

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/12/2024
NAME OF PROVIDER OR SUPPLIER  Briarcliff Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5024 Western Avenue South Bend, IN 46619	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>47419</p> <p>Based on interview and record review the facility failed to include the resident, or representative, in meetings to review the plan of care for 1 of 3 residents reviewed for care planning. (Resident 17)</p> <p>Finding includes:</p> <p>A record review for Resident 17 was completed on 8/9/2024 at 1:27 P.M. Diagnoses included, but were not limited to, stage 5 chronic kidney disease, unspecified osteoarthritis, and type 2 diabetes mellitus.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 6/5/2024, indicated Resident 17's cognition was intact and she participated in goal setting.</p> <p>During an interview on 8/6/2024 at 9:28 A.M., the resident indicated she had not attended a care plan meeting since her admission on 5/29/2024.</p> <p>A Social Service Progress Note, dated 5/30/2024, included a brief medical history and her goal of returning to the community after therapy was completed.</p> <p>The record lacked any notes indicating a care plan meeting had been planned or had taken place since Resident 17 was admitted .</p> <p>During an interview on 8/12/2024 at 10:00 A.M., the Social Services Director indicated she had met with the resident and should have documented the discussion but had not.</p> <p>On 8/12/2024 at 8:52 A.M. the Director of Nursing provided a current policy titled, Comprehensive Care Plans.</p> <p>The policy indicated, .4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: .v. Family members, surrogate or others desired by the resident</p> <p>3.1-35(c)(2)(C)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>48145</p> <p>Based on interview, observation and record review, the facility failed to implement fall prevention interventions related to signage and an adaptive call light system for a resident with repetitive falls for 1 of 20 residents reviewed for falls. (Resident 10)</p> <p>Finding includes:</p> <p>During an interview on 8/7/2024 at 1:41 P.M., Resident 10 indicated she had fallen the previous day and her leg was sore. The staff had told her to call for help when she needed to use the bathroom.</p> <p>A record review was completed for Resident 10 on 8/7/2024 at 1:40 P.M. Diagnoses included, but were not limited to: glaucoma, dementia, type 2 diabetes mellitus, and syncope.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 5/23/2024, indicated the resident had severe cognitive impairment and required extensive assistance for transfers.</p> <p>A quarterly Fall Risk Evaluation, dated 8/5/2024, indicated the resident was at high risk for falls.</p> <p>The clinical record indicated Resident 10 had fallen within the last year on the following dates:</p> <p>-8/14/2023</p> <p>-8/16/2023</p> <p>-9/6/2023</p> <p>-9/23/2023</p> <p>-10/28/2023</p> <p>-12/6/2023</p> <p>-5/15/2024</p> <p>-8/5/2024</p> <p>A Nursing Progress Note, dated 8/5/2024, indicated the resident had an unwitnessed fall when she attempted to self-transfer from the bed to her adjacent wheelchair. An X-ray was performed and an equivocal (positive or negative) fracture was noted. The recommendation was for follow-up care but the resident and the resident's family had elected not to seek further evaluation.</p> <p>A current Care Plan, dated 3/7/2018, indicated Resident 10 had a risk for falls with a goal for the resident to be free of minor injury from falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions to the Risk for Falls Care Plan included but were not limited to:</p> <ul style="list-style-type: none"> <li>-Place Call don't fall signs in bathroom and Resident's room.</li> <li>-Touch pad call light given with red tape with help put on it to encourage use when in need of assistance. Instruction and frequent reminders to be given.</li> </ul> <p>During an observation of Resident 10's room on 8/7/2024 at 1:45 P.M., no signs reading Call don't Fall could be located and the call light was not a touch pad with Help spelled out in red tape on it.</p> <p>During an interview on 8/7/2024 at 2:44 P.M., the Unit Manager indicated the Resident 10 did not have a touch pad call light and there were no signs that read Call don't Fall in her room or bathroom. The facility should have followed the Care Plan or should have removed any interventions that were no longer used.</p> <p>During an interview on 08/07/2024 at 3:06 P.M., the Regional Nurse indicated the policy on accidents was what the facility followed for creating and updating Care Plans related to falls.</p> <p>On 8/7/2024 at 2:20 P.M., the Regional Nurse provided a policy, dated 6/5/2023, titled Accidents and Supervision and identified it as the policy currently used by the facility. The policy indicated, It is the practice of this facility to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to accidents . 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: a. Communicating the interventions to all relevant staff . d. Documenting interventions (e.g., plans of action developed through the QAA Committee or care plans for the individual resident)</p> <p>3.1-45(2)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>49994</p> <p>Based on observation, interview and record review, the facility failed to administer medication as needed prior to a dressing change. This deficient practice resulted in severe pain during a treatment for 1 of 1 residents observed for wound care. (Resident 35)</p> <p>Finding includes:</p> <p>During an observation of wound care for Resident 35, on 8/08/2024 at 3:13 P.M. with the ADON and the Unit Manager, the ADON indicated the resident's treatment was to cleanse the resident's wound with wound wash, apply calcium alginate and medi- honey ointment, sprinkle Flagyl (an antibiotic) n the wound bed, and cover the wound with a dry dressing.</p> <p>First, CNA 2 wiped away some zinc barrier cream from around Resident 35's wound with a wet rag. Next, the ADON removed the soiled dressing from the resident's wound. After she washed her hands and donned clean gloves and a clean gown, she cleansed the wound and applied the medi honey ointment and packed the wound. The Resident began yelling Ouch, it hurts! and Please, it hurts! numerous times, during the removal of soiled dressing and packing, cleansing and medication application and repacking of the wound. The ADON replied by saying, I'm sorry, and continued to complete the wound care.</p> <p>During an interview, on 8/08/2024 at 3:29 P.M., the ADON indicated the resident was not given pain medication, by her, prior to the dressing change and she was not sure if anyone else may have administered pain medication to the resident. When asked if the resident should have been given pain medication prior to a wound dressing change, she indicated, Yes, I believe that's fair that he should have been given medication prior to the dressing change.</p> <p>During an interview, on 8/08/2024 at 3:33 P.M., the Unit Manager indicated Resident 35 had been administered Norco (a pain medication) at 1:35 P.M. and he could have a dose of the medication every 8 hours. The resident had been administered Morphine (a pain medication) around 10-10:30 A.M. and could have a dose of the medication every 4 hours. She indicated the resident should have received another dose of Morphine prior to the dressing change.</p> <p>During an interview, on 8/09/2024 at 11:03 A.M., with the CNO (Corporate Chief Nursing Officer) and the DON, the DON indicated when the resident expressed sounds of pain, during the observed wound care, it would have taken more time to stop and address the resident's pain rather than to finish with what they were doing. The CNO stopped the DON and stated, So, at the first sign of pain, they should have stopped the dressing change and assessed the resident. The DON responded by indicating, Yes, and if you look, they did medicate him prior to the morning dressing change.</p> <p>On 8/7/2024 at 10:44 A.M., a record review was completed for Resident 35. Diagnoses included but were not limited to pressure ulcer of sacral region, mild cognitive impairment, and dementia.</p> <p>The residents' medications to address pain included:</p> <p>-Morphine Sulfate oral solution 20 mg/5 ml, give 0.25 ml every 4 hours as needed for shortness of breath and comfort.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Norco oral tablet 5-325 mg, give 1 tablet by mouth three times per day.</p> <p>-Fentanyl transdermal patch 12 mcg per hour, apply patch every 72 hours.</p> <p>A review of Resident 35's Medication Administration Record (MAR) for August 2024 indicated the resident received Morphine 5 mg, sublingual tablet, at 10:33 A.M. and Norco 5-325 mg oral tablet at 1:35 P.M on 8/8/2024. The resident could have received a PRN, as needed, dose of Morphine at 2:30 P.M., prior to the dressing change which was completed at 3:13 P.M on 8/8/2024.</p> <p>A Physicians Order, dated 7/6/2024, indicated may give as needed medication prior to dressing change.</p> <p>A Care Plan, dated 5/23/2024, indicated the resident was at risk for pain related to pressure injury to the right buttock. Interventions included, administer pain medication as needed, evaluate for non-verbal indicators of pain, and evaluate pain.</p> <p>On 8/9/2024 at 10:15 A.M., the CNO provided the policy titled, Pain Management, dated 11/1/2023 and indicated it was the policy currently in use by the facility. The policy indicated . 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 2. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to: i. Negative vocalizations (e.g. groaning, crying, whimpering, or screaming) .</p> <p>3.1-37(a)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48145</p> <p>Based on observation, interview and record review, the facility failed to maintain a system for reconciliation of controlled substances for 1 of 3 medication carts reviewed. (800 hall medication cart)</p> <p>Finding includes:</p> <p>During an observation on 8/8/2024 at 9:41 A.M. of the Medication Cart on the 800 Hall, the Shift Change Accountability Record for Controlled Substances was missing signatures to indicate the controlled substances had been counted and reconciled by two staff members (the on coming an out going nursing staff member) on the following dates and shifts:</p> <ul style="list-style-type: none"> <li>-8/1/2024 fist shift did not contain two signatures.</li> <li>-8/4/2024 first shift did not contain two signatures.</li> <li>-8/4/2024 third shift did not contain two signatures.</li> <li>-8/5/2024 third shift did not contain two signatures.</li> <li>-8/6/2024 third shift did not contain two signatures.</li> <li>-8/7/2024 first shift did not contain two signatures.</li> </ul> <p>During an interview, on 8/8/2024 at 9:42 A.M., Qualified Medication Aide (QMA) 6 indicated there should not be any missing signatures and staff should always count the controlled substances with another staff member, and both staff members should have signed off on the controlled substance count by initialing the Shift Change Accountability Record for Controlled Substances form.</p> <p>On 8/8/2024 at 10:06 A.M., the Unit Manager provided a policy, dated, 1/2023, titled Controlled Substances, and identified it as the policy currently used by the facility. The policy indicated, . b. All scheduled II controlled substances (and other schedules if facility policy so dictates) will be counted each shift or whenever there is an exchange of keys between off-going and on-coming licensed nurses . 4. Both nurses will sign the Shift/Shift Controlled Substance Count Sheet acknowledging that the actual count of controlled substances and count sheet matches the quantity documented</p> <p>3.1-25</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>48145</p> <p>Based on record review and interview, the facility failed to ensure pharmacy recommendations were reviewed and addressed timely by a physician for 2 of 5 residents reviewed for medications. (Residents 55 and 10)</p> <p>Findings include:</p> <p>1. Resident 55's record review was completed on 8/7/2024 at 9:58 A.M.</p> <p>A Consult Pharmacist's Medication Regimen Review, dated 12/14/2023, indicated the Pharmacist recommended discontinuing 500 micrograms of Cyanocobalamin (Vitamin B12). The order for Cyanocobalamin was discontinued on 2/12/2024.</p> <p>A Pharmacy Medication Regimen Review form, from the Pharmacist to the Physician, dated 11/13/2023, indicated the Pharmacist recommended discontinuing Biofreeze Gel 4% topical analgesic. The Physician responded to the recommendation form to discontinue the Biofreeze on 12/12/2023 and the Biofreeze Gel 4% was discontinued on 1/11/2024.</p> <p>A Pharmacy Medication Regimen Review form, from the Pharmacist to the attending Physician, dated 2/19/2024, indicated the Pharmacist recommended weekly blood glucose monitoring and the Physician had agreed to the recommendation but did not date the form. An order for weekly blood glucose checks was initiated on 3/28/2024.</p> <p>On 8/8/2024 at 11:10 A.M., the dates of the responses from the physician related to ordering weekly blood glucose checks and discontinuing Vitamin B12 were requested, but were not provided before the survey exit date.</p> <p>2. Resident 10's record review was completed on 8/7/2024 at 1:09 P.M.</p> <p>A Pharmacy Medication Regimen review form, from the Pharmacist to the attending Physician, dated 11/13/2023, indicated the Pharmacist recommended discontinuing an order for 40 milligrams (mg) of Pantoprazole and the Physician had agreed, but did not date the form. The order for Pantoprazole was discontinued on 1/11/2024.</p> <p>A Pharmacy Medication Regimen review form, from the Pharmacist to the attending Physician, dated 12/14/2023, indicated the Pharmacist recommended discontinuing an order for 40 milligrams (mg) of Atorvastatin and the Physician agreed on 2/8/2024. The order for 40 mg Atorvastatin was discontinued on 2/12/2024.</p> <p>On 8/8/2024 at 11:10 A.M., the date of the response from the Physician related to discontinuing the order for 20 mg of Pantoprazole was requested, but one was not provided before the survey exit</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/8/2024 at 11:05 A.M., the Director of Nursing (DON) indicated an acceptable time frame for the Medical Director to reply to the Pharmacists recommendations was two weeks. However, the facility had problems with their previous Medical Director responding timely to the Pharmacist recommendations and she had used her personal cell phone to reach out to the Medical Director to request he review the facility's Pharmacy recommendations numerous times. Documentation regarding the facility's attempt to contact the Medical Director about the Pharmacy recommendations was requested, but none was received before the survey exit.</p> <p>On 8/9/2024 at 11:02 A.M., the Regional Nurse provided an undated, unsigned letter and indicated it was a copy of a letter sent to the Medical Director from the Executive Director of the facility. The letter indicated the facility was terminating the recipient's position as Medical Director, effective 4/1/2024, due to the timeliness of reviewing compliance documents.</p> <p>On 8/7/2024 at 2:40 P.M., the Regional Nurse provided an undated policy, titled Addressing Medication Regimen Review Irregularities and identified it as the policy currently used by the facility. The policy indicated, .The pharmacist must report any irregularities to the attending physician, the facility's medical director and the director of nursing, and the reports must be acted upon</p> <p>3.1-25(i)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47419</p> <p>Based on observation, interview and record review, the facility failed to store and prepare food in a sanitary manner in 1 of 1 kitchens. This had the potential to affect 88 out of 89 residents who ate food prepared in the kitchen.</p> <p>Finding includes:</p> <p>During an observation of the kitchen, with the Dietary Manager (DM), on 8/5/2024 at 9:07 A.M., the following was noted:</p> <ul style="list-style-type: none"> <li>-Vegetable burgers, strawberries, and 3 tubs of ice cream in the reach-in freezer were not dated.</li> <li>-Food processor bowls stacked together and stored as clean, were still wet on the inside.</li> <li>-The ductwork and ceiling in the food preparation area had a thick layer of dust.</li> <li>-The electrical outlet above the spices was dusty.</li> <li>-Two large and one small pans had missing and/or flaking Teflon coating on the cooking surface.</li> </ul> <p>During an interview on 8/5/2024 at 9:20 A.M., the DM indicated the food in the reach-in freezer should have been dated, the food processor bowls should have been dry before stacking them, the ceiling, ductwork, and electrical outlet should have been free of dust, and the Teflon pans should have been replaced.</p> <p>On 8/12/2024 at 10:52 A.M., the Director of Nursing provided a current policy titled, Food Safety and Sanitation. The policy indicated, .Label foods with delivery date and discard date . Freezer temperatures should be 0 [degrees] or below to ensure frozen foods remain frozen . and .Follow a regular written cleaning schedule and document cleaning</p> <p>3.1-21(i)(3)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44111</p> <p>Based on observation, interview and record review, the facility failed to ensure 2 of 2 laundry staff transported residents clothing appropriately when delivering them.</p> <p>Finding includes:</p> <p>During an observation on 8/5/2024 at 11:00 A.M., Laundry Aide 4 was pushing a cart with residents personal clothing partially covered with a draw sheet. The sheet only covered the top of the clothing to middle of the items and the lower portion of the clothing was exposed and uncovered.</p> <p>During an observation on 8/8/2024 at 12:55 P.M., Laundry Aide 5 was coming down the hall with a cart with residents' personal items covered with a draw sheet. The items were covered from the top of the clothing to middle of the items and the lower portion of the clothing was exposed and uncovered.</p> <p>During an interview on 8/8/2024 at 12:58 P.M., Laundry Aide 5 indicated they (the resident's clothing)probably should be covered up more.</p> <p>During an interview on 8/8/2024 at 1:03 P.M., the Housekeeping/Laundry Director indicated the draw sheet was what they had to cover the rack, they did not have a cover that covered the whole rack.</p> <p>On 8/8/2024 at 2:37 P.M., the Regional Nurse provided a policy titled, Handling Clean Linen, dated 2/2024, and indicated it was the policy currently used by the facility. The policy indicated, .4. Clean linens must be transported by methods that ensure cleanliness and protect from dust and soil during intra or inter-facility loading, transport and unloading, such as: b. Placing clean linen in a properly clean cart and covering with disposable material or a properly cleaned reusable textile material that can be secured to the cart. c. Wrapping the individual bundles of clean textiles in plastic or other suitable material and sealing or taping the bundles .</p> <p>3.1-18</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>48145</p> <p>Based on observation, interview, and record review, the facility failed to maintain a sanitary environment related to clean air vents and dirty ceiling tiles on the 500 Hall.</p> <p>Finding includes:</p> <p>During an observation, on 8/8/2024 at 12:30 P.M., a food cart was sitting under an air vent on the 500 hall. The vent had a thick layer of dust and the dust was mixing with condensation, forming droplets of mud. The droplets were falling onto the food cart below it.</p> <p>During a environmental tour with the Director of Maintenance (DM) on 8/8/2024 at 12:30 P.M., the 500 hall had five vents on the ceiling and all 5 vents and the four ceiling tiles surrounding the vents and/or light covers had a thick build up of dust. One of the vents had condensation mixed with the dust and mud colored droplets were dripping down to the floor.</p> <p>During an interview with the DM on 8/9/2024 at 8:30 A.M., he indicated the reason there was condensation on the ceiling vents was due to residents opening their windows in their rooms and causing humidity in the facility. The vents and ceiling tiles should not be dirty and the DM was unsure if it was the maintenance department or housekeeping's role to clean the vents and ceiling tiles.</p> <p>During an interview with the DM on 8/12/24 11:29 A.M., the DM indicated it was the responsibility of the maintenance department to clean the ceiling tiles and vents. The facility was working on adding cleaning the vents and ceiling tiles to the maintenance department's current tasks to ensure the vents and ceiling tiles would be cleaned regularly in the future.</p> <p>On 8/12/2024 at 10:52 A.M., the Director of Nursing provided a policy, dated 4/2024, titled, Safe and Homelike Environment and identified it as the policy currently used by the facility. The policy indicated, . 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment</p> <p>3.1-19(f)</p>