is the ensure	• D: SERVICES PROVIDED BY FIED PERSONS/CARE PLANS • intent of the facility to that services are provided b ed persons and care plans are ed What corrective action(s)	y	09/20/201
	reviewed on 8/2 Resident K was	ord for Resident K was 24/17 at 11:00 A.M admitted on 9/1/15 with ding, but not limited to		will be resider affecte	accomplished for those its found to have been d by the deficient practice: dent identifier given due to		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/25/2017	
	NAME OF PROVIDER OR SUPPLIER		52654	ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD H BEND, IN 46635		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTI		
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
		tension, peripheral e, critical lower limb		anonymous complaint		
	ischemia, non c	ompliance with meds,				
	gangrene foot, a	•		 How other residents has the potential to be affected by same deficient practice will be 	-	
	indicated, "CI	LEAN WITH NS [normal BETADINE [a cream		identified and what corrective a will be taken:	action	
	used to keep a w WET TO DRY GREAT TOE A DAILY/PRN IF	vound clean and dry] DRESSING TO LEFT MPUTATION SITE DRESSING IS & COMES OFF"		Treatment sheets have been reviewed and Physician notified needed for any unsigned wound treatments		
	A Medication A (MAR), dated 7 documentation been completed	Administration Record /1/17 to 7/31/17 lacked to show the treatment had on the following dates: 7/14/17, 7/17/17,		 What measures will be into place or what systematic changes will be made to ensure the deficient practice will not reoccur: Systematic changes will include 	that	
		7, 7/25/17, and 7/27/17.		Licensed nurses have been		
	A.M., the DON indicated that tr	view, on 8/24/17 at 10:40 I (Director of Nursing) eatments should be e physician ordered them.		 re-educated on Facility Policy and Procedure as it relates to comp and signing off on Physician ord treatments. 4. How the corrective act 	leting lered ion(s)	
		eatment policy was ne was not provided.		will be monitored to ensure the deficient practice will not reocc	ur:	
	This Federal tag IN00327622.	g is related to Complaint		Omission reports for treatment be printed out Monday through Friday and brought to and revie at daily clinical meeting ongoing	n wed g. If	
	3.1-35(g)(2)			an omission is noted DON/Desig will follow up immediately to en treatment is completed.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3LNI11

Facility ID: 000124

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	A.	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 08/25/2017	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CO N IRONWOOD RD	DE		
SIGNAT	URE HEALTHCAR	E OF SOUTH BEND			BEND, IN 46635			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
⁼ 0309 SS=D Bldg. 00	 HIGHEST WELL 483.24 Quality of Quality of life is a applies to all card facility residents. receive and the f necessary care a maintain the high mental, and psyc consistent with th comprehensive a care. 483.25 Quality of Quality of care is that applies to al provided to facility comprehensive a the facility must of receive treatment with professional comprehensive p and the residents limited to the follow (k) Pain Manage The facility must management is p require such serv professional start comprehensive p 	2/SERVICES FOR BEING f life a fundamental principle that e and services provided to Each resident must facility must provide the and services to attain or nest practicable physical, chosocial well-being, he resident's assessment and plan of f care a fundamental principle I treatment and care ty residents. Based on the assessment of a resident, ensure that residents it and care in accordance I standards of practice, the berson-centered care plan, s' choices, including but not owing: ment. ensure that pain provided to residents who vices, consistent with hadards of practice, the berson-centered care plan, s' goals and preferences.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219			r í	LTIPLE C LDING IG	(X3) DATE SURVEY COMPLETED 08/25/2017		
NAME OF PROVIDER OR SUPPLIER				STREET 52654			
SIGNAI	URE HEALTHCAR	E OF SOUTH BEND		SOUT	H BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	services, consist standards of prac- person-centered residents' goals a Based on record the facility faile their policy for and tracking of residents review	quire dialysis receive such ent with professional ctice, the comprehensive care plan, and the and preferences. d review and interview, ed to ensure they followed the weekly assessment wounds for 2 of 3 ved for non-pressure dent K and Resident L)	F 030)9	F 309– D: CARE AND SERVICES It is the intent of the facility to provide care/services to residents to maintain their highest well being	,	09/20/2017
	reviewed on 8/2 Resident L was 5/27/15 with di- limited to, end s diabetes mellitu with diabetic per with left side w mrsa (methicilla aureus) bacterie femoral dialysis mrsa-urine. A nursing progra 11:00 A.M., ind 7/18/17 Res [re nurse tht left too bleeding after s further this nurs	record for Resident L was 24/17 at 10:00 A.M admitted to the facility on agnoses including, but not stage renal disease, as, type 2diabetes mellitus eripheral angiopathy, cva eakness and history of an resistant staphyloccus emia from previous as cath, and history of ress note, dated 7/19/17 at licated " Late entry sident] reported to this e was noted with scant hower, after inspecting se removed res left shoe pen area to the surface of			 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No resident identifiers given due to anonymous complaint How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: A house wide skin sweep has been completed to identify any new potential skin issues. Pressure and non-pressure sheets have been brought current for all residents with identified areas. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not 	1	

Event ID:

3LNI11

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 155219 B. WING 08/25/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD SIGNATURE HEALTHCARE OF SOUTH BEND SOUTH BEND. IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG skin off measuring 5 x [by] 3cm reoccur: [centimeters]. area cleaned and bacitracin Systematic changes will include: applied covered with a dry drsg. [dressing] when asked what happened to Licensed Nurses have been toe, res stated that he noted some loose re-educated on Facility Policy and skin and peeled it resulting in open area Procedure related to Pressure Ulcer Prevention, treatment, weekly skin and bleeding to left 5th toe, res c/o evaluations and how to utilize [complained of] pain to area sensitivity to Pressure and non-pressure ulcer touch re and with prn tylenol with some sheets relief met. res told to keep shoe off and wear sock/non skid socks to left foot, 4. How the corrective action(s) even while up in wheelchair " will be monitored to ensure the deficient practice will not reoccur: A physician's progress note, dated Weekly skin evaluation books have 7/31/17 at 9:51 A.M., indicated "... Plan: been set up for each unit. Pressure He has got a trash to the fifth digit. We and Non-pressure books have been are going to put a Prevelon boot on this set up for each unit. DON/Designee will bring all books to daily clinical gentleman, and we are going to address meeting Monday through Friday to his insulin by checking his sugars. We ensure weekly skin evaluations have need to check his sugars before meals and been completed and Pressure at bedtime...The trash foot is concerning. Non-Pressure sheets are current. We will put a Prevelon boot on and Pressure Ulcer review is a standing watch that toe. It may self -amputate. I agenda item at monthly QAPI meeting and will continue to be will talk to Renal about his need for reviewed monthly anticoagulation. It looks like trash foot ot me. I will order certain studies to maintain this gentleman to see. I will get a 12 lead electrocardiogram to make sure he is in sinus rhythm and discuss anticoagulation " A weekly wound assessment, dated 8/3/17, indicated "... Wound Location: Left 5th toe...Wound Measurements: 4x2 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3LNI11 Facility ID: 000124

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PRINTED: 09/18/2017 FORM APPROVED

OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			СОМІ 08/2	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 08/25/2017	
NAME OF PROVIDER OR SUPPLIER			STREET A 52654 I SOUTH	IP CODE				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETIC DATE	
	cm [centimeter] orNotes: New verbally decline orders" During an inter A.M., the DON indicated she co wound assessm but that there w wound assessm assessment of the clinical record a had been follow	Blister due to pressure orders in place resident ed to comply with dr. view, on 8/24/17 at 10:40 (Director of Nursing) ould not find any weekly ents/tracking until 8/3/17 as documentation of ent and physician ne wound in the residents and that physicians orders yed as resident would had a history of non						
	reviewed on 8/2 Resident K was diagnoses inclu dementia, hype vascular disease ischemia, non c gangrene foot, a A nursing progr "Resident c/o Area is dark in appears to be no	record for Resident K was 24/17 at 11:00 A.M admitted on 9/1/15 with ding, but not limited to rtension, peripheral e, critical lower limb ompliance meds, and amputation. ress note indicated pain in left great toe. color, non blanchable and ecrotic" A weekly ent, dated 8/1/17,						
	indicated "Wo ToeWound M	bund Location: Left Great leasurement: 4 x lepth: 0 cm. Tissue Types:						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155219 B. WING 08/25/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD SIGNATURE HEALTHCARE OF SOUTH BEND SOUTH BEND. IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG Eschar/Necrtic Tissue...Notes: Toe has been amputated gangrene continues, podiatrist attending to residents needs...." During an interview, on 8/24/17 at 10:40 A.M., the DON indicated she could not find any weekly wound assessments/tracking until 8/1/17. She indicated there was consistent documentation in the nurses notes and clinical record of assessment, physician care and labs. She indicated the clinical record documented residents non compliance with treatments at times. During an interview, on 8/25/17 at 2:57 P.M., the DON indicated all residents who have wounds should have weekly assessment of their skin and documentation of that assessment as per the policy and physicians orders. A "Skin Assessments and Evaluations" policy that was undated but deemed current by the facility, was provided by the Administrator on 8/25/17 at 10:00 A.M.. The policy, indicated "...18. All resident alterations in skin integrity will be tracked weekly in WoundSence. If WoundSence is not implemented or is not operational, the facility will use appropriate tracking forms for Pressure/ Non-Pressure, Surgical, Vascular, and other " FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3LNI11 Facility ID: 000124 If continuation sheet Page 17 of 22

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	R MEDICARE & MEDI					OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/25/2017		
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CO N IRONWOOD RD	ODE	
SIGNAT	URE HEALTHCAR	E OF SOUTH BEND		BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
	This Federal tag IN00237622.	g is related to Complaint				
	3.1-37(a)					
- 0323 SS=D	483.25(d)(1)(2)(r FREE OF ACCIE	DENT				
Bldg. 00	(d) Accidents. The facility must	ERVISION/DEVICES ensure that -				
		environment remains as nt hazards as is possible;				
		t receives adequate assistance devices to s.				
	use appropriate a installing a side o rail is used, the fa installation, use,	The facility must attempt to alternatives prior to or bed rail. If a bed or side acility must ensure correct and maintenance of bed ut not limited to the following				
	(1) Assess the re entrapment from installation.					
	I		1	1		1

(2) Review the risks and benefits of bed rails

FORM CMS-2567(02-99) Previous Versions Obsolete

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 08/25/2017	
	PROVIDER OR SUPPLIEF	E OF SOUTH BEND		52654	ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD H BEND, IN 46635	
X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAU	with the resident of	or resident representative ed consent prior to		IAU		DAIL
	appropriate for the weight.	e bed's dimensions are e resident's size and review and interview,	F 03	323	F 323– D: CARE AND	09/20/201
	the facility failed fall risk assessm	to complete quarterly ents for 3 of 3 residents s. (Residents E, F and G)			SERVICESACCIDENTS/HAZARDS	
	Findings include				It is the intent of the facility to provide care/services to residents t prevent accidents and provide	0
	indicated Reside 10/12/2013. Her not limited to M lumbago with sc hypertension, hy	ord review was 24/17 at 10:26 A.M., and nt E was admitted on diagnosis included, but ultiple Sclerosis, iatica to left side, pothyroidism, peripheral and osteoporosis.			 appropriate supervision 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No resident identifiers given due to anonymous complaint)
	dated 5/18/17, in BIMS (Brief Int	um Data Set)assessment, adicated Resident E had a erview for Mental Status) hitive impairment and ills.			2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:	
	A current care plan problem, dated 8/31/15, indicated the resident was at risk for fall related injury. Interventions for this problem included "Report falls to physician and responsible party, observe for side effects of any drugs that				A 100% audit has been completed and all residents fall evaluations have been brought current and care plans updated to reflect residents current status. 3. What measures will be put into place or what systematic	

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

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155219	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 08/25/2017
	PROVIDER OR SUPPLIE	E OF SOUTH BEND	52654	ADDRESS, CITY, STATE, ZIP COD N IRONWOOD RD 1 BEND, IN 46635	E
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL TAG DEFICIENCY)		LD BE COMPLETIC
	hypotension, pr	listurbances, orthostatic ovide low platform bed, hts within reach, tab alarm el chair"		changes will be made to ensur the deficient practice will not reoccur: Systematic changes will includ	
	fall on 8/21/17.	dicated Resident E had a No fall assessments were ident's chart from January 2017.		Licensed Nurses have been re-educated on Facility Policy a Procedure related to timely completion of quarterly nursin evaluations	
	completed on 8 indicated Resid 1/4/06. Her diag not limited to: 4 hearing loss, de	cord review was /24/17 at 12:15 P.M., and ent F was admitted on gnosis included but were Alzheimer's disease, ementia without behavior d diabetes mellitus.		 4. How the corrective activity will be monitored to ensure the deficient practice will not record. A PI tool has been developed to will monitor compliance with Quarterly Nursing Evaluations. DON/Designee will complete F weekly in accordance with MD 	ne :cur: that PI tool
	dated 6/15/17, i BIMS of 2, sev and was at risk			Quarterly Nursing evaluation schedule weekly for one mont then monthly for three month results being forwarded to QA committee for further follow up/recommendations	s with
	4/4/16, indicate for fall related i unsteady gait, h wears pants too for this problem	plan problem, dated ed the resident was at risk injury related to" history of tremors, often o long". Interventions in included " Use fall dentify risk factors on quarterly"			
		dicated Resident F had a No fall assessments were			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	COME	(X3) DATE SURVEY COMPLETED 08/25/2017	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CO	DDE		
SIGNAT	URE HEALTHCAR	E OF SOUTH BEND		N IRONWOOD RD H BEND, IN 46635			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID			(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	COMPLETIO DATE	
	found in the chi 2017.	art from January to August					
	completed on 8 indicated Resid 12/8/16. His dia not limited to: c obstructive pub	cord review was /24/17 at 2:20 P.M., and lent G was admitted on agnosis included, but were encephalopathy, chronic monary disease, vascular ele weakness and viral					
	dated 8/2/17, in	num Data Set) assessment, adicated Resident G had a ere cognitive impairment for falls.					
	indicated Resid related injury re mobility,transfe right sided wea this problem in	er with two and hoyer and kness. Interventions for cluded " Use fall risk fy risk factors on					
	fall on 8/16/17. was completed the resident had days. There we	dicated Resident G had a A fall risk assessment on 8/16/17 and indicated I no falls in the last 90 re no further fall risk n the chart from January					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 155219 B. WING 08/25/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD SIGNATURE HEALTHCARE OF SOUTH BEND SOUTH BEND, IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG On 8/24/17 at 11:45 A.M., the DON (Director of Nursing) provided the policy titled "Falls", dated 6/1/15, and indicated this was the current policy used by the facility. The policy indicated "...1. All residents will have a comprehensive fall risk assessment on admission, quarterly, and with significant change of condition....". During an interview, on 8/25/17 at 10:30 A.M., the DON indicated that Resident E, F and G did not have any fall risk assessments completed from January 2017 to August 2017. This Federal tag is related to Complaint IN00327622. 3.1-45(a)(2)

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