STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155684	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southfield Village	6450 Miami Cir South Bend, IN 46614

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49994 Based on observation, record review and interview, the facility failed to notify the physician of elevated blood glucose levels for 2 of 2 residents reviewed for blood glucose levels (Residents 7 and 3). Findings include: 1. On 10/28/2024 at 10:02 A.M., a record review was completed for Resident 7. Diagnoses included, but were not limited to: type 2 diabetes A Physician's order, dated 6/11/2024, indicated the physician was to be notified if Resident 7's blood glucose levels were below 70 or above 200. A review of Resident 7's blood glucose results for the months of August, September and October 2024 indicated the record lacked documentation the physician was notified of elevated blood glucose levels above 200 mg/dl for the following dates: - On 8/4/2024, Resident 7's blood glucose level was 263 mg/dL. - On 8/10/2024 the resident's blood glucose level was 276 mg/dL. - On 8/17/2024 the resident's blood glucose level was 319 mg/dl. - On 8/18/2024 the resident's blood glucose level was 222 mg/dL. - On 8/19/2024 the resident's blood glucose level was 236 mg/dL. - On 8/20/2024 the resident's blood glucose level was 210 mg/dL. - On 8/25/2024 the resident's blood glucose level was 301 mg/dL. - On 9/14/2024 the resident's blood glucose level was 266 mg/dL. - On 9/28/2024 the resident's blood glucose level was 221 mg/dL. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 10/25/2024 the resident's blood glucose level was 258 mg/dL. During an interview, on 10/28/2024 at 11:17 A.M., the Director of Nursing (DON) indicated a nursing note should have been associated with Resident 7's elevated blood glucose levels indicating the physician had been notified and would have been found in the residents electronic medication administration record (EMAR). During an interview, on 10/28/2024 at 2:15 P.M., the DON indicated Resident 7's EMAR lacked documentation the physician was notified of the residents elevated blood glucose levels and she indicated the physician should have been notified. 44111 2. A record review was completed on 10/28/2024 at 10:08 A.M., for Resident 3. Diagnoses included, but were not limited to: type 2 diabetes mellitus with chronic kidney disease. A Physician's Order, dated 4/28/2023, indicated accuchecks were to be done weekly twice a day. The Physician the residents blood glucose level to be called if it was less than 70 or greater than 200. The Medication Administration Record (MAR) dated September 2024, indicated the following P.M. blood sugars: on 9/6/2024 was 321, and on 9/27/2024 was 221. The MAR dated October 2024, indicated the following P.M. blood sugars: on 10/4/2024 was 254 and on 10/18/2024 was 207. During an interview, on 10/28/2024 at 2:18 P.M., LPN 6 indicated when a physician was notified of an elevated blood sugar it would have been documented in the nursing progress notes. During an interview, on 10/28/2024 at 2:23 P.M., the DON indicated when a Physician was notified of an elevated blood sugar, the documentation could be found in a note with the order in the MAR, or in the nursing progress notes. DON was unable to locate in the electronic medical record any documentation of Resident 3's blood glucose levels of the Physician being notified. On 10/28/2024 at 2:44 P.M., the DON provided a policy titled, Blood Glucose Monitoring, revised 4/3/2023, and indicated the policy was the one currently used by the facility. The policy indicated .Policy: It is the policy of the facility to perform blood glucose monitoring to diabetic residents as per physician's orders. 20. Report critical test results to physician timely . 3.1-5(a)(2)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 47419 Based on interview and record review, the facility failed to provide a copy of the Bed Hold Policy to a resident when admitted to the hospital for 1 of 3 residents reviewed for hospitalization . Finding includes: A record review was completed on 10/28/2024 at 10:00 A.M. for Resident 4. Diagnoses included, but were not limited to, Alzheimer's Disease, chronic obstructive pulmonary disease and atrial fibrillation. A Nursing Progress Note, dated 9/7/2024, indicated Resident 4 had complained of shortness of breath and was confused at times. The resident's daughter indicated she thought the resident had pneumonia. The Medical Director was notified and gave an order for the resident be sent to the emergency room for an evaluation. An emergency room nurse called the facility and reported Resident 4 had pneumonia and was going to be admitted to the hospital. The record indicated the Notice of Transfer/Discharge was given but lacked documentation the Bed Hold Policy had been given to Resident 4. During an interview on 10/28/2024 at 11:04 A.M., the Employee 6 indicated a copy of the Bed Hold Policy, or documentation that it was given to the resident, was not located in the chart. On 10/30/2024 at 9:00 A.M., the MDS (Minimum Data Set) Nurse provided a copy of the Bed Hold Policy that should have been given to a resident when they were transferred and admitted to the hospital but the facility did not provide a policy indicating situations when the document was to be provided to the resident. 3.1-12(a)(25)(26)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48145 Based on interview and record review, the facility failed to have Care Plan meetings, quarterly, with residents and/or resident representatives for 2 of 2 residents who were reviewed for Care Plan meetings. (Resident 6 & 7) Findings include: 1. During an interview on 10/24/2024 at 10:35 A.M., Resident 6 indicated she had not been invited to Care Plan meetings with the facility staff. Resident 6's record review was completed on 10/25/2024 at 2:56 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, hemiplegia of the right side, dysphagia, aphasia, vascular dementia and emphysema. A Quarterly Minimum Data Set (MDS) assessment, dated 9/24/2024, indicated Resident 6 had intact cognition. Resident 6's record lacked the documentation a Care Plan meeting had been conducted on a quarterly basis with Resident 6 and/or her representative from 11/29/2023 through 5/2/2024. During an interview on 10/29/2024 at 10:42 A.M., the Social Services Director (SSD) indicated Care Plan meetings were completed after a MDS assessment, or at minimum, quarterly. The SSD indicated Resident 6 should have had a Care Plan meeting after she received an MDS assessment on 1/31/2024. 2. During an interview on 10/24/204 at 10:45 A.M., Resident 7's representative indicated he could not remember being invited to a Care Planning meeting. Resident 7's record review was completed on 10/28/2024 at 10:02 A.M. Diagnoses included, but were not limited to: type 2 diabetes mellitus, sick sinus syndrome, cardiomegaly and adjustment disorder. A Quarterly MDS assessment, dated 9/24/2024, indicated Resident 7 had severe cognitive impairment. Resident 7's record lacked the documentation indicating she had a Care Plan meeting had been conducted between 11/27/2023 through 4/8/2024. During an interview on 10/29/2024 at 10:42 A.M., the Social Services Director (SSD) indicated Resident 7 should have had a Care Plan meeting after November 2023 and before April 2024. On 10/29/2024 at 10:00 A.M., the SSD provided a policy, dated 1/2024, titled, Care Plan Meetings, and identified it as the policy currently used by the facility. The policy indicated, .Care plan meetings must occur every three months, and whenever there is a major change in a resident's physical or mental health that might require a change in care 3.1-(d)(2)(B)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49994 Based on observation, interview and record review the facility failed to store and seal food in a sanitary manner related to sealing food appropriately in the walk-in cooler and failed to ensure serving utensils were clean in 1 of 1 kitchens. This had the potential to affect 53 of 53 residents who received their meals from the kitchen. Findings include: 1. During the initial kitchen tour with the Director of Food Services on 10/24/2024 at 9:43 A.M., the following was observed in the walk-in cooler: - a container of pickles was stored without a secure lid and was open to air. During an interview on 10/24/2024 at 9:45 A.M., the Director of Food Services indicated the lid of the pickles should have been secured. 2. During a follow-up kitchen tour with the Director of Food Services on 10/25/2024 at 9:45 A.M., the following was observed: - a metal scoop with dried food on it was stored in the clean utensils drawer. - a pair of metal tongs with dried food on it was stored in the clean utensils drawer. - the bottom of the clean utensils drawer had dried food and other debris. During an interview on 10/25/2024 at 9:52 A.M., the Director of Food Services indicated utensils should be clean before placing them in the drawers and the utensil drawer should have been cleaned. On 10/28/2024 at 11:27 A.M., the Director of Food Services provided the policy titled, Date Marking for Food Safety Policy, dated 4/17/2024 and indicated it was the policy currently used by the facility. The policy indicated, . 7. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49994 Based on observation, record review and interview, the facility failed to ensure infection control practices were followed by 1 of 1 staff observed cleaning an isolation room and 1 of 1 staff observed providing catheter care.(Housekeeper 3 and CNA 4). Findings include: 1. During an observation on 10/25/24 at 11:18 A.M., Housekeeper 3 was observed cleaning Resident 251's room. The resident was on contact precautions due to Clostridium difficile. Housekeeper 3 wore a pair of gloves, but did not have on a gown. The Assistant Director of Nursing (ADON) was overheard telling Housekeeper 3 that she needed to have a gown on when in a residents room because the resident was on contact precautions. Housekeeper 3 indicated she thought the sign on Resident 249's room, which read Enhanced Barrier Precautions, and the sign on Resident 251's room, which read Contact Precautions were both the same. During an observation and interview on 10/ 25/2024 at 11:29 A.M., Housekeeper 3 was observed cleaning another room after leaving Resident 251's room. Housekeeper 3 indicated she did not remember having any training on the differences between contact precautions and enhanced barrier precautions and stated she only remembered learning that it was important to knock prior to entering a residents room. She indicated she did not realize there was a difference between the sign on Resident 249's room and the sign on Resident 251's room. After reading the signs, she indicated she should have donned a gown prior to entering and cleaning Resident 251's room. During an interview on 10/25/2024 at 11:45 A.M., the ADON indicated Housekeeper 3 should have had a gown on prior to entering Resident 251's room. On 10/25/2024 at 1:38 P.M., a record review was completed for Resident 251. Diagnoses included, but were not limited to: entercolitis due to clostridium difficile. A Physician's Order, dated 10/22/2024 indicated Resident 251 may participate in activities outside the facility related to contact and droplet isolation. A review of Resident 251's Physicians Progress Notes indicated a positive Clostridium difficile result on 10/15/2024. 2. On 10/29/2024 at 9:35 A.M., a record review was completed for Resident 1. Diagnoses included, but were not limited to: neuromuscular dysfunction of bladder. A current Care Plan, initiated on 2/24/2020 indicated Resident 1 had an indwelling Foley catheter with the potential for infection related to neurogenic bladder and bladder spasms. Interventions included were to provided catheter care per protocol and Enhanced Barrier Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of catheter care on 10/29/2024 at 10:20 A.M., CNA 4 put on a pair of gloves and a gown and removed Resident 1's brief. CNA 4 did not change her gloves prior to beginning catheter care. She proceeded to wash the resident's lower abdomen and under the residents abdominal folds. She then washed the residents perineal area and catheter without changing gloves or getting a clean wash cloth. CNA 4 then dried Resident 1 with a towel and applied a clean brief on the resident. During an interview on 10/29/2024 at 10:46 A.M., CNA 4 indicated she did not think she did anything wrong during catheter care. Upon further discussion, CNA 4 agreed she should have changed her gloves and used a clean wash cloth before providing catheter care. On 10/25/2024 at 12:05 P.M., the ADON provided the policy titled, Isolation Precautions, dated 6/5/2022 and indicated it was the policy currently being used by the facility. The policy indicated, Policy: it is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents. This policy specifies the different types of precautions, including when and how isolation should be used for a resident. Contact precautions are measures that are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms which are spread by direct or indirect contact with the resident or the residents environment. Recommendations for personal protective equipment: Contact; Gowns whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. [NAME] gown upon entry into the room or cubicle On 10/25/2024 at 12:06 P.M., the ADON provided the policy titled, Routine Cleaning and Disinfection Policy, dated 3/30/2024 and indicated it was the policy currently being used by the facility. The policy indicated, .1. Staff will look for precautions signage prior to entering a resident's room. a. Use standard precautions, including appropriate personal protective equipment, for all rooms, unless transmission based precautions are identified. b. Adhere to transmission-based precautions as indicated on precaution signs On 10/31/2024 at 10:44 A.M., the ADON provided the policy titled, Clostridium difficile (C.diff), dated 1/23/2024 and indicated it was the policy currently being used by the facility. The policy indicated, .8. Environmental infection control: a. Housekeeping team member(s) shall adhere to standard and contact precautions On 10/29/2024 at 2:10 P.M., the DON provided the policy titled, Catheter Care Policy, dated 1/29/2024 and indicated it was the one currently being used by the facility. The policy indicated, .Female: 9. Gently separate the labia to expose the urinary meatus. 10. Wipe from front to back with a clean cloth moistened with water and perineal cleaner (soap). 11. Use a new part of the cloth or different cloth for each side. 12. With a new moistened cloth, start at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter 3.1-18(a)