

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER 1019 BELLE'S PLACE OF WABASH		STREET ADDRESS, CITY, STATE, ZIP CODE 3037 W DIVISION RD, WABASH, , 46992		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: August 16 and August 17, 2022 Facility number: 003466 Residential Census: 21 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 19, 2022.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment;	R 0052	Statement of Correction: All new admissions will have a Fall Risk Assessment completed prior to move in, 30 days after move-in, at bi-annual service assessment and as needed for falls by RN-C or other delegated staff member. The Divisional Director of Resident Services (DDRS) will audit new	09/15/2022

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

(5) neglect; and

(6) involuntary seclusion.

Based on record review and interview, the facility neglected a resident resulting in multiple falls with severe injury for 1 of 7 residents reviewed for resident rights a (Resident 23). This deficient practice resulted in Resident 23 falling multiple times resulting in a subdural hematoma and a fracture.

Findings include:

Resident 23's clinical record was reviewed on 8/17/22 at 12:32 p.m. Diagnoses included, but were not limited to, hallucinations, falls, altered mental status, delirium, muscle weakness, depression, and memory impairment.

A progress note, dated 9/2/21 with no time documented, indicated the resident told the staff she fell and hit her head on the floor. No injuries were identified.

A fall risk assessment, dated 9/14/21 at 2:30 p.m., indicated the resident was a high risk for falls.

A nursing assessment, dated 9/14/21 at 2:35 p.m., indicated the resident used a wheeled walker for ambulation, frequently walked at a very fast

admission charts for next three move-ins and next three 180-day assessments, to ensure all assessments have been completed, interventions have been identified, established, and added to the residents Service Plan. The DDRS will also audit falls logs monthly for three months to determine if appropriate interventions have been put in place. All fall risk assessments, falls reports and nursing and bi-annual service assessments will be completed and signed by the RNC, and audited for completion and signed by the Director.

The RN-C will review Resident Rights and provide a signed copy of Resident Rights in-service completed by all employees to Divisional of Operations/DDRS no later than

September 15, 2022. All Fall Risk Assessments, Falls Report and Nursing and bi-annual service assessments will be completed and signed by the RNC, and audited for completion by the Director.

Date of Completion: September 15, 2022.

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

pace, and had to be reminded to slow down.

A progress note, dated 12/7/21 at 6:00 p.m., indicated the resident yelled in the hallways and said she had fallen. The recliner in her room was in the middle of the room and on its side. The resident was sent to the hospital for evaluation.

A progress note, dated 12/8/21 at 9:10 a.m., indicated the resident returned from the hospital with no injuries identified.

A fall risk assessment, dated 2/22/22 at 10:30 a.m., indicated the resident was a high risk for falls.

A nursing assessment, dated 2/22/22 at 10:30 a.m., indicated the resident had poor balance, used a wheeled walker for ambulation, walked with a very fast pace, and had to be reminded to slow down.

A progress note, dated 2/25/22 at 5:45 p.m., indicated the resident was found on the floor between a couch and an ottoman in a common area. She indicated she had tried to sit on the ottoman and did not realize it was not a chair. Her legs were partially bent under her. She indicated she had hit her head and her lower back was sore. She was sent to the hospital for evaluation and was returned

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

with no injuries identified.

An unusual occurrence report dated 2/25/22 indicated interventions for the recent fall included, but were not limited to, encourage participation in activities and rearrange or remove extra furniture.

A progress note, dated 3/1/22 at 8:45 a.m., indicated the resident's family requested the resident to not be sent to the hospital if she reported a fall and hit her head. She indicated the resident had fallen 15 years ago and still remembered the incident, but not when it occurred. She requested the facility to call the family when the resident fell.

A progress note, dated 3/12/22 with no time documented, indicated the resident was found on the floor in front of her closet and bedroom across from the bathroom. She indicated she was going to the bathroom, fell, and could not get up. She indicated her back hurt. Pain medication was given. Family, on call nurse, and physician were notified. No injuries were identified.

An unusual occurrence report, dated 3/12/22, indicated interventions for the recent fall included, but were not limited to, encourage resident to wear appropriate footwear, perform

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

apartment check to ensure proper interventions and techniques are being employed, and to remove unnecessary furniture and equipment.

A progress note, dated 3/22/22 at 4:40 p.m., indicated the resident was found on the floor on her left side with rolling walker tipped over. She indicated she tripped. No injuries were identified. The nurse practitioner was called. A message was left for the family to call the facility.

A progress note, dated 3/22/22 at 4:45 p.m., indicated the family returned the call and declined to have the resident sent to the hospital

An unusual occurrence report, dated 3/22/22, indicated interventions for the recent fall included, but were not limited to, encourage family to remove excess furniture from the resident's apartment.

A progress note, dated 4/15/22 at 12:30 p.m., indicated the resident was found lying on her right side by the end of the bed in her apartment. The resident indicated her right upper leg and right hip hurt. She rolled onto her back and indicated it really hurt. The family, emergency medical services (EMS), and Assistant Director (AD) were notified. Emergency medical

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

technicians (EMTs) assisted the resident to stand. She indicated she had neck pain. Resident was sent to the local hospital. The local hospital called facility and indicated resident had been sent to another hospital for a 3 to 4 millimeter (mm) bleed in the right frontal region of the brain.

An unusual occurrence report, dated 4/15/22, indicated interventions for the recent fall included, but were not limited to, increase involvement with meaningful activities, take resident to bathroom prior to and following meals and at bedtime, encourage activities, and put a sign on walker to remind resident to use walker.

A computed tomography (CT) of the head without contrast (brain scan) on 4/15/22 at 12:51 p.m., indicated a 3 to 4 mm hemorrhage (bleed) in the brain.

A progress note, dated 4/16/22 at 9:30 p.m., indicated the resident returned from the hospital with no new orders last evening.

A progress note, dated 4/25/22 at 1:25 a.m., indicated resident was in the hall and with blood running down her neck. An injury to her head was noted two inches above her ear on the right side of her head. The registered nurse in charge (RNC) was notified. The RNC

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

notified the family. The resident was sent to the hospital.

A progress note, dated 4/25/22 at 3:50 a.m., indicated the resident returned from the hospital.

An unusual occurrence report, dated 4/25/22, indicated interventions for the recent fall included, but were not limited to, explain importance of care conference to family, educate the staff on service plan, perform resident checks every two hours, and remove unnecessary equipment.

A progress note, dated 5/6/22 at 3:03 p.m., indicated the resident was found sitting on her buttocks with legs in front of her. She indicated she needed to go to the bathroom.

A progress note, dated 5/10/22 at 8:45 p.m., indicated the resident was found on the floor by staff. The RNC was notified. The RNC notified the family. The resident was sent to the hospital.

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

An unusual occurrence report, dated 5/10/22, indicated interventions for the recent fall included, but were not limited to, add nightlights to the bathroom, smaller bed put in apartment, furniture removed, and hospice referral. Resident was to be admitted to hospice upon return to facility

A CT of the head without contrast on 5/10/22 at 10:53 p.m., indicated a small acute (new) subdural hematoma measuring 5.3 mm in thickness.

A progress note, dated 5/11/22 at 9:10 a.m., indicated the hospital reported had an acute subdural hematoma to the left brain and was stable.

A progress note, dated 5/12/22 at 4 p.m., indicated resident returned to the facility.

A progress note, dated 5/13/22 with time of 11-7, indicated the staff performed hourly checks on the resident.

A progress note, dated 5/14/22 at 8:10 p.m., indicated resident was found lying on her right side on the floor in the dining room. She indicated she tripped over the dog. No new injuries were identified.

An unusual occurrence report, dated 5/14/22, indicated interventions for recent fall included, but were not limited to,

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

check every 30 minutes and one-on-one activities.

A progress note, dated 5/15/22 at 11:00 p.m., indicated the resident fell in her room. She was observed lying on her back under her sink. The staff reported resident hit her head. She indicated she had severe back pain and right hip pain. The nurse on call, family, and hospice were notified. The resident was sent to the hospital.

A CT of the head without contrast on 5/15/22 at 12:44 a.m., indicated the prior subdural hematoma was unchanged from 5/11/22. A marked enlargement of the lateral ventricles of proportion to the sulci was found and questioned to be normal pressure hydrocephalus (NPH - an abnormal buildup of cerebrospinal fluid in the brain).

A CT of the lumbar spine on 5/15/22 at 12:45 a.m., indicated the resident had an acute mild compression fracture to the top of the lowest thoracic vertebrae (T12).

A progress note, dated 5/16/22 at 2:15 p.m., indicated the resident returned from the hospital.

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

Visual checks were documented every half hour from 5/16/22 through 5/22/22.

A progress note, dated 5/22/22 at 8:00 a.m., indicated the resident screamed in pain. Pain medication and shower were given. Hospice and the RNC was notified.

A progress note, dated 5/22/22 at 10 a.m., indicated a new order from hospice was received to move the resident to the hospice home for pain management.

A progress note, dated 5/22/22 at 2:30 p.m., indicated the resident was sent to the hospice home.

A progress note, dated 6/1/22 at 6:45 p.m., indicated the resident returned to the facility

A progress note, dated 6/2/22 at 8:33 p.m., indicated the resident had expired.

During an interview, on 8/17/22 at 2:36 p.m., the Assistant Director indicated frequent checks were performed on the resident to prevent falls. She was uncertain when they started or where additional documentation of the checks were located. She indicated Licensed Practical Nurse (LPN) 2 had more knowledge about the resident's falls.

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

During an interview, on 8/17/22 at 2:50 p.m., LPN 2 indicated she had followed the resident's falls. She indicated she had implemented interventions with each fall to prevent additional falls like having the family remove furniture and clutter from the resident's room and frequent checks on the resident. She indicated the resident check logs should be in the resident's clinical record. She was uncertain if there were additional resident check logs.

A current facility policy, titled "Falls" and provided by the Corporate Consultant on 8/17/22 at 5:51 p.m., indicated "...assess the situation: determine if emergency action is needed...Re-establish order...Give appropriate information about the situation in brief and accurate terms. Complete an Incident Report and Fall Investigation Form following established procedures and contact appropriate supervisors..."

Based on record review and interview, the facility neglected a resident resulting in multiple falls with severe injury for 1 of 7 residents reviewed for resident rights a (Resident 23). This deficient practice resulted in Resident 23 falling multiple times resulting in a subdural hematoma and a fracture.

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

Findings include:

Resident 23's clinical record was reviewed on 8/17/22 at 12:32 p.m. Diagnoses included, but were not limited to, hallucinations, falls, altered mental status, delirium, muscle weakness, depression, and memory impairment.

A progress note, dated 9/2/21 with no time documented, indicated the resident told the staff she fell and hit her head on the floor. No injuries were identified.

A fall risk assessment, dated 9/14/21 at 2:30 p.m., indicated the resident was a high risk for falls.

A nursing assessment, dated 9/14/21 at 2:35 p.m., indicated the resident used a wheeled walker for ambulation, frequently walked at a very fast pace, and had to be reminded to slow down.

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

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

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

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

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

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A CT of the head without contrast on 5/10/22 at 10:53

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

p.m., indicated a small acute (new) subdural hematoma measuring 5.3 mm in thickness.

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

resident was sent to the hospital.

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A progress note, dated 5/16/22 at 2:15 p.m., indicated the resident returned from the hospital.

Visual checks were documented every half hour from 5/16/22 through 5/22/22.

A progress note, dated 5/22/22 at 8:00 a.m., indicated the resident screamed in pain. Pain medication and shower were given. Hospice and the RNC was notified.

A progress note, dated 5/22/22 at 10 a.m., indicated a new order from hospice was received to move the resident to the hospice home for pain

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

management.

A progress note, dated 5/22/22 at 2:30 p.m., indicated the resident was sent to the hospice home.

A progress note, dated 6/1/22 at 6:45 p.m., indicated the resident returned to the facility

A progress note, dated 6/2/22 at 8:33 p.m., indicated the resident had expired.

During an interview, on 8/17/22 at 2:36 p.m., the Assistant Director indicated frequent checks were performed on the resident to prevent falls. She was uncertain when they started or where additional documentation of the checks were located. She indicated Licensed Practical Nurse (LPN) 2 had more knowledge about the resident's falls.

During an interview, on 8/17/22 at 2:50 p.m., LPN 2 indicated she had followed the resident's falls. She indicated she had implemented interventions with each fall to prevent additional falls like having the family remove furniture and clutter from the resident's room and frequent checks on the resident. She indicated the resident check logs should be in the resident's clinical record. She was uncertain if there were additional resident check logs.

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

	A current facility policy, titled "Falls" and provided by the Corporate Consultant on 8/17/22 at 5:51 p.m., indicated "...assess the situation: determine if emergency action is needed...Re-establish order...Give appropriate information about the situation in brief and accurate terms. Complete an Incident Report and Fall Investigation Form following established procedures and contact appropriate supervisors..."			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of	R 0117	No residents were negatively affected by this deficiency although potential for harm did exist. Director or designee, RN-C and ACC will be re-educated in requirement for all personnel to be certified in First Aid and CPR by 9/2/22. All CPR and First Aid certifications will be audited for expired status by 9/2/22. Any staff member without a current CPR and First Aid certification will be scheduled for training by 9/30/22 and any new hires will be scheduled within 30	09/02/2022

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

medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Based on record review and interview, the facility failed to ensure a minimum of one awake staff member certified in first aid was on site for 2 of 7 days reviewed for staffing sufficiency. (CNA 3, CNA 4, and QMA 5)

Findings include:

The staffing schedule for August 11 through August 17, 2022, provided by the Assistant Director on 8/17/22 at 10:02 a.m., was reviewed on 8/17/22 at 2:02 p.m. CPR and first aid certifications were not located for the employees (CNA 3 and QMA 5) who worked third shift on August 11, 2022, or for the employees (CNA 4 and QMA 5) who worked third shift on August 15, 2022.

During an interview, on 8/17/22 at 4:10 p.m., the Assistant Director (AD) indicated she would look for the CPR and first aid certifications for CNA 3, CNA 4, AND QMA 5.

During an interview on 8/17/22 at 5:02 p.m., the AD provided a

days of hire date.

Divisional Director of Operations will audit all new hire files to insure CPR and First Aid certifications are current and in file for the next 5 newly hired employees.

Date of completion 9/2/22 and on-going.

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

CPR certification for QMA 5. She was unable to locate CPR certifications for CNA 3 and CNA 4. She was unable to locate first aid certifications for CNA 3, CNA 4, or QMA 5.

A current policy, titled "Policies and Procedures - Category: Personnel - Certification and Licensure" and provided by the AD on 8/17/22 at 5:51 p.m., indicated " ...Bickford requires Bickford Family Members to maintain current licensure and certification, including CPR and First Aid.

Based on record review and interview, the facility failed to ensure a minimum of one awake staff member certified in first aid was on site for 2 of 7 days reviewed for staffing sufficiency. (CNA 3, CNA 4, and QMA 5)

Findings include:

The staffing schedule for August 11 through August 17, 2022, provided by the Assistant Director on 8/17/22 at 10:02 a.m., was reviewed on 8/17/22 at 2:02 p.m. CPR and first aid certifications were not located for the employees (CNA 3 and QMA 5) who worked third shift on August 11, 2022, or for the employees (CNA 4 and QMA 5) who worked third shift on August 15, 2022.

During an interview, on 8/17/22

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

	at 4:10 p.m., the Assistant Director (AD) indicated she would look for the CPR and first aid certifications for CNA 3, CNA 4, AND QMA 5. During an interview on 8/17/22 at 5:02 p.m., the AD provided a CPR certification for QMA 5. She was unable to locate CPR certifications for CNA 3 and CNA 4. She was unable to locate first aid certifications for CNA 3, CNA 4, or QMA 5. A current policy, titled "Policies and Procedures - Category: Personnel - Certification and Licensure" and provided by the AD on 8/17/22 at 5:51 p.m., indicated " ...Bickford requires Bickford Family Members to maintain current licensure and certification, including CPR and First Aid.			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:	R 0121	This RULE is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of health screening completion for 3 of 3 newly hired employees of the 5 employee records reviewed. No residents were harmed by this deficient practice although potential for harm did exist	09/30/2022

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

(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.

(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.

Based on record review and interview, the facility failed to provide documentation of health screening completion for 3 of 3

Director or designee, RN-C and ACC will have re-training on regulations/policies on tuberculosis screening by 9/2/22. All employee files will be audited by RN-C or designee to insure tuberculosis screening is up to date. Mantoux testing will be completed for any employee whose records show incomplete testing. Upon hire, all new employee's will have first step Mantoux testing completed and read prior to first day of contact with residents.

Divisional Director of Residential Services will audit next 5 new employee charts to insure completion of Mantoux testing.

Date of completion 9/30/22 and on-going.

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

newly hired employees of the 5 employee records reviewed.

Findings include:

The employee files were reviewed on 8/17/22 at 3:48 p.m. and indicated CNA 4, hired on 3/11/22, CNA 6, hired on 7/9/22, and CNA 7, hired on 6/1/21, were lacking health screens.

During an interview, on 8/17/22 at 4:21 p.m., the Assistant Director (AD) indicated she did not believe health screenings were required.

During an interview, on 8/17/22 at 5:32 p.m., the Corporate Consultant indicated he did not believe health screenings had been completed since the pandemic began and could not produce them.

A current policy, titled "Policies and Procedures - Category: Personnel - Personnel File Management" and provided by the Corporate Consultant on 8/17/22 at 5:51 p.m., indicated "...Bickford complies with all federal and state records management laws and regulations ..."

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

Based on record review and interview, the facility failed to provide documentation of health screening completion for 3 of 3 newly hired employees of the 5 employee records reviewed.

Findings include:

The employee files were reviewed on 8/17/22 at 3:48 p.m. and indicated CNA 4, hired on 3/11/22, CNA 6, hired on 7/9/22, and CNA 7, hired on 6/1/21, were lacking health screens.

During an interview, on 8/17/22 at 4:21 p.m., the Assistant Director (AD) indicated she did not believe health screenings were required.

During an interview, on 8/17/22 at 5:32 p.m., the Corporate Consultant indicated he did not believe health screenings had been completed since the pandemic began and could not produce them.

A current policy, titled "Policies and Procedures - Category: Personnel - Personnel File Management" and provided by the Corporate Consultant on 8/17/22 at 5:51 p.m., indicated " ...Bickford complies with all federal and state records management laws and regulations ..."

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

R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interview, the facility failed to ensure drug regimen review was completed by the consultant pharmacist for 1 of 7 residents reviewed for pharmacy services. (Resident 2) Findings include: Resident 2's clinical record was reviewed on 8/17/22 at 9:45 a.m. Diagnoses included, but were not limited to, atrial	R 0298	This RULE is not met as evidenced by: R 298 Based on record review and interview, the facility failed to ensure drug regimen review was completed by the consultant pharmacist for 1 of 7 residents reviewed for pharmacy services. (Resident 2) No residents were negatively affected by this although potential for harm did exist. RN-C, ACC and Pharmacy manager will be re-educated on requirement for pharmacy consultant review every 60 days. All current charts will be audited by October 10th, 2022. Pharmacist will audit all charts on regularly scheduled visits to insure on-going compliance with regulations. At time of visit, pharmacist will review and provide list of audited charts with RN-C or designated staff prior to leaving the branch to insure all resident charts have been audited.	08/30/2022
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

fibrillation, hypertension, hyperlipidemia, diabetes mellitus type 2, and gastroesophageal reflux disease.

The resident's service assessment completed on 12/22/21 indicated her medications were to be given by the facility.

Documentation of the pharmacist drug regimen review was located for 4/22/21, 6/16/21, 8/10/21, 2/23/22, 4/18/22, and 6/29/22.

During an interview, on 8/17/22 at 12:22 p.m., the Assistant Director (AD) indicated she was unable to locate documentation for drug regimen reviews for the resident for October 2021 or December 2021. She indicated she would check with the pharmacist.

During an interview, on 8/17/22 at 2:34 p.m., the AD indicated the pharmacist had not completed a drug regimen review for the resident for December 2021.

Based on record review and interview, the facility failed to ensure drug regimen review was completed by the consultant pharmacist for 1 of 7 residents reviewed for pharmacy services. (Resident 2)

RN-C or designated staff to inform Divisional Director of Residential Services when pharmacy audits are complete and the Divisional Director of Residential Services will audit next 2 pharmacy reviews on all charts to insure all residents have complete pharmacy review.

Date of completion: 8/30/2022 and on-going

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

Findings include:

Resident 2's clinical record was reviewed on 8/17/22 at 9:45 a.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, hyperlipidemia, diabetes mellitus type 2, and gastroesophageal reflux disease.

The resident's service assessment completed on 12/22/21 indicated her medications were to be given by the facility.

Documentation of the pharmacist drug regimen review was located for 4/22/21, 6/16/21, 8/10/21, 2/23/22, 4/18/22, and 6/29/22.

During an interview, on 8/17/22 at 12:22 p.m., the Assistant Director (AD) indicated she was unable to locate documentation for drug regimen reviews for the resident for October 2021 or December 2021. She indicated she would check with the pharmacist.

During an interview, on 8/17/22 at 2:34 p.m., the AD indicated the pharmacist had not completed a drug regimen review for the resident for December 2021.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See

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

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