STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00407080. Complaint IN00407080 - No deficiencies related to the allegations are cited. Survey dates: June 26, 27, 28, 29 and 30, 2023 Facility number: 000094 Provider number: 155178 AIM number: 100290310 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 4 Medicaid: 56 Private: 2 Other: 8 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 7/6/2023.	F 0000	/p> This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Facility Respectfully request paper compliance. ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

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

Roberta Shull | Executive Director | 07/24/2023

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

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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on interview and record review, the facility failed to provide a dignified environment when conducting an interview for 1 of 3 residents reviewed for dignity. (Resident 176)	F 0550	What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	08/08/2023

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	Finding includes: During an interview on 6/26/2023 at 11:20 A.M., Resident 176 indicated she filed a grievance with the Activity Director, during an interview, concerning activities preferences. She indicated she reported a male nurse who insisted on completing code status forms while she was on the bed pan with her gown above her pelvis and bed covers around her private areas. She indicated she informed the male nurse she wanted to be cleaned up prior to completing the code status paperwork. She indicated the male nurse continued to ask questions and wanted her to sign the POST (Physician's Orders for Scope of Treatment) form. She again, informed the nurse she wanted cleaned up prior to completing the paperwork. The male nurse, then left the room, and got a certified nursing assistant (CNA) to complete the care needed. Resident 176 indicated she informed the Director of Nursing (DON) during interview as well. A record review was completed on 6/28/2023 at 11:19 A.M. Diagnoses included, but were not limited to: functional quadriplegia, diabetes mellitus type 2, and pulmonary embolism. Resident 176 was cognitively intact. On 6/28/2023 at 11:33 A.M., a review of the facility's grievance logs was completed. The grievance Resident 176 indicated she reported was not listed on the grievance log. During an interview with the DON, on 6/29/23 at 11:30 A.M., the DON indicated she was not aware of Resident 176's complaint. On 6/29/2023 at 11:40 A.M., during an interview		Resident 176 filed a grievance; investigation was in process. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected, but no other concerns related to dignity were identified. All staff will be educated on customer service related to bedside manner. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. All staff to be educated on customer service related to bedside manner. Social Service Director/designee will follow up with new admissions/readmissions to ensure no dignity concerns are noted during admission process. These admission audits to be conducted with every new admission x 4 weeks, then 3 admissions weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place Results of the audits will be reviewed by the QAPI Committee	

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	with the Activity Director, she indicated during the activity assessment the resident stated she was upset, and told her a male staff member (the Admission's Nurse) had come in and wanted her to sign Do Not Resuscitate (DNR) paperwork. The Activity Director indicated Resident 176 did not say no, but she needed to use the restroom and be cleaned. The activity director indicated resident 176 was covered below the waist, and the nurse proceeded to ask questions about the DNR paper without regard to her dignity and respect. The Activity Director indicated; Resident 176 indicated she felt she was under pressure to sign the paperwork. The Activity Director asked if Resident 176 would like to write a grievance. A grievance form was completed and placed on the receptionist's desk. The Business Office Manger indicated she would scan the form to the Executive Director. A document, titled, "Grievance form, dated 6/23/2023, heard by the Activity Director, indicated, " ...Lit bit around noon the admission nurse cane in to finish my DNR paperwork to sign during this time. I stated to him that I was waiting to be toileted. Staff continued to proceed in asking questions staying there with my gown pulled up because I was wet. He still made me sign the paperwork with no regards to my dignity and respect. I was very uncomfortable ...." The steps to investigate the concern/grievance including: 1. Spoke with Resident 176, and she has no idea who "he" was. 2. A nurse on duty completed the med pass, but no paperwork 3. Education provided to the Activity Director During an interview with the Executive Director on 6/29/2023 at 11:56 A.M., she indicated that the grievance reported from Resident 176 was in her		for a period of at least 6 months to determine the need for further monitoring.	

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	hand and was buried on the desk. The Executive Director indicated she spoke with Resident 176, and Resident 176 had no idea who the nurse was, but described him as a big, fat, black male. On 6/29/2023 at 1:09 P.M., Resident 176 indicated the nurse who was in the room was a white male of average size. On 6/29/2023 at 1:17 P.M., the Executive Director, indicated Resident 176 was upset that the nurse didn't provide toileting care, and sent a CNA into the room to complete the care. A current policy was provided on 6/3/2023 at 1:09 P.M., by the Vice President of Compliance. The policy, titled, "Resident Rights", indicated " ...9. Grievances. The resident has the right to: a.Voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal, such grievances include those with respect to care and treatment which has been furnished as that which has not been furnished; and the behavior of staff and of other residents; and other concerns regarding their LTC [long term care] facility stay. B. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances they may have ...." 3.1-3(t)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.			

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	§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review the facility failed to provide choices for care for 1 of 4 residents reviewed for showering. (Resident 176) Finding includes: During an interview on 6/27/2023 at 9:23 A.M., Resident 176 indicated that she was not given a choice of when to take a shower. She indicated the CNA's (Certified Nursing Assistant) are coming to her room at night to give her a shower. She indicated that she has never taken a shower at night in her life. A record review was completed on 6/28/2023 at 8:33 A.M. Diagnoses included, but were not limited to: anxiety disorder, osteoarthritis, and	F 0561	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 176 preferences have been updated to reflect when resident prefers to take a shower. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the deficient practice. Audit completed to identify current preferences for showers/bathing for all other	08/08/2023

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	congestive heart failure. An Admission Minimum Data Set (MDS) Assessment, dated 6/16/2023, indicated Resident 176 was cognitively intact and required extensive assistance with two or more staff members for bathing. A Care Plan, dated 6/13/2023, indicated Resident 176 had a self-care deficit. The interventions did not address bathing. A Resident Preference Evaluation, dated 6/14/2023 at 2:36 P.M., indicated it was very important to choose between a tub bath, shower, bed bath or sponge bath. On 6/29/2023 at 3:24 P.M., Resident 176 indicated she had only had a shower one time the prior week and the current week. She indicated she had never refused a shower. A form, titled, "C-Wing Day Shift Showers and Evening Shift Showers", indicated Resident 176 shower was scheduled on Mondays and Fridays. The activities of daily living (ADL) documentation indicated Resident 176 received a shower on 6/19/2023 at 7:01 P.M. and on 6/26/2023 at 6:48 P.M. Resident 176 refused showers on 6/12/2023 at 8:45 P.M., 6/16/2023 at 7:59 P.M., and on 6/23/2023 at 8:12 P.M. During an interview on 6/29/2023 at 3:18 P.M., LPN 13 indicated the showers are scheduled twice a week, and the shower days were scheduled based upon "where the load is light" when residents admit to the facility. On 6/30/2023 at 1:09 P.M., the Vice President of		residents. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. Nursing staff educated on ensuring residents are offered showers/baths based on their preferences. Nursing staff in-serviced on completing shower sheets and documenting showers in Point of Care when showers are completed. An updated shower/bathing schedule was developed and presented to nursing staff. UM/designee to review shower sheets from previous day to ensure residents are receiving showers per preference. The shower sheets will be audited by UM/designee daily for 5 days per week x 30 days, then 2 times weekly x 5 months. Random interviews with residents will be conducted throughout this monitoring to validate that showers are being given. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place: Results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.	

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	Compliance provided four forms titled, "Resident Shower Sheet/Skin Concern Documentation". On 6/12/2023, the form indicated Resident 176 refused to have a shower. On 6/16/2023, the form indicated Resident 176 refused her shower, and stated she would take the shower another day. On 6/19/2023, Resident 176 received a shower. On 6/23/2023, the indicated Resident 176 refused to take a shower in the morning. During an interview on 6/30/2023 at 9:00 A.M., the Director of Nursing indicated that Resident Preference Evaluations were completed, but the evaluation does not address specifically the desire for bathing frequency or the time of day. She indicated the staff would ask the resident their preference. There were no forms utilized to document any further preference questions. A current policy was provided on 6/30/2023 at 1:09 P.M., by the Vice President of Compliance. The policy, titled, "Promoting/Maintaining resident Self-Determination", indicated, " ...It is the practice of this facility to protect and promote resident rights by promoting and facilitating resident self-determination through support of resident choice. The facility will ensure that each resident has the opportunity to exercise his/her autonomy regarding those things that are important in his/her life such as interest and preferences ...3. Each resident has the right to choose their schedules (including sleeping, eating, bathing, and waking times), consistent with their interests, assessments, and plans of care ...." 3.1-3(u)(1)			
F 0570 SS=D	483.10(f)(10)(vi) Surety Bond-Security of Personal Funds			

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Bldg. 00	§483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. Based on interview and record review, the facility failed to ensure the Surety Bond amount was sufficient to cover the Resident's personal fund account daily. This deficient practice had the potential to effect 36 of 70 residents who had personal fund accounts in the facility. Finding includes: During an interview, on 6/30/2023 at 7:50 A.M., the Administrator indicated the Surety Bond amount was $70,000.00. On 6/30/2023 at 8:27 A.M., the Business Office Manager provided the monthly balances for the Resident Funds for March, April and May 2023. The balance for March 2023 was $72,188. 90, for April, the balance was $83,156.27. During an interview, on 6/30/2023 at 8:30 A.M., the Administrator indicated the amount of the bond had not covered the resident funds. On 6/30/2023 at 8:52 A.M., the Administrator provided the policy titled, "Surety Bond Requirements", undated, and indicated the policy was the one currently used by the facility The policy indicated,"... Any resident funds that are entrusted to the facility for a resident must be covered by the surety bond, including refundable deposit fees. 2. The surety bond, or alternative to a surety bond, must be equal to or greater than the total amount of resident's funds, as of the	F 0570	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the alleged deficient practice. The Business Office Manager immediately requested an increase to cover current balance. Surety Bond is now $100,000. Signs have been laminated and posted to reflect banking hours. What measures will be put into place and what systematic changes will be made to ensure that the The Business Office Manager and ED were Educated on the Surety Bond Policy Business Office Manager will print current resident trust balance and Surety Bond balance 1 x weekly for 8 weeks, then monthly x 4.	08/08/2023

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	most recent quarter...." 3.1-6(i)		How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place. ED or designee will monitor for compliance weekly x 8 weeks then monthly x 4 months. **The results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph			

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	(g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review, observation and interview, the facility failed to inform a physician of a significant weight loss for 2 of 3 residents reviewed for nutrition. (Resident 59 & 39) Findings include: 1. During an interview, on 6/26/2023 at 10:40 A.M., Resident 59 indicated "they (the staff) say I lost 30 lbs." A record review was completed on 6/28/2023 at 2:41 P.M. Resident 59's diagnoses included, but	F 0580	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. NP was notified of significant weight change and documentation completed for resident #39 and #59. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/08/2023

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	were not limited to: congestive heart failure, dementia, osteoarthritis, chronic kidney disease, retention of urine, and neurogenic bladder. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/17/2023, indicated Resident 59 required extensive staff assist of 1 staff for bed mobility, transfers, dressing and limited assist of 1 staff for toilet use. Resident 59's weights included the following: On 12/16/2022 weight was 171.0. On 1/16/2023 weight was 172.0 On 2/14/2023 weight was 175.2. On 3/7/2023 weight was 174.2. On 4/14/2023 weight was 173.6. On 5/5/2023 weight was 172.8. On 6/13/2023 weight was 149.0. On 6/14/2023 weight was 148.0 On 6/15/2023 weight was 147.0 Resident 59 had a loss 23.8 Lbs. (13.9%) of her body weight in 1 month from May to June and lost 24 Lbs. (12.87%) of her body weight in 6 months from December 2022 to June 2023. A current care plan, dated 6/16/2023, indicated the resident was at risk for altered nutrition/hydration related to weakness, dementia, osteoarthritis, chronic kidney disease and malignant neoplasm of the uterus. Interventions included, but were not limited to notify Physician and family of significant weight changes. A NP (Nurse Practitioner) Note, dated 5/8/2023, indicated Resident 59's weight was documented as 173.6 with no other documentation of a weight change. A NP Note, dated 6/8/2023, indicated Resident		actions will be taken: All weights have been reviewed by the Dietitian; physician notified of any resident with a significant weight change. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. Licensed staff educated on weight monitoring policy and notification of change policy. Residents with significant weight changes to be discussed weekly at NAR. All significant weight changes will be noted with notification to resident/representative and MD. DNS or designee to audit residents with significant weight changes to ensure notification of physician. Audits to be completed weekly x 6 months. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place Results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.	

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	155178	A. BUILDING 00 B. WING	06/30/2023

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	59's weight was documented as 147 with no other documentation of a significant weight loss from May to June and or from December to June. A Progress Note, dated 6/16/2023 at 10:22 A.M., indicated "...RD (Registered Dietician) review: Resident is on a regular diet. Intake varies. No pressure areas per skin assessment dated 6/13/2023. 6/15 wt=147 lbs; 6/14=148 lbs; 6/13 wt=149 lbs; wt 30 days ago=172.8 lbs; 90 days ago=174.2 lbs; 180 days ago (admit wt)=171. Resident 59 had a 13.9% weight decline from May to June. Weight verified x 3. Resident 59 is also 93 year old with dementia diagnosis and weight loss is often unavoidable with dementia. Recommend starting 120 ml (milliliters) med pass (supplement) twice a day to aid in maintaining weight. Nutritional care plan updated. Recommend resident be followed with weekly weights...." The last weight documented was on June 15, with no weekly weights documented after June 15th, 2023. The clinical record lacked the documentation to show the physician had been notified of the significant weight loss in 1 month and in 6 months. 2. A record review was completed on 6/28/2023 at 1:26 P.M. Resident 39's diagnoses included, but were not limited to: chronic kidney disease, scoliosis, urine retention, dementia, anxiety, and encephalopathy. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/31/2023, indicated Resident 39 required extensive assist of 1 staff for bed mobility and dressing, 2 assist for transfers and limited assist for eating. Had no weight loss.			

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A current care plan, dated 5/2/2023, indicated "At risk for inadequate protein/calorie intake and abnormal laboratory values as related to nutritional status: diagnoses of Muscle Wasting & Atrophy, chronic kidney disease, osteoporosis, Pneumonia, and hypomagnesemia. Diet as ordered. Honor resident food preferences as much as is feasible. Monitor lab data as available. Monitor weights as ordered. Notify family/physician of any weight changes. Provide supplements as ordered...."

Resident 39's documented weights:
On 12/19/2022 her weight was 118.4
On 1/12/2023 her weight was 118.4
On 2/13/2023 her weight was 115.2
On 3/15/2023 her weight was 115.6
On 4/11/2023 her weight was 114.2
On 5/5/2023 her weight was 115.0
On 6/20/2023 her weight was 102.2.

Resident 39 was down 11.13% in 1 month from May to June and down 13.68% in 6 months from December to June.

During an interview, on 6/29/2023 at 9:59 A.M., LPN 4 indicated the physician had not been notified of the weight loss per the documentation and should have been.

On 6/30/2023 at 10:07 A.M., the Corporate Nurse provided the policy titled," Notification of Changes", dated October 2022, and indicated the policy was the one currently used by the facility. The policy indicated "...The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification... 2. Significant change in the

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	resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status...." On 6/30/2023 at 10:07 A.M., the Corporate Nurse provided the policy titled, " Weight Monitoring", October 2022, and indicated the policy was the one currently used by the facility. The policy indicated"...6. Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: a. 5% change in weight in 1 month (30 days). b. 7.5% change in weight in 3 months (90 days). c.10 % change in weight in 6 months (180 days)... 7. Documentation: a. The physician should be informed of a significant change in weight...." 3.1-5(a)(3)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey			

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	Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report to state agencies an injury of unknown source for 1 of 1 residents reviewed for injury of unknown source. (Resident 15) Finding includes: A record review was completed, on 6/29/2023 at 10:18 A.M. Resident 15's diagnoses included, but were no limited to depression, osteoarthritis, dementia, anxiety, insomnia, and heart failure. A Significant Change MDS (Minimum Data Set) Assessment, dated 4/18/2023, indicated Resident 15 was severely cognitive impaired, required extensive assist of 2 staff for bed mobility, transfers, toilet use and total assist for bathing, and was incontinent of bladder and bowels. A current care plan, dated 9/30/2021, indicated the resident had a physical functioning deficit related to: Self-care impairment due to history of stroke, dementia, arthritis, and chronic pain. Incontinent of bowel and bladder. Personal hygiene: one assistance. Toileting assistance. Offer to toilet after meals as resident tolerates requires one assist. Initiated on 6/27/2023.	F 0609	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Bruise of unknown origin for Res 15 was reported to ISDH on 7/24/2023. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Progress notes reviewed times past 30 days to identify any other resident with an injury of unknown origin. State agencies notified of any resident identified with an injury of unknown origin. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. Administrator and Director of Nursing Services educated on Abuse, neglect, and exploitation policy and on Indiana State	08/08/2023

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	A Progress Note, dated 5/4/2023 at 5:15 A.M., indicated the Nurse was called to the residents room where a large bruise was noted on the left hip, measuring 40 cm (centimeters =19 inches) in length. The hip area appeared to be swollen. Director of Nursing made aware. A bruise in the middle of her forehead, was also reported to the Director of Nursing. A current care plan, dated 5/4/2023, indicated the resident had bruises to the left hip and mid forehead. Anticoagulant use. Interventions included, but were not limited to: Conduct weekly skin inspection. Measure bruised area upon initial observance and weekly until healed. Notify family and physician of area and any changes. Observe bruised area for signs of enlargement/reabsorbing. Provide treatment to area and observe effectiveness as ordered. During an interview, on 6/30/2023 at 9:55 A.M., the Director of Nursing indicated the bruise was not reported to the state and there was no investigation. She indicated they did an IDT meeting, but no other staff and or residents were interviewed. On 6/29/2023 the Director of Nursing provided a typed paper with the heading (Resident 15's name-room number: date of occurrence 5/4/2023). The paper indicated that the resident's trunk and left hip area were rigid and pronounced off to the left side. The wheel chair was noted to be small and staff reported that when the resident is positioned in the wheelchair, she appears to have minimal clearance between her body and the sides of the wheelchair. Nursing staff also reported that the resident lies in bed favoring her left side even with repositioning.		Department of Health Abuse and incident reporting policy. DNS/designee to review progress notes daily in clinical start up to identify any resident with an injury of unknown origin to ensure injury is investigated and reported per guidelines. These audits to be completed 5 times weekly x 30 days, then 3 times weekly x 30 days, then weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place weeks. Results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.	

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	During an interview, on 6/30/2023 at 11:20 A.M., the Administrator indicated she had nothing for reporting to the state, and no other resident and or staff interviews concerning the bruises. Weekly Skin Reviews completed on 5/8, 5/15, 5/22, 6/3 and 6/10 indicated the resident had redness that was preexisting and an open area that was preexisting documented the same on each review. Review of the weekly skin assessments and Nurse's Progress Notes dated 5/4/2023 to 6/28/2023 lacked the documentation to show the bruised areas had been measured weekly. During an interview, on 6/30/2023 at 11:49 A.M., the Director of Nursing indicated the skin assessments should have been completed with measurements of the bruises but were not. On 6/30/2023 at 10:17 A.M., the Corporate Nurse provided the policy titled, "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations with prescribed timeframe's... d. Injuries of unknown source: Includes circumstances when both the following conditions are met: i. The source of the injury was not observed by any person or could not be explained by the resident, ii The injury is suspicious because of the extent of the injury,			

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	location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time... 6. Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response ass described below... 8. Reporting/Response: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required...." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, record review and interview, the facility failed to ensure a thorough investigation was completed for an injury of unknown origin for 1 of 2 residents reviewed for abuse. (Resident 15)	F 0610	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Investigation completed for bruise of unknown injury for Res 15.	08/08/2023

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	Finding includes: A record review was completed, on 6/29/2023 at 10:18 A.M. Resident 15's diagnoses included, but were no limited to depression, osteoarthritis, dementia, anxiety, insomnia, and heart failure. A Significant Change MDS (Minimum Data Set) Assessment, dated 4/18/2023, indicated Resident 15 was severely cognitive impaired, required extensive assist of 2 staff for bed mobility, transfers, toilet use and total assist for bathing, and was incontinent of bladder and bowels. A current care plan, dated 9/30/2021, indicated the resident had a physical functioning deficit related to: Self-care impairment due to history of stroke, dementia, arthritis, and chronic pain. Incontinent of bowel and bladder. Personal hygiene: one assistance. Toileting assistance. Offer to toilet after meals as resident tolerates requires one assist. Initiated on 6/27/2023. A Progress Note, dated 5/4/2023 at 5:15 A.M., indicated the Nurse was called to the residents room where a large bruise was noted on the left hip, measuring 40 cm (centimeters =19 inches) in length. The hip area appeared to be swollen. Director of Nursing made aware. A bruise in the middle of her forehead, was also reported to the Director of Nursing. A current care plan, dated 5/4/2023, indicated the resident had bruises to the left hip and mid forehead. Anticoagulant use. Interventions included, but were not limited to: Conduct weekly skin inspection. Measure bruised area upon initial observance and weekly until healed. Notify family and physician of area and any changes. Observe bruised area for signs of enlargement/reabsorbing.		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Progress notes reviewed for past 30 days to identify any other resident with an injury of unknow origin. Investigation completed for any identified resident. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. Administrator and Director of Nursing in-serviced on Abuse, Neglect, and exploitation policy and ensuring a thorough investigation is completed for all injuries of unknown origin. DNS/designee to review progress notes daily in clinical start up to identify any resident with an injury of unknown origin to ensure injury is investigated and reported per guidelines. These audits to be completed 5 times weekly x 30 days, then 3 times weekly x 30 days, then weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place weeks. Results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further	

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	Provide treatment to area and observe effectiveness as ordered. During an interview, on 6/30/2023 at 9:55 A.M., the Director of Nursing indicated the bruise was not reported to the state and there was no investigation. She indicated they did an IDT meeting, but no other staff and or residents were interviewed. During an interview, on 6/30/2023 at 11:20 A.M., the Administrator indicated she had nothing for reporting to the state, and no other resident and or staff interviews concerning the bruises. On 6/26/2023 at 11:27 A.M., the Administrator provided the policy titled,"Abuse, Neglect and Exploitation", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property... B. Possible indications of abuse include, but are not limited to: ...3. Physical injury of a resident, of unknown source... V. Investigation of Alleged Abuse, Neglect and Exploitation. A. An immediate investigation is warranted when suspicious of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur... 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 5. Focusing the investigation on determining is abuse, neglect, exploitation, and/or		monitoring.	

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	mistreatment has occurred, the extent, the cause: and 6. Providing complete and thorough documentation of the investigation...." 3.1-28(d)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and			

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	desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review, and interview, the facility failed to develop person-centered care plans related to mood, behaviors, and activities for 3 of 29 residents whose care plans were reviewed. (Residents 14, 37, and 39) Findings include: 1. On 6/28/2023 at 8:51 A.M., a record review was completed. Resident 14's diagnoses included, but were not limited to: dementia, major depressive disorder, bipolar disorder, and anxiety disorder. A current care plan, dated 5/13/2023, indicated Resident 14 had diagnoses of anxiety, bipolar, and depression, and received antidepressant and antipsychotic medications. The care plan goal was the resident will focus on the future and find one enjoyable thing. Interventions included but were not limited to: offer to help resident keep in touch with family, encourage activities, and give medications that help with depression. A current care plan, dated 2/27/2023, indicated	F 0656	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Mood/Behavior and activity care plans for resident #14, #37, and #39 have been updated to include resident centered care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: **All residents have the potential to be affected by the alleged deficient practice. Residents care plans have been reviewed and any noted not to have res centered care plans for mood and behaviors and preferences to include activities have been updated**. What measures will be put into place and what systematic	08/08/2023

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BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

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	resident 14 had cognitive loss related to dementia. The goal for care plan included, but were not limited to: resident developing skills to cope with cognitive decline. Interventions included but were not limited to: administer medications as ordered, encourage family to visit and bring in photos and mementos, and involve in activities that doesn't require resident's ability to communicate. During an interview, on 6/30/2023 at 1:25 P.M., the Director of Nursing indicated care plans should be created based on each resident's preferences. The DON indicated resident 14's care plans were not person centered and should be updated to include the resident's preferences. 2. A record review was completed on 6/29/23 at 08:39 A.M. Resident 37's diagnoses included, but were not limited to: depression, anxiety disorder, and unspecified psychosis. A current care plan, dated 2/27/2023, indicated Resident 37 had mood indicators of being tired, had little energy, and trouble sleeping. The goal of the care plan was the Resident 37 would focus on the future and find one thing they enjoy. Interventions included but were not limited to: encourage resident to get involved in activities related to my interests, keep in contact with family and friends and introduce me to others with similar interests. A current care plan, dated 2/07/2023, indicated Resident 37 had a diagnosis of anxiety whose symptoms include verbalizing worried feelings, and feeling anxious. The goals of the care plan were to demonstrate two or fewer incidents of anxiety weekly and remain comfortable while talking to someone when feeling anxious. Interventions included assisting resident to call		changes will be made to ensure that the deficient practice does not recur. Resident care plans will be monitored and updated quarterly or as indicated with changes. Preferences will be identified in person centered care plan. ED or designee will monitor 5 x weekly for 4 weeks, then 3 times weekly x 4 weeks, then weekly x **4 months** How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place weeks. **The results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.**	

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	family and offer psychiatric services. A current care plan, dated 2/07/2023, indicated Resident 37 had a diagnosis of depression. The goals were to eat in the dining room three times a week, participating in an activity of choice daily, and will voice feelings of happiness when asked. Interventions included assisting resident in talking about her feelings and offer psychiatric services. During an interview, on 6/30/2023 at 1:30 P.M., the Director of Nursing indicated care plans should be created based on each resident's preferences. The DON indicated Resident 37's care plans were not person centered and should have been updated to include the resident's preferences. 3. During an observation, on 6/27/2023 at 9:45 A.M., Resident 39 was observed in bed. A record review was completed on 6/28/2023 at 1:26 P.M. Resident 39 diagnoses included, but were not limited to chronic kidney disease, scoliosis, urine retention, dementia, anxiety, and encephalopathy. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/31/2023, indicated Resident 39 required extensive assist of 1 staff for bed mobility, dressing, and 2 assist for transfers and toilet use. It was documented in the activity section somewhat important to do things with groups, somewhat important to to her favorite activities. A current care plan, dated 5/2/2023, indicated at times the resident had the following mood indicators: Little interest or pleasure in doing things. "Encourage me to get involved in activities related to my interests. Help me to keep			

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	in contact with family and friends. Offer me food and beverages I like. Please tell my doctor if my symptoms are not improving to see if I need a change in my medication. Take the time to discuss my feelings when I'm feeling sad." During an interview, on 6/29/2023 at 9:08 A.M., the Activity Director indicated she would sing with the resident at times and the resident would come down every now and then to observe activities. The Activity Director indicated she did not have a participation log of when the resident did attend activities. During an interview on 6/29/2023 at 9:21 A.M., the Activity director indicated the care plan was not person centered with activities that the resident likes to do. On 6/30/2023 at 10:07 A.M. the Corporate Nurse provided the policy titled," Comprehensive Care Plans", undated and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of this facility yo develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment... Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives... 1. The care planing process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. f. Resident specific interventions that reflect the			

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	resident's needs and preferences and align with the resident's cultural identity, as indicated...." 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review, and interview, the facility failed to update/revise care plans related to falls, peripherally inserted central catheter (PICC), and significant weight loss for 3	F 0657	What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	08/08/2023

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	of 29 residents whose care plans were reviewed. (Residents 7, 35, and 39) Findings include: 1. During an observation, on 5/26/2023 at 1:50 P.M., Resident 7 was in bed without a fall mat or non-skid strips next to the bed. A record review, completed on 6/29/2023 at 10:40 A.M., indicated Resident 7's diagnoses included, but were not limited to: benign prostatic hyperplasia, non-pressure chronic ulcer of right lower leg, tremor, personality disorder, and insomnia. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/20/2023, indicated Resident 7 had severely impaired cognition, and required extensive assist with bed mobility, transfers, and toilet use. A current care plan, dated, 3/16/2023, indicated Resident 7 had a risk for falls related to history of falls, sitting self on floor from bed and wheelchair, and refusing to ask for assistance from staff when needed. Interventions included but were not limited to: fall mat next to bed when occupied, and non-skid strips to right side of bed. During an interview, on 6/30/2023 at 1:25 P.M., the Director of Nursing indicated that neither the fall mat nor the non-skid strips were being used for Resident 7, and the care plan was not up to date and should have been.2. A record review was completed on 6/28/2023 at 9:05 A.M. Resident 35's diagnoses included, but were not limited to: seizure disorder, neurogenic bladder, depression, paraplegia and spinabifada.		Care plans for Res 35 and 39 were reviewed and revised. Resident 7 no longer resides at facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents with falls, peripherally inserted central catheters, and significant weight loss reviewed to ensure care plans have been revised/updated as needed. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. Licensed staff in-serviced on Care plans Revision Upon Status Change Policy. DNS/designee to review during clinical start up progress notes and new orders to identify residents with falls, peripherally inserted central catheters and significant weight changes to ensure care plans are revised/updated as indicated. Care plans will also be monitored and updated quarterly or as indicated with changes. These audits to be completed 5 times weekly x 30 days, then 3 times weekly x 30 days, then weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place weeks.	

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	A Significant Change MDS (Minimum Data Set) Assessment, dated 3/16/2023, indicated Resident 35 required extensive assist of 2 staff for bed mobility, dressing and total assist for transfers. A current care plan, dated 3/9/2023, indicated the resident had a PICC line and had the potential risk of infection at the site. During an interview, on 6/29/2023 at 9:49 A.M., LPN 4 indicated the resident did have a PICC line a few months ago, but not now. LPN 4 indicated the care plan should have been updated. 3. A record review was completed on 6/28/2023 at 1:26 P.M. Resident 39's diagnoses included, but were not limited to: chronic kidney disease, scoliosis, urine retention, dementia, anxiety, and encephalopathy. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/31/2023, indicated Resident 39 required extensive assist of 1 staff for bed mobility and dressing, 2 assists for transfers and limited assist for eating. Had no weight loss. A current care plan, dated 5/2/2023, indicated the resident was at risk for inadequate protein/calorie intake and abnormal laboratory values as related to nutritional status: diagnoses of Muscle Wasting & Atrophy, chronic kidney disease, osteoporosis, Pneumonia, and hypomagnesemia. Diet as ordered. Honor resident food preferences as much as is feasible. Monitor lab data as available. Monitor weights as ordered. Notify family/physician of any weight changes. Provide supplements as ordered. Resident 39's documented weights: On 12/19/2022 her weight was 118.4		Results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.	

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	On 1/12/2023 her weight was 118.4 On 2/13/2023 her weight was 115.2 On 3/15/2023 her weight was 115.6 On 4/11/2023 her weight was 114.2 On 5/5/2023 her weight was 115.0 On 6/20/2023 her weight was 102.2. Resident 39 was down 11.13% in 1 month from May 2023 to June 2023 and down 13.68% in 6 months from December 2022 to June 2023. During an interview, on 6/29/2023 at 9:59 A.M., LPN 4 indicated the care plan had not been updated with the weight loss. On 6/30/2023 at 10:07 A.M., the Corporate Nurse provided the policy titled, "Care Plan Revisions Upon Status Change", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change... b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options... d. The care plan will be updated with the new or modified interventions... th. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time change is status is identified, to ensure care plan have been updated to reflect current resident needs...." 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good			

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	nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide dressing tasks for 1 of 4 residents reviewed for activity of daily living. (Resident 16) Finding includes: During an interview on 6/27/2023 at 9:00 A.M., Resident 16 indicated he had been in the same clothing for two days, even sleeping in the clothing. He was wearing green Notre Dame pants, a veteran's t-shirt, an a red/black plaid flannel. On 6/27/2023 at 3:47 P.M., Resident 16 was observed sitting outside with blue sweatpants, a pullover shirt with buttoned neck, and a t-shirt. A record review was completed on 6/27/2023 at 3:47 P.M. Diagnoses included, but were not limited to: fatigue, post traumatic stress disorder, and dementia. An Annual Minimum Data Set (MDS) Assessment, dated 5/25/2023, indicated Resident 16 was cognitively intact, and required extensive assistance with the assistance of one staff member for dressing. A Care Plan, dated 6/18/2023, indicated Resident 16 had a physical functioning deficit related to mobility impairment related to increased weakness and fatigue. An intervention included assistance of 1-2 staff members as needed for dressing assistance. A Care Plan dated 1/4/2022, indicated Resident 16 had mood indicators. Refusal of care was not	F 0677	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. **Resident 16 was offered and assisted to change into night clothing. Resident will be provided and assisted with clean clothing daily.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: **All residents have the potential to be affected by the alleged deficient practice.** What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. **The nursing staff has been educated on the Activities of Daily Living Policy to include assisting res with changing clothing in the AM and PM. Audit will be completed by the ED or designee at various times and on various shifts to observe res is dressed per preference x 5; 5 x weekly for 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.** How the corrective action will be monitored to ensure the deficient practice will not recur ie what	08/08/2023

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	indicated on the care plan. On 6/28/2023 at 8:23 P.M., Resident 16 was observed wearing plaid flannel pants, polo shirt, and a pullover sweatshirt. On 6/29/2023 at 10:20 A.M., Resident 16 was observed wearing the same clothing as on 6/28/2023. During an interview on 6/29/2023 at 11:31 A.M., the Director of Nursing (DON) indicated bedtime routines should include changing the resident into their bedtime clothing. During an interview on 6/29/2023 at 11:49 A.M., Resident 16 indicated he was wearing the same clothing from the previous day, and slept in his clothing. He indicated he did not want to sleep in his clothing. A policy was provided on 6/30/2023 at 1:09 P.M., by the Vice President of Compliance. The policy titled, "Activities of Daily Living (ADLs)", indicated, " ...Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care ...3. The resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene ...." 3.1-38(b)(4)		quality assurance will be put into place weeks. **The results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure that a fractured humerus was mobilized in a sling per the physician order, and notify the physician of the resident's noncompliance for 1 of 1 residents reviewed for range of motion. (Resident 56). Finding includes: During an observation on 6/26/2023 at 11:08 A.M., Resident 56 was observed sitting in the hallway with a sling to her right arm. The sling did not immobilize the arm, and Resident 56 had her right arm resting on the wheelchair armrest with the right arm improperly positioned in the sling pocket to provide immobilization. A record review was completed on 6/29/2023 at 10:03 A.M. Diagnoses included, but were not limited to: fracture of right humerus, atrial fibrillation, and hypertension. A diagnostic imaging report of the right shoulder on 6/13/2023, indicated Resident 56 had an acute appearing fracture of the surgical neck and greater tuberosity. An AfterVisit Summary from the hospital dated 6/13/2023, indicated Resident 56 was seen for a fall with a humeral head fracture. She was prescribed pain medication, a consultation with orthopedics, and given instruction for the use of a sling. The sling instructions indicated, "...A sling supports your forearm. It keeps an injured arm or shoulder	F 0684	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 56 MD was notified residents noncompliance for wearing sling appropriately and Care plan updated. Resident will be educated on and encouraged to wear sling appropriately for proper placement and healing. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Residents with orders for slings have the potential to be affected by the alleged deficient practice. An audit will be completed to assure any other residents that have orders for slings have them on per orders and are in proper placement and MD notified if non-compliant. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. Nursing staff will be educated on	08/08/2023

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	from moving ...." A Physician's order dated 6/14/2023, indicated " ...Sling to be worn to right arm at all times. May remove for bathing, hygiene, dressing ...." A Care Plan dated 6/14/2023, indicated Resident 56 had a fracture of the right shoulder related to a fall. The goal was to have the fracture heal without complications. The interventions included, but were not limited to, assist Resident 56 with repositioning of her sling and observe to assist in preventing unnecessary rubbing or irritation, ensure mobility restrictions were reviewed and adhered to, and sling to be worn to the right upper extremity as ordered. A Significant Change Minimum Data Set (MDS) Assessment, dated 6/16/2023, indicated Resident 56 had moderate cognitive impairment. She required extensive assistance with two or more staff members for bed mobility and extensive assistance with one staff member for transfers. The MDS indicated Resident 56 had a fall with major injury. An Orthopedic Office Visit Note, dated 6/26/2023, indicated, " ...Patient is here today for evaluation and treatment of the right humerus fracture she suffered on 6/16/2023. Pain is 10/10 Patient states the pain is so bad it makes her sick to her stomach. ..." The Office Note had recommendations given, including no weight bearing on affected side, protected activities, and continued use of the sling. A document titled, Skilled Nursing Facility Orders, dated 6/29/2023, indicated for Resident 56 to wear her sling at all times, be non-weightbearing on the affected upper extremity and to keep the arm		the prevention of decline in Range of Motion policy to include splint usage and notification of non-compliance. DNS or designee will complete audits 5 times a week on various shifts to assure splints are in place and worn appropriately and if noncompliant MD is notified x 4 weeks, then 3 x a week x 4 weeks, then weekly x 4 months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	protected for activities. During an observation on 6/29/2023 at 10:41 A.M., Resident 56 was observed lying in bed in a facility gown. Her sling was lying on her chest and her right arm was lying beside her in the bed. During an interview on 6/29/2023 at 10:52 A.M., Licensed Practical Nurse 14 (LPN), indicated Resident 56 was last seen around 7:30 A.M., when her breakfast tray was served in her room, and possibly seen by the Qualified Medication Assistant (QMA) for medication administration. LPN 14 indicated Resident 56 was to wear the right arm sling at all times except for bathing, hygiene, and dressing. LPN 14 indicated she was not sure if Resident 56 had issues with keeping the sling in place, and a negative outcome could happen if the sling was not kept in place or worn correctly. LPN 14 indicated she would notify the physician if she noted Resident 56 of wearing the sling improperly or being non-compliant with its use. On 6/29/2023 at 11:00 A.M., LPN 14 observed Resident 56 with the sling off. Resident 56 responded, "It hurts so bad it is giving me a headache. 3.1-37			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent			

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	pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview, record review, and observation, the facility failed to ensure infection control practices were maintained during the care of a pressure ulcer to prevent the spread of infection for 1 of 1 resident reviewed for pressure ulcers. (Resident 35) Finding includes: During an interview, on 6/27/2023 at 9:13 A.M., Resident 35 indicated she had pressure areas to her buttocks. A record review was completed on 6/29/2023 at 1:57 P.M. Resident 35's diagnoses included, but were not limited to: seizure disorder, anemia, neurogenic bladder, depression, paraplegia and spinabifada. A Significant Change MDS (Minimum Data Set) Assessment, dated 3/16/2023, indicated Resident 35 required extensive staff assist of 2 for bed mobility, dressing, and total assist of 2 staff for transfers. Had an Indwelling Foley catheter and pressure ulcers: 1 stage II, 1 stage III and 1 stage IV. During a pressure ulcer treatment administration, on 6/28/2023 at 9:29 A.M., the following was observed: RN 5 applied gloves, then remove them and left the room to get gauze. She then returned	F 0686	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. RN5 educated on clean dressing change policy and hand hygiene policy. RN5 was observed completing a wound dressing change by Resource Nurse utilizing wound care validation checklist How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents with pressure ulcers have the potential to be affected by this deficient practice. Licensed staff educated on clean dressing change policy and hand hygiene policy. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur; Licensed staff educated on Clean dressing change policy and hand hygiene policy. DNS/designee to	08/08/2023

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	to the room and applied gloves. RN 5 sprayed wound cleanser to a piece of gauze and wiped from top to bottom in the right groin area and with the same gauze, she wiped the left side groin area. She then removed her gloves, threw them on the floor and applied new gloves with no hand washing after removal of the dirty gloves. RN 5 applied Desitin (barrier cream) to both sides of the groin area and to the right posterior thigh, then removed her gloves and threw on the floor. Without washing hands, she applied gloves again and opened a foam dressing package. RN 5 applied the dressing to the right post upper thigh indicating it was an unstageable area on top of the area that had desitin. She removed her gloves, threw on the floor, and applied new gloves and wiped a small amount of bowel movement from the anal area. She removed the gloves and put on the floor, and indicated she had to get a q tip. RN 5 returned and then applied new gloves with no hand washing. She placed a pair of scissors on the bed sheet and then removed a container of a packing strip and with the q-tip, she packed the packing strip into an open area to the coccyx. She cut the strip and placed the scissors back on the bed sheet. She removed her gloves, placed on the floor and with no hand washing, applied gloves and removed a foam dressing from the package and applied it to the area she had just packed. RN 5 applied more desitin to the entire area, and removed her gloves, threw on the floor, and with no hand washing, applied another foam dressing to the top of the first dressing she applied. RN 5 then took all the trash off the floor and placed in a plastic bag. She used a wipe to wipe the floor and then removed her gloves and washed her hands. During an interview, on 6/27/2023 at 10:00 A.M., the RN 5 indicated she should have washed her hands or used hand sanitizer after removing her		observe Licensed staff completing wound dressing changes. These observations to be random and include all shifts. DNS or designee will complete audits 5 times a week x 4 weeks, then 3 x a week x 4 weeks, then weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place Results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.	

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	gloves, should have cleaned the scissors before cutting the packing strip and should not have put the trash on the floor. On 6/30/2023 at 10:07 A.M., the Corporate Nurse provided the policy titled,"Hand Hygiene", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is a general term for cleaning your hands by hand-washing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR)...6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves...." 3.1-40			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was			

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	necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to provide timely incontinence care and implement infection control practices to prevent the spread of infection for 1 of 2 residents reviewed for urinary incontinence (Resident 15) and failed to provide timely physician ordered testing for a resident with hematuria, urine retention, and pain in the abdomen for 1 of 3 residents (Resident 172) reviewed for urinary tract infection. Findings include: 1.During an interview, on 6/27/2023 at 9:57 A.M., the family of Resident 15 indicated the resident "is left in the dining room and the staff don't change her. The staff have not changed or checked on her for 2-3 hours." A record review was completed, on 6/29/2023 at 10:18 A.M. Resident 15's diagnoses included, but	F 0690	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. CNA 17 educated on incontinence policy and perineal care policy. MD notified that lab testing for Res 172 was not timely. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Nursing staff educated on incontinence policy and perineal care policy. Residents who received lab testing related to symptoms for urinary tract infection for past 30 days reviewed to ensure that testing was	08/08/2023

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	were no limited to depression, osteoarthritis, dementia, anxiety, insomnia, and heart failure. A Significant Change MDS (Minimum Data Set) Assessment, dated 4/18/2023, indicated Resident 15 was severely cognitive impaired, required extensive assist of 2 staff for bed mobility, transfers, toilet use and total assist for bathing, and was always incontinent of bladder and bowels. A current care plan, dated 9/30/2021, indicated the resident had a physical functioning deficit related to: Self-care impairment due to history of stroke, dementia, arthritis, and chronic pain. Incontinent of bowel and bladder. Personal hygiene: one assistance. Toileting assistance. Offer to toilet after meals as resident tolerates requires one assist. Initiated on 6/27/2023. A current care plan, dated 6/21/2019, indicated the resident had an alteration in elimination of bowel and bladder. History of UTI's, (urinary tract infections). Incontinence of bowel and bladder. Check and change prn (as needed). Use of briefs/pads for incontinence protection. An Incontinent Report, dated 5/31/2023 through 6/30/2023, lacked the documentation to show Resident 15 was being checked and or toileted every 2 hours. On 6/28/2023 at 9:21 A.M., QMA 15 removed the resident from the dining room and took to her room. QMA 15 indicated she was going to change her shirt because she had pudding on it. QMA brought Resident 15 back out of the room without being toileted. On 6/28/2023 at 11:39 A.M., Resident 15 was		completed timely. MD notified of any resident who did not receive timely testing. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. Nursing staff in-serviced on incontinence care policy and perineal care policy. Licensed nursing staff in-serviced on Diagnostic Testing Services policy and Lab Services and Reporting Policy and ensuring that MD is notified if testing cannot be completed timely. Nurse Manager/designee to round on units to ensure residents being provided timely incontinence care and implement infection control practices to prevent the spread of infection when providing perineal care. These observations to be random and include all shifts. Rounding/observations to be completed daily x 30 days, then 3 times weekly times 30 days, then weekly x 4 months. DNS/designee to review in clinical start up new orders for lab/diagnostic testing related to symptoms for urinary tract infection and to ensure tests are completed and MD aware of any tests that are not completed timely. These audits to be completed 5 times weekly x 30 days, then 3 times weekly x 30	

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	observed in the dining room. The meal tray was brought in at 12:05 P.M. Resident 15 was not observed to be toileted prior to the lunch meal. On 6/28/2023 at 1:53 P.M., LPN 7 brought the resident to her room and pulled her brief down a little from the front and indicated ," she was a little wet." On 6/28/2023 at 1:55 P.M., CNA 17 entered the residents room and applied gloves. She assisted the resident to stand and pivot to the bed and the pulled her pants down. Having the same gloves on she removed the soaked brief along with 2 other peri pads that were soaked. CNA 17 indicated there should have only been 1 pad and not 2 inside the brief. CNA 17 used a wet towel to wipe the groin area on the left side and on the right side. CNA 17 repositioned the resident on her left side and wiped the right buttocks with a wet towel. She moved over to the other side of the bed and repositioned the resident on the right side. CNA 17 used the wet towel to wipe the left buttocks, then repositioned the resident on her back and spread her legs apart to expose the vaginal area. The area was observed with pieces of dried feces. CNA 17 took another towel, wet it in the bathroom and wiped the peri area again. CNA 17 moved the resident in bed, touched the bed control, the linens, and the clean brief. She applied the new brief, and touched the residents' clothes. CNA 17 went to the closet and picked out another pair of pants. CNA 17 applied the pants, fixed the bed linens and touched the bed control to move the bed into a lower position. CNA 17 completed the incontinence care wearing the same gloves from dirty areas to clean areas and performed no hand washing during the procedure. During an interview, on 6/28/2023 at 2:24 P.M.,		days, then weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place Results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.	

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	CNA 17 indicated she should have washed her hands, changed gloves and used soap and water to clean the resident. On 6/30/2023 at 10:07 A.M., the Corporate Nurse provided the policy titled," Incontinence", undated, and indicated the policy was the one currently used by the facility. The policy indicated "... Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services... 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible...." On 6/30/2023 at 10:07 A.M., the Corporate Nurse provided the policy titled,"Hand Hygiene", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is a general term for cleaning your hands by hand-washing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR)...6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves...." 2. During an interview with Resident 172 on 6/26/2023 at 10:00 A.M., Resident 172 indicated she had been at the facility for a week, and developed a urinary tract infection. She indicated 1000 milliliters of urine was drained from her bladder the previous evening and was experiencing burning. She indicated as soon as her bladder was drained of the urine, she had			

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	immediate relief. On 6/26/2023 at 2:04 P.M., Resident 172 indicated she was receiving an antibiotic and waiting for urine culture results. A Care Plan on 6/26/2023 indicated Resident 172 had a urinary tract infection related to hematuria, burning, and incomplete bladder emptying. An intervention included to obtain and monitor lab/diagnostic work as ordered, and report results to physician and follow up as indicated. A clinical record review was completed on 6/28/2023 at 9:30 A.M. Diagnoses included, but were not limited to: acute kidney failure, anxiety disorder, and depressive disorder. An Admission Minimum Data Set (MDS) Assessment on 6/19/2023, indicated Resident 172 was cognitively intact. She was frequently incontinent of bladder and bowel. A Nurse's Note on 6/25/2023 at 7:41 P.M., indicated Resident 172 presented with complaints of burning with urination and blood in the urine. Keflex (antibiotic) was ordered. A Nurse's Note on 6/25/2023 at 8:06 P.M., 1000 cc of urine was obtained during a straight catheterization. A Physician's Note on 6/26/2023, indicated Resident 172 was seen for follow up of additional lab results as well as complains of dysuria, hematuria, and lower abdominal/pelvic pain. Physician Orders were obtained on 6/27/2023. The orders included: monitor output every shift, Flomax 0.4 mg (milligrams) once daily, KUB			

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	(kidney, ureter, and bladder) x-ray, STAT (immediately, without delay), a urology consult for incidental triple phosphate renal calculi, and lab orders of a complete blood count with differential, comprehensive metabolic panel, magnesium, phosphorus, and uric acid level. On 6/28/2023 at 2:05 P.M., Resident 172 indicated around 11:00 P.M. last night, the facility performed a straight catheterization, and obtained around another 1000 cc (cubic centimeter) of urine due to not urinating all day. She indicated after this happened; LPN 13 informed her of many test that had been ordered. Resident 172 indicated she was having abdominal pressure.The KUB x-ray was signed off on the Treatment Administration Record on 6/28/2023 at 1:45 P.M. The renal ultrasound was not signed off on the administration record. On 6/29/2023 at 11:09 A.M., Resident 172 indicated she was urinating, and she had a blood draw this morning. She indicated the x-ray and renal ultrasound had not been performed. She continued to have red urine. During an interview on 6/30/2023 at 10:28 A.M., the Medical Records Coordinator indicated that the laboratory results had not been received by the facility for review, they were in the nurse practitioner binder for review. On 6/30/2023 at 10:30 A.M., during an interview, Resident 172 indicated she continued to urinate, and the ultrasound and x-ray were completed about ten minutes ago. On 6/30/2023 at 10:36 A.M., LPN 13 indicated she ordered the renal ultrasound as STAT, and the radiology company just came today to complete			

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	the ultrasound. A policy for sling use was requested on 6/30/2023 at 11:49 A.M. The Administrator did not provide the requested policy prior to the survey exit. On 6/30/2023 at 10:47 A.M., LPN 13 indicated the order for the renal ultrasound was placed accidently as STAT. During an interview on 6/30/2023 at 10:48 A.M., RN 5 indicated ordered labs for an acute issue should be completed the next morning. She indicated radiology orders should be completed the next day, but an ultrasound could take longer. She indicated she would contact the radiology company to see when the orders would be completed, and then contact the physician to inform if a wait period would occur, so the resident could possibly be sent to the emergency room to complete needed testing. A policy for labs testing, radiology testing, and following physician orders was requested on 6/30/2023 at 11:49 A.M., The Director of Nursing did not provide the policies prior to the survey's exit. 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the			

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	comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was stored and maintained per physicians orders and standard of practice for 1 of 1 residents reviewed. (Resident 175) Finding includes: During an observation on 6/26/2023 at 10:19 A.M., the continuous positive airway pressure (C-Pap) mask was located on the bed, the oxygen concentrator tubing was not dated, and the portable oxygen tubing was observed on the seat of the wheelchair. On 6/26/2023 at 2:40 P.M., the oxygen concentrator tubing was observed on the floor, and the portable oxygen tubing was observed in the seat of the wheelchair. The tubing continued to not be dated. During an observation on 6/27/2023 at 3:36 P.M., Resident 175 was observed with the nasal cannula in his nose while wearing his C-Pap machine. The nasal cannula was disconnected from the oxygen concentrator, and the connection of the nasal canula was observed on the floor. A record review was completed on 6/28/2023 at 10:21 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes mellitus type 2, and chronic lymphocytic leukemia of B-call type in remission. Physician's Orders dated 6/23/2023, indicated, change and date all oxygen tubing every night	F 0695	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident no longer resides in this facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents with orders for oxygen and/or CPAP have the potential to be affected. An audit of all residents with oxygen and or CPAP will be completed to assure all items are stored and dated appropriately. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. Nursing staff will be educated on the Oxygen Policy to include proper storage and dating of oxygen tubing and CPAP equipment. DNS or designee will complete audits 5 times a week on various shifts to observe that oxygen and CPAP tubing is stored to avoid contamination and tubing is date appropriately x 4 weeks, then 3 x a week x 4 weeks, then weekly x 4 months. How the corrective action will be	08/08/2023

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BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

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	shift on Sunday midnight shift and as needed for soilage, and may use home Bi-Pap/C-Pap (bilevel positive airway pressure/continuous positive airway pressure) device as needed and at bedtime. A Care Plan dated 6/26/2023 indicated Resident 175 had altered respiratory status/difficulty breathing related to congestive heart failure and COPD. Resident 175 had a Care Plan that indicated a -BiPap machine while sleeping related to COPD. During an observation on 6/28/2023 at 1:48 P.M., the portable oxygen nasal cannula was observed on the seat of the wheelchair. On 6/29/2023 at 10:49 A.M., the C-Pap was observed lying on the bedside table. During an interview on 6/29/2023 at 3:29 P.M., LPN 13 indicated that a C-pap mask should be stored in a dated respiratory bag when not in use, and oxygen tubing should be in a dated respiratory bag when not in use, dated, and changed weekly. A policy was provided on 6/30/2023 at 1:09 P.M., by the Vice President of Compliance. The policy, titled, "Oxygen Concentrator" indicated, " ...The purpose of this policy is to establish responsibilities for the care and use of oxygen concentrators ...5.Care of the Concentrator: c. Nurse responsibilities: i. Change oxygen tubing and mask/weekly and as needed if it becomes soiled or contaminated ...." On 6/30/2023 at 1:55 P.M., a policy titled, "Noninvasive Ventilation (CPAP, BiPAP< AVAPS, Trilogy) was provided by the Administrator in Training. The policy indicated, " ...It is the policy of this facility to provide		monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place **The results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.**	

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	noninvasive ventilation as per physician's orders and current standards of practice ...." 3.1-47(a)			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to have 8 consecutive hours of RN coverage in the facility. Finding includes: The PBJ (Payroll Based Journal) staffing data report dated January, February, and March 2023, indicated the facility did not have 8 hours of continuous RN coverage on the following dates: 1/28/2023, and 2/25/2023; 2/11/2023 only 1.7 hours covered, 2/17/2023 only 5.68 hours covered, 3/11/2023 only 1.5 hours covered, 3/25/2023 5.77 hours covered, and 3/19/2023 only 7.87 hours covered. During an interview, on 6/28/2023 at 2:47 P.M., the	F 0727	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents have been affected by the alleged deficient practice How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: No other residents have been affected by the alleged deficient practice. What measures will be put into	08/08/2023

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	Director of Nursing (DON) indicated the facility staffs the day shift with 1 Registered Nurse (RN), 2 Licensed Practical Nurses (LPN), and 6 Certified Nurse's Aides (CNA). They staff evening shifts with 2 LPNs, 2 Qualified Medication Aides (QMA) and 6 CNAs, and night shift should be staffed with 1 RN, 1 LPN, and 3 CNAs. The DON indicated if the facility were without RN coverage, the DON would be the one to come in and cover the shift, the facility was without a DON during the time no RN coverage was reported. A policy for RN coverage was requested, and the DON indicated there is no policy for RN coverage. During an interview, on 6/28/2023 at 3:15 P.M., the Administrator indicated the Director of Nursing had not worked the above times for RN coverage, but there should have been 8 consecutive hours of RN coverage on those times. On 6/30/2023 at 1:45 P.M., a copy of the "Facility Wide Assessment" was provided by the Administrator. In section 3, titled "Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies", the staff plan indicated 8 hours of RN coverage should be provided by the facility every day shift, and every night shift. 3.1-17(b)(3)		place and what systematic changes will be made to ensure that the deficient practice does not recur. DNS and Scheduler were educated on the nursing staff and sufficient staffing policy to include RN 8 consecutive hours a day. DNS or designee will monitor compliance 5 times a week on all shifts for compliance x 4 weeks, then 3 x a week x 4 weeks, then weekly x 4 weeks unless non compliance continues. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place DNS or designee will audit schedule 5 x weekly x 4 weeks, then 3 times weekly x 4 week, and then monthly x 4 months. : **The results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when			

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	applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure a medication room was locked when not in use for 1of 1 medication rooms randomly observed. (Hall 100 medication room) Finding includes: During a random observation, on 6/30/2023 at 4:38 A.M., the medication door was observed propped open with a trash can and not locked. During an interview, on 6/30/2023 at 4:40 A.M., LPN 12 indicated the door should not have been propped open, On 6/30/2023 at 10:07 A.M., the Corporate Nurse provided the policy titled,"Medication Storage", undated, and indicated the policy was the one	F 0761	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents have the potential to be affected by the deficient practice. Nursing staff in-serviced on Medication Storage Policy to include medication storage rooms to be always locked. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the deficient practice. Nursing staff in-serviced	08/08/2023

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	currently used by the facility. The policy indicated "...a. All drugs and biological's will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls...." 3.1-25(m)		on Medication Storage Policy to include medication storage rooms to be always locked. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur. DNS/designee will observe medication rooms to ensure doors are always locked. These observations to be random and occur on all shifts and be conducted 5 times weekly x 2 weeks, then 3 times weekly x 2 weeks, then weekly x 5 months. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place Results of the audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.			

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	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure food items in the freezer were dated/labeled and sealed securely after opening and to ensure cooking utensils, skillets, microwave, and refrigerators were clean and in good condition in one kitchen observed. This deficient practice had the potential to affect 68 of 70 residents who received meals out of the kitchen. Finding includes: On 6/27/2023 at 10:49 A. M., during a follow up observation of the kitchen with Cook 3, the following were observed: -4 of 12 metal scoops had dried food substances on them. -A skillet had missing areas of black Teflon around the edges and on the skillet base. -The microwave had an area that appeared to be burnt with peeling plastic along the top edge. The refrigerator had a dried substance along the rubber seals. -The steam table had brown stains of grease running down the front of the table and 8 cans of vegetables/fruits that were dented.	F 0812	The facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. No residents were harmed in the observations made *What corrective actions will be accomplished for those residents found to have been affected by the deficient actions: The microwave was replaced on the day of the observation-June 27th. The scoops that were dirty were removed from service on June 27th and sent thru the dish machine. The items found that were not closed properly and w/ no open dates in the freezer were discarded by the Regional CDM on June 26th. The Teflon skillet in question was discarded immediately. The Regional RDN, checked all other	08/08/2023

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	During an interview, on 6/27/23 at 11:00A.M, Cook 3 indicated: the scoops should have been cleaned; the skillet and the the microwave should not have been used, the refrigerator and steam table should have been cleaned, the scoops should have been cleaned, and there should not have dented cans of foods in the pantry. On 6/27/2023 at 3:17 P.M., the Regional Dietician provided the policy tiled, "Food Safety Requirements", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms... Equipment used in the handling of food, includes dishes, utensils, mixers, grinders, and other equipment that comes in contact with food... Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage. Follow contract/vendor procedures when food arrives damage or concerns are noted. Remove these foods from use... All equipment used in the handling of foods shall be cleaned and sanitized, and handled in a manner to prevent contamination...." 3.1-21(3)		pans for issues and discarded those not in good condition on June 27th. The seal on the reach in cooler was cleaned on June 27th. Dented cans were removed from the storeroom on June 26th by the Regional CDM. The steam table was cleaned on all sides on June 27th. *What measures will be put into place or what systemic changes will be made to ensure that the deficient practices will not recur: An audit tool for monitoring the deficient practices has been developed-see attached. Audits will be completed by the DSM or designee 5x per week for 1 month; 3x per for 1 month; and then weekly x 4 months for a total of 6 months unless further monitoring is deemed necessary. Monitoring times will vary to include all shifts. *How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place: Audit tool findings and trends will be reviewed in QAPI on a monthly basis for 6 months unless further monitoring is deemed necessary.	

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