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	01/13/2026

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. Based on interview and record review, the facility failed to follow physician orders and notify the physician of elevated blood pressures for 1 of 5 residents reviewed for unnecessary medications. (Resident 2)Finding includes: A record review was completed on 1/9/2026 at 12:19 P.M. Diagnoses included, but were not limited to, essential (primary) hypertension. A Physician's Order, dated 8/5/2025, indicated Resident 2 was to receive hydralazine 10 milligrams (mg) by mouth every 8 hours for essential hypertension. The medication was to be held if Resident 2's systolic blood pressure was less than120 millimeters of mercury (mmhg) the facility and was to call the physician if Resident 2's systolic blood pressure was greater than 150 mmhg, or if the resident's diastolic blood pressure was greater than 90 mmhg, or if the resident's diastolic blood pressure was less than 60 mmhg. On 1/1/2026 the medication administration record (MAR) indicated Resident 2's systolic blood pressure was 165/73 mmhg, which was greater than 160 mmhg systolic. The physician was not notified of the elevated systolic blood pressure. On 1/5/2026 the MAR indicated Resident 2's blood pressure was 193/99, which was greater than 160 systolic and 90 diastolic. The physician was not notified of the elevated systolic and diastolic blood pressures. On 1/12/2026 at 12:24 P.M. the DON indicated the physician should have been notified of the elevated blood pressures. She also indicated the facility did not have a policy for following physician orders or the plan of care as it is considered the standard of care.3.1-5(a)(2)

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to assist a resident with eating during meal time for 1 of 2 residents reviewed for activities of daily living. (Resident 13)Finding includes:A record review for Resident 13 was completed on 1/9/2026 at 9:14 A.M. Diagnoses included, but were not limited to, cerebral infarction with hemiplegia/hemiparesis to left side, dementia, and dysphagia.A Quarterly Minimum Data Set (MDS) assessment, dated12/11/2025, indicated Resident 13 had severe cognitive impairment and required supervision and/or touch assist for eating needs.A current Care Plan problem, initiated on 9/23/2025, indicated Resident 13 was at risk for weight fluctuations and nutrition problems. Interventions indicated the resident was to eat in the assist dining room for supervision and cueing.During an observation on 1/7/2026 at 12:13 P.M., lunch had been served to Resident 13 at 12:01 P.M. At 12:13 P.M. the resident ate 1 bite of her chili soup. She then began taking spoonfuls of soup and dumping them onto her plate. Staff did not offer assistance or cueing to encourage Resident 13 to eat. At 12:22 P.M. Resident 13 told a CNA the chili was too hot. Upon clarification she meant spicy. She also asked for a cup of coffee. The CNA provided coffee but did not offer a substitute for the chili soup. During an observation on 1/8/2026 at 9:17 A.M., Resident 13 was seated at a table in the unit's common area with her breakfast tray in front of her. She was drinking her coffee, but her cereal had spilt in her lap and onto the floor. She attempted to eat a few pieces from her lap but staff made no attempt to assist her. At 9:29 A.M. a CNA asked her if she was done and the resident stated, No. However, the CNA removed the tray. The CNA then noted the spilled cereal and indicated she needed to go and take care of it. She then took the resident to her room, changed her top, and returned her to the table. No other food was offered to the resident. During an interview on 1/12/2026 at 12:24 P.M. the DON indicated the resident should have received assistance and have been offered substitutions for uneaten and spilled food, especially if she indicated she was not done. She also indicated the facility did not have a policy for following physician orders or the plan of care as it is considered the standard of care. 3.1-38(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to follow the plan of care for 2 of 16 residents reviewed for vascular needs (Resident 54) and pressure relief (Resident 18).Findings include: 1.During an observation on 1/7/2025 at 2:59 P.M., Resident 54 was not been wearing Tubigrip (elastic tubular bandage providing continuous support for swelling) on either lower extremity. Resident 54's left foot and ankle had plus 2 pitting edema (swelling of the skin that takes 2 seconds to return to normal after pressing the skin with the index finger) and non-pitting edema (swelling of the skin that rebounds instantly when pushed on with index finger) on the right foot and ankle. During an interview on 1/7/2025 at 3:00 P.M., Resident 54 indicated the facility had not provided leg wraps for the edema (swelling) for either one of his lower legs or feet. During observations on 1/08/2026 at 9:16 A.M. and 2:10 P.M., Resident 54 was not wearing tubigrips. Resident 54's record review was completed on 1/9/2025 at 11:05 A.M. Diagnoses included, but were not limited to: stage 3 chronic kidney disease, fracture of the left femur and atrial fibrillation. A Quarterly Minimum Data (MDS) assessment dated , 12/19/2025, indicated Resident 54 had moderate cognitive impairment, had not rejected care or had any behaviors and received a diuretic (medication that makes the kidneys remove excess salt and water from the body). A current Physician's order initiated on 11/14/2025, indicated Resident 54 was to have Tubigrips applied to her bilateral lower extremities in the morning and removed at bedtime for edema. A review of Resident 54's January Treatment Administration Record (TAR) was reviewed on 1/9/2025 at 11:00 A.M. Although Resident 54 was observed without Tubigrips applied, on both 1/7/and 1/8, the January TAR had documented the resident as having worn the wraps. Resident 54's record lacked the documentation to indicate the resident had refused wearing Tubigrips on either one of his lower extremities. During an interview on 1/9/2025 at 1:00 P.M., the Regional Nurse Consultant (RNC) indicated Resident 54 had not been wearing Tubigrips and she would cancel the order because the resident had refused to wear the Tubigrips. The RNC indicated the TAR should not have been marked completed because the task had not been completed on 1/7 and 1/8/2025. 2. Resident 18 was observed laying in bed with her heels laying directly on the mattress during the following times:-1/7/2025 at 3:18 P.M.-1/8/2025 at 9:31 A.M.-1/8/2025 at 2:45 P.M.-1/9/2025 at 8:45 A.M. During an interview on 1/09/2026 at 9:48 A.M., a local Hospice Provider CNA indicated Resident 18's heels were not floated, but should have been. Resident 18's record review was completed on 1/9/2025 at 11:45 A.M. Diagnoses included, but were not limited to: chronic pulmonary obstructive disorder, anxiety disorder, chronic pulmonary edema and dysphagia. A Quarterly MDS assessment dated [DATE], indicated Resident 18 had moderate cognitive impairment, had not rejected care, had been receiving Hospice services and was at risk for pressure injury. A current Physician's order initiated on 12/25/2025, indicated Resident 18 was to have her heels floated (soft object placed under knees or calfs to lift heels) at all times, except during care. A review of Resident 18's January 2026 TAR indicated the resident's heels had been documented as having been floated on 1/7 and 1/8/2026, even though they had been observed not elevated and/or floated. There was no documentation that Resident 18's had refused floating of her heels on 1/7, 1/8 or 1/9/2026. During an interview on 1/9/2025 at 1:00 P.M., the Regional Nurse Consultant (RNC) indicated it was unclear why Resident 18's heels had not been floated and she would have to look into it. During an interview on 1/12/2025 at 12:30 P.M., the RNC indicated the facility did not have a policy for following Physician's orders, but the facility followed the Standards of Care and following the Physician's orders was included in the Standards of Care. The RNC indicated tasks should not have been marked as completed on the TARs if the task had not been completed. On 1/12/2025 at 10:26 A.M. the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) provided a policy dated, 1/31/2024, and titled, Documentation in the Medical Record. The DON indicated the policy was the one currently used by the facility. The policy indicated, . 3. Principles of documentation include, but are not limited to: .b. Documentation shall be accurate, relevant and complete, containing sufficient details about the resident's care and/or responses 3.1-37

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview and record review, the facility failed to ensure staff providing wound care and directing wound and infection control measures in the facility was competent. (Employee 9) Finding includes:During an observation of Resident 6's wound care on 1/12/2026 at 11:06 A.M., the Wound Nurse/Infection Preventionist Nurse (WN/IPN) removed a dressing from Resident 6's right buttocks, removed the packing from the wound and took the protective dressing off of the resident's coccyx (a small triangular bone at the base of the spinal column). The WN/IPN inserted her index finger into the wound on the buttocks to assess the channeling of the wound, measured the wound with a cotton swab, cleaned the wound with a sterile saline solution, wiped a medicated pad around the wound's edges, applied medicated ointment around the wound, packed the wound with a medicated packing material and covered both the wound on the buttocks and the coccyx with clean bandages.Next, the WN/IPN repositioned the resident onto her back and provided urinary catheter care by cleaning the catheter with soap and water. The WN/IPN's gloves were not changed nor was hand sanitizer used after removing the dirty dressings, before applying the treatments, before or after applying the new bandages, nor before providing urinary catheter care.After the WN/IPN had provided the resident with urinary catheter care, the WN/IPN used hand sanitizer and changed her gloves. She then proceeded to remove a border gauze dressing from the resident's thigh wounds. Sterile saline was then used, followed by wiping a medicated pad around both wounds. The WN/IPN used the same medicated pad to wipe both wounds and the same cotton swab to measure both wounds and then applied a border gauze dressing to the wounds on the residents' left and right thigh. The WN/IPN gloves were not changed after she removed the old bandage and before treating, measuring or covering either thigh wound.Next, the WN/IPN removed the band aides from the resident's second and third toes. The WN/IPN did not change her gloves or use hand sanitizer after removing the bandages and before cleaning the 4th toe, measuring the wound or putting a clean bandage on the wounds.The WN/IPN then removed the dressing off Resident 6's left heal, measured the heal, used sterile saline to clean the heel, wiped a medicated pad around the wound, applied a collagen wound treatment , covered the wound with a bandage and then placed the resident's sock back on her foot. The WN/IPN did not use hand sanitizer or change her gloves after removing the dressing, before starting the treatment or before applying a clean bandage. During an interview on 1/12/2026 at 11:40 A.M., the WN/IPN indicated she had been changing dressings for over 20 years and did not needed to change her gloves or use hand sanitizer after removing dirty dressings, after applying treatments or before applying a clean bandage. The WN/IPN indicated she should have changed her gloves and used hand sanitizer before starting urinary catheter care. During an interview on 1/12/2026 at 11:45 A.M., the Director of Nursing (DON) indicated during wound care, gloves should be changed and hand sanitizer used after removing a dirty dressing, after completing the wound treatment and before applying a clean bandage. Although the WN/IPN's skills check off titled, Validation Checklist for Catheterization, and dated 5/29/2025, indicated the WN/IPN had been trained and observed for hand washing and wearing gloves before catheter care and the WN/IPN's skill check off title, Wound Care Observation Checklist for Infection Control, and dated 5/29/2025, indicated the WN/IPN had been trained and observed for hand hygiene before wound care treatment started, after removing the dirty dressing, after applying the treatment and before applying the clean bandage. It was unclear why the WN/IPN had indicated the hand sanitation and changing of gloves was not necessary during wound care and treatments.On 1/12/2025 at 10:46 A.M., the DON provided a policy, dated 6/12/2025 and titled, Enhanced Barrier Precautions, and identified the policy as the one currently used by the facility. The policy indicated, . b. An order for enhanced (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	barrier precautions will be obtained for residents with any of the following: wounds, indwelling medical devices (e.g., central lines, urinary catheters, ventilator tubes/tracheostomy, hemodialysis catheters and PICC lines) even if the resident is not known to be infected or colonized by MDRO On 1/12/2025 at 1:46 P.M., the DON provided a policy, dated 1/29/2024 and titled, Catheter Care Policy, and identified the policy as the one currently used by the facility. The policy indicated, . Implementation Guidelines: . 7. perform hand hygiene 8. don gloves On 1/12/2025 at 10:46 A.M., the DON provided a policy, dated 7/16/2025 and titled, Wound Treatment Policy, and identified the policy as the one currently used by the facility. The policy indicated, . 2. All wound care shall be performed using appropriate infection control practices and per community guidelines 3.1-14(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to keep medication and treatment carts secured on 3 of 3 halls. (100, 200 and 300 Halls)Findings include: 1. During an observation of the medication cart, on the 100 Hall, on 1/9/2026 from 8:52 A.M. until 8:57 A.M., the medication cart had been unlocked and unattended. During an interview on 1/9/2026 at 8:57 A.M., Registered Nurse 5 indicated the medication cart was not locked, but should have been locked. 2. During an observation of the medication cart, on the 300 Hall, on 1/9/2026 from 8:58 A.M. until 9:03 A.M., the medication cart was unlocked and unattended. During an interview on 1/9/2026 at 9:03 A.M., RN 6 indicated she had been responsible for the medication cart and the medication cart was not locked while she had been in a resident's room and was unable to visualize the cart from the room. 3. During an observation of the treatment cart, on the 300 Hall, on 1/9/2026 from 9:05 A.M. until 9:07 A.M., the cart had been unlocked and was unattended. The treatment cart contained prescribed topical creams and gels, antifungal cream and antifungal powder for residents. During an interview on 1/9/2025 at 9:07 A.M., RN 6 indicated the treatment cart had not been locked, but should have been locked. 4. During an observation of the medication cart on the 200 Hall on 1/11/2026 at 4:25 P.M., the medication cart was unlocked and unattended. During an interview on 1/11/2026 at 4:26 P.M., LPN 3 indicated the medication cart had not been locked but should have been locked. 5. During an observation of the treatment cart on the 200 Hall on 1/11/2026 from 4:29 P.M. until 5:50 P.M., the treatment cart was unlocked and unattended. The treatment cart contained prescribed topical creams and gels, antifungal cream and antifungal powder for residents. During an interview on 1/11/2026 at 5:50 P.M., the Executive Director indicated the treatment cart should not have been left unlocked. On 1/9/2025 at 1:59 P.M., the Director of Nursing (DON) provided a policy dated, 4/9/2019 and titled, Medication Storage Policy. The DON indicated it was the policy currently being used by the facility. The policy indicated, . 1. General Guidelines a. All drugs and biologicals will be stored in locked compartments (i.e., medications carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls 3.1-25 (m)

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	155684	A. Building B. Wing	01/13/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interview, observation and record review, the facility failed to provide meals at a palatable temperature for the 100 Hall meal trays. This had the potential to affect 18 of 18 residents who received their meals in their rooms or on the 100 Hall common area. Finding includes: During an interview on 1/7/2025 at 11:18 A.M., Resident 11 indicated he ate all of his meals in his room and most of his meals were served to him cold. Resident 11 indicated he was able to ask for the meal to be reheated but then he had to wait to eat and it was every meal. During an interview on 1/7/2025 at 11:50 A.M., Resident 6 indicated she ate her meals in the common area of the 100 Hall. She indicated most of her meals had been served lukewarm or cold and she had stopped requesting her food to be reheated. During an observation of the 100 Hall lunch meal service on 1/12/2025. The meal cart arrived at 12:02 P.M. and at 12:15 P.M., Directory of Dietary (DOD) had taken the temperature of the grilled cheese sandwich on the last meal tray for the 100 Hall. The grilled cheeses' temperature was 107 Fahrenheit (F). During an interview with the DOD on 1/12/2025 at 12:20 P.M., the DOD indicated he was not sure what the temperature of the grilled cheese should have been when it was served. The DOD indicated the hold temperature for hot food was 135 F. The Executive Director (ED) provided a policy dated, 11/28/2025 and titled, Food Safety Requirements. The ED indicated the policy was the one currently used by the facility. The policy indicated, . 4. When preparing food, team members should take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards . d. Holding - Maintain proper hot and cold holding temperatures. Team members should refer to the current FDA Food Code and community policy for foor temperatures as needed. The Federal Department of Agriculture 2022 Food Code was retrieved on 1/14/2025 from the FDA's website at https://www.fda.gov/media/164194/download?attachment. The guidance indicated food should be held and served at 135 F to avoid the growth of harmful bacteria. 3.1-21(a)(2)

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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. Based on observation and interview the facility failed to provide a clean and sanitary environment for food preparation and failed to ensure meals served to Resident 11 were within safe serving temperatures. This had the potential to affect 57 of 57 residents who consumed food prepared in the kitchen. Finding includes: 1. During a tour and observation of the kitchen on 1/7/2026 at 9:51 A.M. the following issues were noted: -3 fans in the food preparation area were dusty. -the walls, ceiling, and light fixtures were dusty. -the wall behind the stove and griddle had yellowish-brown matter on it. During an interview on 1/7/2025 at 10:05 A.M., the Dietary Manager indicated there should not be dust on the fans, walls, ceiling, and light fixtures, and the wall behind the griddle should have been clean. On 1/12/2026 at 10:04 A.M. the Dietary Manager indicated there was not a policy for cleaning the kitchen but provided the cleaning schedule that staff followed. 2. During an observation on 1/9/2026 at 9:30 A.M., Resident 11's breakfast tray had been placed on a table in the common area of the 100 Hall. Resident 11 was still sleeping. During an interview on 1/9/2026 at 10:04 A.M., CNA 7 indicated she had taken the tray from the table and heated Resident 11's food in the microwave. CNA 7 indicated Resident 11 was having an omelette, a danish and a cup of coffee. CNA 7 had not taken the temperature of any of the food after she microwaved it and before she gave Resident 11 his tray. CNA 7 indicated the breakfast trays had arrived at 7:40 A.M. During an observation on 1/12/2025 7:50 A.M., 100 Hall breakfast trays arrived to the unit. Resident 11 was still sleeping. During an observation on 1/12/2025 at 9:04 A.M., CNA 7 gave Resident 11 his breakfast tray. Resident 11 was having a omelette and a cup of coffee. During an interview on 1/12/2025 at 9:05 A.M., CNA 7 indicated Resident 11's breakfast tray had been heated in the microwave and had not had the food's temperature taken before giving the food to the resident. During a follow-up interview on 1/12/2025 at 9:07 A.M., CNA 7 indicated she had misspoke and the breakfast tray she had just delivered to Resident 11 had been a new tray the kitchen had just made. During an interview on 1/12/2025 at 9:08 A.M., the Director of Dining (DOD) indicated the kitchen had not remade Resident 11's breakfast tray. The DOD indicated he did not know how long high-risk food could remain out before it would have needed to be remade. The DOD indicated the nursing staff (continued on next page)

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	155684	A. Building B. Wing	01/13/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should have taken the temperature of the omelette after it had been reheated. During an interview on 1/13/2025 at 10:15 A.M., the DOD indicated high-risk foods such as eggs could safely sit out for four hours before the food needed to be refrigerated or discarded. On 1/12/2025 at 9:47 A.M., the Executive Director provided a policy, dated 10/28/2025 and titled, Food Safety Requirements, and identified it as the policy currently used by the facility. The policy indicated, . a. Reheating . i. Foods reheated in a microwave oven must be reheated so that all parts of the food reach a temperature of at least 165 F The Federal Department of Agriculture 2022 Food Code was retrieved on 1/14/2025 from the FDA's website at https://www.fda.gov/media/164194/download?attachment. The guidance indicated food should be placed into the refrigerator 2 hours after it is removed from its holding temperature to avoid the growth of harmful bacteria. 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow infection prevention practices during wound care, Foley (indwelling urinary catheter) care and failed to keep a urinary drainage bag off the floor during for 1 of 3 residents observed for infection control. (Resident 6)Findings include: 1. During an observation on 1/9/2026 at 2:30 P.M., Resident 6's door to her room had a sign indicating the resident was in Enhanced Barrier Precautions (EBP) and staff should wear a gown, gloves and mask anytime staff was providing care related to the resident's indwelling catheter. CNA 2 was observed emptying the foley urinary drainage bag without wearing Personal Protective Equipment (PPE). During an interview on 1/9/2025 at 2:34 P.M., CNA 2 indicated she did not believe she needed to wear the PPE while emptying Resident 6's urinary drainage bag. During a follow-up interview on 1/9/2025 at 2:36 P.M., CNA 2 indicated PPE should have been worn while emptying Resident 6's urinary catheter bag. Resident 6's record review was completed on 1/11/2026 at 5:15 P.M. Diagnoses included, but were not limited to: spinal stenosis, anemia, unstageable pressure ulcer on buttocks and fractured vertebrae. A current Physician's order, initiated on 10/6/2025, indicated Resident 6 was to be in Enhanced Barrier Precautions. Staff were wear gloves and gowns when providing high risk activities (dressing, bathing, showering, transferring, changing linens, providing hygiene, changing or assisting with toileting, device care and wound care) related to Foley catheter and surgical/pressure wounds. A current Care Plan, initiated on 8/20/2025 indicated Resident 6 required EBPs related to pressure injuries and foley catheter. An intervention to the Care Plan, initiated on 8/20/2025 indicated as part of standard precautions, additional PPE may be required. 2. During an observation on 1/12/2026 at 8:40 A.M., Resident 6 was seated in the common area of the 100 Hall eating breakfast. The urinary drainage bag was laying on the ground under the resident's chair. During an interview on 1/12/2026 at 9:00 A.M., RN 5 indicated the urinary drainage bag should not have been on the floor. During an interview on 1/12/2026 at 10:00 A.M., the Director of Nursing (DON) indicated the facility did not have a policy regarding urinary drainage bags, but the facility followed the Standards of Care. 3. During an observation of Resident 6's wound care on 1/12/2026 at 11:06 A.M., the Wound Nurse/Infection Preventionist Nurse (WN/IPN) removed a dressing from Resident 6's right buttocks, removed the packing from the wound and took the protective dressing off the resident's coccyx (a small triangular bone at the base of the spinal column) . The WN/IPN inserted her index finger into the wound on the buttocks to assess the direction of wound channeling, measured the wound with a cotton swab, cleaned the wound with sterile saline solution, used a medicated pad around the wound's edges, applied medicated ointment, packed the wound with a medicated packing material and covered both the buttocks wound and the coccyx with clean bandages. Next, the WN/IPN turned the resident onto her back and provided urinary catheter care by cleaning the catheter with soap and water. The WN/IPN's gloves were not changed or hand sanitizer used after removing the dirty dressings, before applying the treatments, before applying the new bandages, nor before providing urinary catheter care. After the WN/IPN provided the resident with urinary catheter care, the WN/IPN used hand sanitizer and put on clean gloves. She then proceeded to remove a border gauze dressing from the resident's thigh wounds. She then cleansed the wounds with sterile saline, followed by wiping a medicated pad on both wounds. The WN/IPN used the same medicated pad to wipe both wounds and the same cotton swab to measure both wounds and then applied a border gauze dressing to the wounds on the residents' left and right thigh. The WN/IPN gloves were not changed after she removed the old bandages nor before treating, measuring or covering either thigh wound. Next, the WN/IPN removed band aides from the resident's second and third toes. The WN/IPN did not change her gloves or use hand sanitizer after removing the bandaids and before cleaning the 4th toe, (continued on next page)

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	01/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measuring the wound or putting a clean bandage on the toe. Finally, the WN/IPN removed the dressing from Resident 6's left heal, measured the heal, used sterile saline to clean the heel, wipes a medicated pad, around the wound's edges, applied a collagen treatment to the wound, covered the wound with a clean bandage and then placed the resident's sock back on her foot. The WN/IPN did not use hand sanitizer or change her gloves after removing the dressing, before starting the treatment or before applying a clean bandage. During an interview on 1/12/2026 at 11:40 A.M., the WN/IPN indicated she had been changing dressings for over 20 years and did not needed to change her gloves or use hand sanitizer after removing dirty dressings, after applying treatments or before applying a clean bandage. The WN/IPN indicated she should have changed her gloves and used hand sanitizer before starting urinary catheter care. During an interview on 1/12/2026 at 11:45 A.M., the Director of Nursing (DON) indicated during wound care, gloves should be changed and hand sanitizer used after removing a dirty dressing, after completing the wound treatment and before applying a clean bandage. On 1/12/2025 at 10:46 A.M., the DON provided a policy, dated 6/12/2025 and titled, Enhanced Barrier Precautions, and identified the policy as the one currently used by the facility. The policy indicated, . b. An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds, indwelling medical devices (e.g., central lines, urinary catheters, ventilator tubes/tracheostomy, hemodialysis catheters and PICC lines) even if the resident is not known to be infected or colonized by MDRO On 1/12/2025 at 1:46 P.M., the DON provided a policy, dated 1/29/2024 and titled, Catheter Care Policy, and identified the policy as the one currently used by the facility. The policy indicated, . Implementation Guidelines: . 7. perform hand hygiene 8. don gloves On 1/12/2025 at 10:46 A.M., the DON provided a policy, dated 7/16/2025 and titled, Wound Treatment Policy, and identified the policy as the one currently used by the facility. The policy indicated, . 2. All wound care shall be performed using appropriate infection control practices and per community guidelines 3.1-18(a)