STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155375	A. BUILDING 00 B. WING	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - PETERSBURG CARE CENTER	309 W PIKE AVE PETERSBURG, IN 47567

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00437005. Complaint IN00437005 - Federal/state deficiencies related to the allegations are cited at F921. Survey dates: August 5, 6, 7, 8, 9, 2024 Facility number: 000033 Provider number: 155375 AIM number: 100266280 Census Bed Type: SNF/NF: 42 Total: 42 Census Payor Type: Medicare: 4 Medicaid: 36 Other: 2 Total: 42 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 21, 2024.	F 0000		
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation, interview, and record review the facility failed to accommodate resident needs for 2 of 13 residents reviewed for call lights within reach. One resident failed to have an available call system in her room and one	F 0558	Facility is requesting paper compliance for this alleged deficient practice. What corrective action will be	09/02/2024

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

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	resident's call light was not within reach. (Resident 26, Resident 38) Findings include: 1. On 8/5/24 at 1:45 P.M., Resident 26 was observed sitting up in a recliner with her call light lying on the floor next to the dresser. On 8/8/24 at 9:47 A.M., Resident 26 was observed sitting up in a recliner with her head covered with a blanket and the call light lying on the floor next to the dresser. On 8/8/24 at 2:45 P.M., Resident 26 was observed sitting in her recliner while the call light was lying on the floor next to the dresser. On 8/9/24 at 11:20 A.M., Resident 26's medical records were reviewed. Diagnosis included, but was not limited to non-Alzheimer's dementia, lymphedema, chronic atrial fibrillation, and heart failure. The most recent Annual and State-Optional MDS (Minimum Data Set) Assessment, dated 7/2/24, indicated Resident 26 was severely cognitively impaired, needed supervision of one for bed mobility, transfers, eating and toilet use. The care plan for potential for physical functioning deficit related to: Mobility impairment due to diagnosis of lymphedema, and morbid obesity. Self care impairment r/t (related to) diagnosis of dementia, unsteady gait, muscle weakness, cognitive communication deficit, dated 4/22/2024. Interventions included, but was not limited to call bell within reach. During an interview on 8/9/24 at 9:31 A.M. CNA		accomplished for those residents found to have been affected by the deficient practice: Resident #26 will have a call light attached to her chair and bed. Resident #28, wander guard has been placed on resident wheelchair. Resident #38 has a cow bell in room in place of facilities call bell system due to safety concerns. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice. DNS/Designee to monitor for placement of call lights in resident rooms. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: DNS/Designee to in-service nursing staff on call light policy and procedures. DNS/Designee to monitor for placement of call lights in resident rooms. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: DNS/Designee will monitor random resident rooms for	

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	(Certified Nurse Aide) 14 indicated Resident 26 was able to use the call light and the call lights should be kept within reach of the residents. 2. On 8/7/24 at 9:32 A.M.. Resident 38 was observed lying in bed watching TV with no call light in reach. and unable to see a Wander Guard. On 8/7/24 at 9:45 A.M., CNA 14 entered Resident 38's room to locate the Wander Guard on her left ankle and was unable to locate it. At that time, CNA 14 indicated they were unable to keep a call light in her room due to her throwing things at the staff and breaking things like the clock, window and dresser. Due to Resident 38 becoming agitated that she was being disturbed while watching TV, CNA 14 left the room and notified LPN (Licensed Practical Nurse) 26 that the Wander Guard was no longer on Resident 38's ankle. On 8/8/24 at 9:38 A.M., Resident 38 was observed lying in bed watching TV (television) with a Wander Guard on left ankle and no call device in her room. On 8/9/24 at 9:26 A.M. Resident 38 was observed lying in bed watching TV with a Wander Guard on left ankle and no call device in her room. On 8/6/24 at 3:12 P.M., Resident 38's Medical Records were reviewed. She was admitted on 4/17/24. Diagnosis included, but were not limited to dementia with behavioral disturbance, delusional disorders, anxiety disorder, and major depressive disorder. The most current Significant Change MDS (Minimum Data Set) Assessment, dated 6/27/24, indicated Resident 38 had a moderate cognitive		call-light placement three times weekly for 4 weeks. Two times weekly for 4 weeks. One time monthly for 4 months. This will be reviewed during facility monthly QAPI meeting for 6 months or as needed.	

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	impairment, needed supervision of one for bed mobility, transfer, eating and extensive assistant of one for toilet use. Behaviors indicated Resident 38 had verbal behavioral symptoms directed toward others on 1-3 days. Resident rejected evaluation or care on 4-6 days. Wander/elopement alarm was used daily. The Physician orders included, but were not limited to the following: Check placement and function of device every shift. Record location of device. Replace device if device is not working. Change device one month prior to expiration date. Wander Guard applied to (Location) left ankle, dated 7/15/24 A current ADL (Activities of Daily Living) Care Plan dated 4/19/24, included, but was not limited to the following intervention: Call bell within reach, dated 4/19/24. A current Wandering/Elopement Care Plan, dated 6/24/24, included, but was not limited to the following intervention: Test my Wander Guard every shift for placement/function. Left ankle, dated 4/19/24. A current Elopement Risk Care plan related to: Anger at placement in living center, attempts to leave Living Center, hx (history) of breaking window trying to escape/leave, dated 6/13/2024, included, but was not limited to, the following intervention: Remove all items that are a potential for breaking glass/window, dated 6/7/24. The TAR (Treatment Administration Record) for August 2024 was reviewed and indicated the placement and function of the Wander Guard had been checked every shift from 8/1/24 through			

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	8/6/24. the placement and function of the Wander Guard had not been checked for the day shift on 8/7/24. During an interview on 8/7/24 at 1:44 P.M., LPN 26 indicated Resident 38 had calmed down and she had a new Wander Guard on her left ankle. LPN 26 indicated Resident 38 used to have a cowbell in her room since they couldn't keep a call light in her room. She was not sure what happened to the cowbell, but Resident 38 was incontinent so they checked her frequently. The clinical record lacked documentation of times Resident 38 was checked on by staff. During an interview on 8/8/24 at 1:28 P.M., LPN 26 indicated the Wander Guard was checked by the nurse with a box that checks the function. She indicated the Wander Guard was checked first thing of the morning when passing medication. This was done every shift. On 8/9/24 at 2:23 P.M., the Administrator provided a Call Lights: Accessibility and Timely Response Policy, dated 2023, which indicated "...5. Staff will ensure the call light is within reach of resident and secured..." On 8/9/24 at 2:23 P.M., the Administrator indicated they did not have a policy for the Wander Guard or following orders, but indicated it was their policy to follow provider's orders and care plan interventions. 3.1-3(v)(1)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility	F 0641	Requesting and IDR for reasons:	09/02/2024

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	failed to ensure Minimum Data Set (MDS) Assessments were completed accurately for 3 of 8 resident MDS Assessments reviewed (Residents 35, 11, and 43). Findings include: 1. On 8/6/24 at 1:32 P.M., Resident 35's clinical record was reviewed. Diagnosis included, but was not limited to dementia, atherosclerotic heart disease, and chronic systolic heart failure. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 6/25/24, indicated Resident 35 had severe cognitive impairment and administered an antianxiety, antidepressant, anticoagulant and antiplatelet during the 7 day look back period. Current Physician's Orders included, but were not limited to, the following: Aspirin EC (Enteric Coated) Tablet Delayed Release (antiplatelet medication) 81 mg (milligrams), give 1 tablet by mouth one time a day for STEMI (ST-elevation myocardial infarction) related to atherosclerotic heart disease of native coronary artery without angina pectoris, dated 6/17/24 Plavix Oral Tablet (antiplatelet medication) 75 mg, give 1 tablet by mouth one time a day for antiplatelet related to atherosclerotic heart disease of native coronary artery without angina pectoris, dated 6/20/24 alprazolam Oral Tablet (antianxiety medication) 0.25 mg, give 1 tablet by mouth two times a day related to anxiety disorder, dated 6/27/2024 trazodone HCl (hydrochloride) Oral Tablet		Requesting a reduction in the scope and severity as we have sufficient evidence that 3 of the 5 records were accurate. Corrective action for Resident affected by the issue identified in the statement of deficiency: Resident 35: the specific deficiency was corrected on 8/29/2024 by modifying and transmitting the MDS with an ARD of 6/25/24. This was completed by MDS Nurse. Resident 1: MDS was reviewed for accuracy using the current version of the RAI Manual Resident 11: the specific deficiency was corrected on 8/29/2024 by modifying and transmitting the MDS with an ARD of 6/25/24. This was completed by MDS Nurse. Resident 23: MDS was reviewed for accuracy using the current version of the RAI Manual Resident 43: MDS was reviewed for accuracy using the current version of the RAI Manual Identification of residents with potential to be affected by deficient practice identified in the statement of deficiency: Current residents of Peterburg with MDS due have the potential to be affected by the alleged deficient practice. A baseline audit of residents with antiplatelets, diagnosis of PTSD, Schizoaffective, atrial fibrillation, anxiety and depression was completed. Systemic changes	

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	(antidepressant medication) 50 mg, give 1 tablet by mouth two times a day related to depression, dated 6/26/2024 During an interview on 8/9/24 at 1:46 P.M., the Regional Nurse indicated the MDS Coordinator was out of the building at that time, but would have coded the aspirin as an anticoagulant and Plavix as an antiplatelet medication. 2. On 8/7/24 at 11:13 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. The most recent Admission MDS (Minimum Data Set) Assessment, dated 7/25/24, indicated that the resident was cognitively intact and did not have PTSD. Resident 11's care plans included, but were not limited to, the following: " I have a history of trauma related to being robbed at gunpoint. I have PTSD from the event and nightmares. I take psychoactive medication", initiated 7/19/24 During an interview on 8/9/24 at 3:28 P.M., the Regional Nurse indicated Resident 11 should have had PTSD marked on the MDS Assessment if he had a care plan related to it. 3. On 8/7/24 at 3:55 P.M., Resident 43's clinical record was reviewed. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease, anxiety, depression, and schizoaffective disorder. The most recent Admission MDS Assessment, dated 6/21/24 indicated Resident 43's cognition was moderately impaired, used tobacco and did		implemented to address and prevent the recurrence of the issue identified in the statement of deficiency: Re-education provided to the MDS nurse by 8/30/24 on accurate coding of the MDS. If help is needed to ask for it as quickly as possible from her supervisor. Monitoring for the effectiveness and sustainability of the corrective action put in place to correct the issues identified in the statement of deficiency: An audit will be completed for MDS accuracy as it relates to antiplatelets, diagnosis of PTSD, Schizoaffective, atrial fibrillation, anxiety and depression on 5 residents biweekly x 2 months then 5 residents monthly x 4 months. Audit results will be monitored for compliance by the Administrator and reported to our QAPI committee for further review and recommendation until deemed resolved.	

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	not have schizophrenia. Resident 43's care plans included, but were not limited to, the following: " I have a level two determination due to diagnosis of Schizoaffective Disorder, Anxiety disorder, Depressive disorder and Polysubstance Abuse ... ", initiated 6/22/24 During an interview on 8/9/24 at 3:28 P.M., the Regional Nurse indicated schizoaffective disorder was on Resident 43's diagnosis list and it should have been marked on the MDS Assessment. The High-Risk Drug Classes: Use and Indication section of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, dated October 2023, was reviewed and indicated " ... Do not code antiplatelet medications such as aspirin/extended release, dipyridamole [Attia], or clopidogrel [Plavix] as N0415E, Anticoagulant .. " During an interview on 8/9/24 at 3:28 P.M., the Regional Nurse indicated she would expect the active diagnoses of residents to be accurate and to be reflected on the MDS Assessment accurately. At that time, she indicated there was no policy for an MDS Assessment, but they used the RAI manual.			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on observation, interview, and record review, the facility failed to ensure necessary care and complete assessments were provided for 1 of 1 residents reviewed for dialysis. The medical record lacked post dialysis assessment documentation. The facility also lacked a current	F 0698	/p> /p> Resident #11 had no negative outcome d/t this alleged deficient practice. Post dialysis form to be completed after each dialysis	09/02/2024

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	dialysis contract at the time of the survey. (Resident 11) Findings include: On 8/7/24 at 11:13 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. Resident 11 was admitted 7/18/24. The most recent Admission MDS (Minimum Data Set) Assessment, dated 7/25/24, indicated that the resident was cognitively intact and on dialysis. Current Physician's Orders included, but were not limited to, the following: Dialysis treatment on Monday, Wednesday, Friday at 11:45 A.M. (Name, address, and phone number of dialysis facility). Complete pre-dialysis form, ordered 7/23/24 Post dialysis assessment. Assess site for signs/symptoms of bleeding, infection, post dialysis complications. Notify MD (Medical Doctor) of any abnormal changes. Every day shift every Monday, Wednesday, Friday for monitoring, ordered 7/19/24 A current Dialysis Care Plan, dated 7/22/24, included, but was not limited to, the following interventions: Observe and document post-dialysis: vital signs, mental status, excessive weight gain between treatments, nausea, vomiting, weakness, headache, severe leg cramps. Report abnormalities to MD. Resident 11's progress notes were reviewed from 7/18/24 through 8/6/24 and lacked documentation		visit. Post dialysis form to be completed after each dialysis visit. Nursing staff in-service on completion of Dialysis Communication Form. DNS/Designee will monitor completion of form and documentation PCC. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: Nursing staff in-serviced on completion of Dialysis Communication Form. DNS/designee will monitor completion of form and documentation PCC weekly times , then monthly times 4, then quarterly as needed. This will be reviewed through the facility monthly QAPI meetings.	

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	of the time the resident returned from dialysis, time of post dialysis vital signs including temperature, HR (pulse/heart rate), BP (blood pressure), and pain. The progress notes lacked post dialysis assessment of the access site, mental status, heart, edema (swelling)/redness/skin concerns, and symptoms post dialysis. Resident 11's vitals were reviewed and lacked documentation of post dialysis vitals including temperature, HR, BP, and pain. Resident 11's MAR (Medication Administration Record) was reviewed from 7/19/24 through 8/6/24 and lacked post dialysis assessment documentation. On 8/8/24 at 11:30 A.M., all dialysis/observation communication forms for Resident 11 were provided by the DON (Director of Nursing) and indicated the following: "7/22" post dialysis assessment section was not completed 7/24/24 post dialysis assessment section was not completed "7/26" post dialysis assessment section was not completed There was no form provided for 7/31/24 7/29/24 post dialysis assessment section was not completed 8/2/24 post dialysis assessment included resident's name, time completed, time returned from dialysis, temperature, HR (pulse/heart rate), BP (blood pressure), and pain but lacked assessment of access site, mental status, heart, edema/redness/skin concerns, and symptoms post dialysis. 8/5/24 post dialysis assessment included the temperature, HR, and BP, but lacked resident's			

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	name, time completed, time returned from dialysis, and assessment of pain, access site, mental status, heart, edema/redness/skin concerns, and symptoms post dialysis. 8/6/24 post dialysis assessment section was not completed 8/7/24 post dialysis assessment section was not completed On 8/5/24 at 9:50 A.M., during the entrance conference, a current dialysis contract was requested but not provided. During an interview on 8/7/24 at 2:40 P.M., LPN (Licensed Practical Nurse) 44 indicated staff was to fill out the pre assessment section of the dialysis form with the vitals and pre-assessment, then the form was taken to dialysis with the resident where their staff filled out the middle section of form with vitals and assessment during dialysis period, and sent the form back with the resident. When resident returned to the facility, staff should do post dialysis vitals, assess the fistula site, and fill out the post dialysis assessment section of the form. The form should get scanned into the resident's clinical record after it was completed. During an interview on 8/9/24 at 2:18 P.M. the DON indicated Resident 11 was scheduled for dialysis on Monday, Wednesday, and Friday at around noon and returned around 6:00 P.M. to the facility. At that time, she indicated staff should take the resident's vitals and assessments that were asked for on the dialysis form every time resident went to dialysis. She would expect the post dialysis assessment to be completed within 30 minutes after arriving back to the facility. She indicated ideally they would fill out the dialysis form entirely but it would be ok if they put pre and			

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	post vitals and assessments under the vitals section or the progress notes in the clinical record as well as scanned the form into the clinical record when completed. During an interview on 8/7/24 at 2:45 P.M., the Administrator indicated the facility did not have a current contract for (Name of dialysis company). On 8/7/24 at 3:08 P.M., a current non dated Hemodialysis Policy was provided by the Administrator and indicated " ... The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility ... ...documentation requirements are met to assure that treatments are provided...monitor for and identify changes in the resident's behavior that may impact the safe administration of dialysis before and after treatment...5. the licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form, that will include, but not limit itself to, a. timely medication administration (initiated, held or discontinued) ... b. physician/treatment orders, laboratory values, and vital signs. c. Advanced directives and code status ... d. nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions ... f. dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring and/or concerns related to the vascular access site. g. Changes and/or declines in condition unrelated to dialysis ... 8. the nurse will monitor and document the status of the resident's access site(s) upon			

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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
	return from the dialysis treatment to observe for bleeding and other complications ... 12 ... There must be a systematic approach between the facility and the dialysis facility when handling situations where the resident has a condition change and/or becomes ill or unstable during dialysis ... 14. The nurse will ensure that the dialysis access site (e.g. Arteriovenous fistula) is checked before and after dialysis treatments and every shift for patency ... " 3.1-37(a)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to ensure a clean and homelike environment for 6 of 13 resident rooms and 1 of 2 shower rooms observed for environment. Bathrooms had holes in the wall, exposed pipes, a baseboard peeling off, uncovered bedpans, and a floor that was badly scuffed. An air condition unit was falling off the wall in a room. Multiple sink water temperatures were higher then 120 degrees. (Rooms 136, 139, 138, 140, 141, 143, East Shower Room) Findings includes: 1. During an observation on 8/5/24 at 1:39 P.M., Room 136's bathroom was observed with the baseboard behind the toilet peeling off and the floor had multiple scuffs. The water temperature was 120.8 degrees Fahrenheit. At that time, the resident indicated the water was "hot" but denied being burned. During an observation on 8/9/24 at 11:06 A.M., the same was observed but the water temperature	F 0921	Facility is requesting paper compliance for this alleged deficient practice. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Main water source temperature adjusted according to regulation, Hole in bathroom wall, baseboard, soap dispenser, air conditioner cover and floor repaired. All bedpans were covered. Wheelchairs inspected. Excess dishware removed from room. How other residents have the potential to be affected by this alleged deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:	09/02/2024

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	155375	A. BUILDING 00 B. WING	08/09/2024

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	was not rechecked. 2. During an observation on 8/5/24 at 1:50 P.M., Room 139's water temperature was 123.3 degrees Fahrenheit. 3. During an observation on 8/5/24 at 1:52 P.M., Room 138's wheelchair had food debris covering the seat and on the wheels. The water temperature was 122.9 degrees Fahrenheit. At that time, the resident indicated the water was "plenty warm" but denied being burned. During an observation on 8/9/24, the same was observed but the water temperature was not rechecked. 4. During an observation on 8/5/24 2:05 P.M., Room 140's water temperature was 124.2. At that time, the resident indicated they "hardly used it". 5. During an observation on 8/5/24 at 2:07 P.M., Room 141's bathroom had a soap dispenser was not adhered to the stickers by the sink and was sitting on the back of the toilet. An uncovered bed pan was sitting on the floor between the sink and the toilet. In the room, the air conditioner unit was falling off of the wall on the left side. The water temperature was 127.5 degrees Fahrenheit. At that time, the resident indicated they used the sink water "sometimes" but denied being burned. During an observation on 8/9/24 at 11:05 A.M., the same was observed but the water temperature was not rechecked. 6. During an observation on 8/5/24 at 2:13 P.M., Room 143's bathroom had 2 uncovered graduated cylinders with a syringe in one and multiple cups on the countertop of the sink, a plate and two		A new thermometer purchased that can be calibrated. Soap dispensers, baseboards and bathroom flooring been audited for any needed repairs. Nursing, Housekeeping and Maintenance staff in- on monitoring/reporting any repairs needed in resident rooms including cleanliness of wheelchairs and excess dishware. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: Maintenance/Housekeeping/Nursing or Designee will monitor resident rooms for any repairs needed and report to the appropriate department. This will be monitored three times weekly for 4 weeks, two times weekly for 4 weeks, 1 time weekly for 4 weeks, quarterly times 3 or as needed. This will be reviewed through the monthly facility QAPI meeting.	

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	bowls with silverware were in the sink. There were two holes in the wall behind the toilet with pipes visible and 8 clean uncovered wash cloths on top of the paper towel holder. The water temperature was 123.6 degrees Fahrenheit. At that time, the resident indicated he "hardly used" the water from the sink, but a visitor with him indicated it "gets hot pretty quick". During an observation on 8/9/24 at 10:59 A.M., there were still 2 uncovered graduated cylinders with a syringe in one and multiple cups on the countertop of the sink and two holes in the wall behind the toilet with pipes still visible. The water temperature was not rechecked. 7. During an observation on 8/5/24 at 4:00 P.M., the East Hall Shower Room's water temperature was 120.7. During an interview on 8/5/24 at 3:26 P.M., the Maintenance Assistant indicated he checked the water temperatures in the rooms at the end of the halls around 6:30 A.M. every weekday morning. He expected the room water temperatures to be between 110 and 120 degrees Fahrenheit. At that time, he indicated the water lines were in the attic and with the hot temperatures outside, it could cause the water temperatures to elevate some. The East Hall is closest to the water heater. He hasn't been notified of any concerns with the water temperatures recently from staff or residents. During an observation on 8/5/24 from 3:39 P.M. to 4:00 P.M., the Maintenance Assistant checked the water temperatures on the East Hall and indicated the following: Room 136 - 119-120 degrees Fahrenheit Room 138 - 119-120 degrees Fahrenheit Room 139 - 119-120 degrees Fahrenheit			

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	Room 140 - 120 degrees Fahrenheit Room 141 - 124 degrees Fahrenheit Room 142 - 119-120 degrees Fahrenheit Room 143 - 119 degrees Fahrenheit East Hall Shower Room - 120 degrees Fahrenheit During a resident council meeting on 8/7/24 at 2:12 P.M., 3 random residents from the West Hall indicated their water was usually cold and took almost 15 minutes to warm up enough sometimes. One random resident from the East Hall indicated his water was pretty hot but he had never burned himself with it. On 8/8/24 at 2:05 P.M., CNA (Certified Nurse Aide) 55 was observed saying "That's hot" referring to the water when she was washing her hands after performing incontinence care in Room 135 on the East Hall. During an interview on 8/9/24 at 1:50 P.M., the Maintenance Assistant indicated he had that thermometer about a year and didn't know if it's ever been calibrated. He indicated he did turn up the temperature in the West Hall a "smidge" but did nothing to East Hall. On 8/5/24 at 3:35 P.M., the Maintenance Assistant provided the log book documentation from 7/1/24-8/5/24 excluding weekends and in the Steps to Test Water Temperatures, it indicated " ... the dial thermometer is accurate to 1 to 2 degrees Fahrenheit - however it is not precision instrument and should be calibrated on a regular basis ... For burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit, although this temp can still cause burns if exposure reaches five minutes ... " On 8/8/24 at 11:30 A.M., a current non dated Safe			

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	Water Temperatures Policy was provided by the Director of Nursing (DON) and indicated " ... Staff will report abnormal findings, such as complaints of water too cold or hot, burns or redness, or any problems with water temperature ... to the supervisor and/or maintenance staff ... water temperatures will be set to a temperature of no more then 120 degrees Fahrenheit ... " On 8/9/24 at 3:55 P.M., a current non dated Safe and Homelike Environment Policy was provided by the Regional Nurse and indicated " ... the facility will provide a safe, clean, comfortable and homelike environment ... " On 8/9/24 at 3:55 P.M., a current non dated Cleaning and disinfection of Resident Care Equipment Policy was provided by the Regional Nurse and indicated " ... Reusable resident care equipment will be cleaned and disinfected ... Direct care staff are responsible for cleaning single-resident equipment when visibly soiled ... " This citation relates to Complaint IN00437005. 3.1-19(e)			