

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

PRINTED: 12/06/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 11/12/2024	
NAME OF PROVIDER OR SUPPLIER  BRICKYARD HEALTHCARE - RICHMOND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 1042 OAK DR RICHMOND, IN 47374			
(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	<p>This visit was for the Investigation of Complaints IN00446761, IN00446364, and IN00446019</p> <p>Complaint IN00446761 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00446364 - Federal/State deficiencies related to the allegations are cited at F554, F578, F583, F689, F755, F757, F761 and F849.</p> <p>Complaint IN00446019 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: November 6, 7, 8, and 12, 2024</p> <p>Facility number: 000077 Provider number: 155157 AIM number: 100266490</p> <p>Census Bed Type: SNF/NF: 62 Total: 62</p> <p>Census Payor Type: Medicare: 4 Medicaid: 57 Other: 1 Total: 62</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November 15, 2024.</p>			F 0000			
F 0554 SS=D	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Laura Fortkamp

DNS

11/29/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 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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Bldg. 00	<p>Based on observation, interview, and record review, the facility failed to have the interdisciplinary team (IDT) determine and document self-administration of medications were clinically appropriate for 1 of 6 residents reviewed for medication administration. (Resident T)</p> <p>Findings include:</p> <p>The clinical record for Resident T was reviewed on 11/8/24 at 10:20 a.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, dry eye syndrome, and chronic viral hepatitis.</p> <p>An Annual Minimum Data Set (MDS) assessment, completed 9/18/24, indicated she was cognitively intact for daily decision making.</p> <p>On 11/6/24 at 10:55 a.m., Resident T had one blue oblong pill sitting in a medicine cup at the bedside. Resident T indicated she did not want the pill, but did not tell the nurse she didn't, so it was left at the bedside.</p> <p>During an observation of Resident T on 11/7/24 at 11:47 a.m., one bottle of Visine eye drops was sitting on the bedside table. Resident T indicated, a nurse just left it here one time, so she just left it.</p> <p>During an interview on 11/7/24 at 11:53 a.m., Licensed Practical Nurse (LPN) 3 indicated Resident T should not have any medications at the bedside and was not sure who left it there. LPN 3 indicated Resident T cannot have any medications left at the bedside nor self-administer medications.</p>			F 0554	<p>Preparation, submission, and implementation of this Plan of Correction does not constitute an admission</p> <p><b>F 554 Resident Self-Admin Meds-Clinically Appropriate</b></p> <p><b>-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b> Medication found at bedside was identified and disposed of properly. Psychiatric NP evaluated and discontinued medication.</p> <p><b>-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken</b> Nursing/QMAs will watch all residents to ensure all medications are taken that are administered. If at any time a medication is not taken, medications are to be disposed of properly and documented as such.</p> <p><b>-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</b> Nursing and QMA staff educated on the proper surveillance of residents taking all medications with each medication administration and/or the proper disposal of refused medication.</p> <p><b>-how the corrective action will</b></p>		11/29/2024

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F 0578 SS=D Bldg. 00	<p>During an interview on 11/8/24 at 1:58 p.m., the Director of Nursing Services (DNS) indicated Resident T had not had a self-administration of medication order or care plan in place for self-administration of medications.</p> <p>On 11/12/24 at 12:05 p.m. a Resident Self-Administration of Medications Policy was provided by Unit Manager. The policy indicated, "...A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely...."</p> <p>This citation relates to Complaint IN00446364.</p> <p>3.1-11(a)</p>			<p><b>be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p><i>Audits to be conducted of the nursing/QMAs medication administrations providing the proper surveillance of the resident taking all administered medications. Audits of 3 residents medication administrations per week for 4 weeks; 2 residents per week for 4 weeks; 1 resident weekly for 4 weeks; 1 resident biweekly for 1 month, then monthly for the remainder of the 6 months. The results of these audits are to be reviewed at QAPI x 6 months to track any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.</i></p> <p><b>-by what date the systemic changes for each deficiency will be completed</b></p> <p><i>Friday, November 29, 2024</i></p>			
	<p>483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir</p> <p>Based on interview and record review, the facility failed to ensure a proper code status order and care plans were in place for 2 of 4 residents reviewed for code status and care plans. (Resident EE &amp; Resident GG)</p> <p>Findings include:</p>		F 0578	<p>Preparation, submission, and implementation of this Plan of Correction does not constitute an admission</p> <p><b>F 578 Advance Directives</b></p> <p><b>-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p>		11/29/2024	

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	<p>1. The clinical record for Resident EE was reviewed on 11/8/24 at 1:55 p.m. The diagnoses included, but were not limited to, essential tremor, peripheral vascular disease, and chronic respiratory failure.</p> <p>Resident EE had a Physician Orders for Scope and Treatment (POST) form dated 4/29/24. The form indicated Resident EE was a Do Not Resuscitate (DNR). Resident EE had a physician order for DNR status placed on 7/30/24. An Advance Directive care plan, initiated 12/7/23, indicated Resident EE was a full code.</p> <p>During an interview with the Director of Nursing Services (DNS) on 11/8/24 at 1:50 p.m., she indicated Resident EE had a full code care plan because it had not been updated properly.</p> <p>2. The clinical record for Resident GG was reviewed on 11/8/24 at 12:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus, depression, and chronic ischemic heart disease.</p> <p>The clinical record indicated Resident GG was admitted to the facility on 10/21/24. No POST form, code status order, or code status care plan were present in the clinical record.</p> <p>During an interview with the DNS on 11/12/24 at 12:25 p.m., she indicated Resident GG had not made her mind up yet about her code status. So, we treat them as a full code, and nothing is documented in the Electronic Health Record (EHR) until we get everything signed and completed.</p> <p>A Communication of Code Status Policy provided by the Unit Manager, on 11/12/24 at 12:04 p.m.,</p>				<p><i>Advance directives review, verified by provider, code status order placed, and care plans updated.</i></p> <p><b>-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken</b></p> <p><i>Audit conducted of all current residents to ensure advance directives (code status) are in place and care planned, as indicated.</i></p> <p><b>-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</b></p> <p><i>Nursing managers and medical records educated on code status orders and care plan updates.</i></p> <p><b>-how the corrective action will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p><i>Audits of all new admissions will be conducted to ensure new admits have code status orders, correct, and care planned, weekly for 2 months, biweekly for 2 months, and monthly for the remainder of the 6 months. The results of these audits are to be reviewed at QAPI x 6 months to track any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.</i></p>		

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F 0583 SS=D Bldg. 00	<p>indicated the following, "...It is policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information ...2. When an order is written pertaining to a resident's presence or absence of an Advanced Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to... a. Full Code, b. Do Not Resuscitate ...4. The designated sections of the medical record are: Orders Section...."</p> <p>This citation relates to Complaint IN00446364.</p> <p>3.1-4(f)(5)</p> <p>483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records</p> <p>Based on interview and record review the facility failed to provide privacy for residents' medical condition by taking pictures and videos on personal cell phones for 2 of 4 residents reviewed for privacy (Resident KK and Resident W).</p> <p>Findings include:</p> <p>During an interview with Licensed Practical Nurse (LPN) 5 on 11/8/24 at 10:40 a.m., she indicated she had called the on-call Nurse Practitioner (NP) about Resident KK's wound on her leg, and they responded with continuation to monitor the area. LPN 5 indicated she was a new nurse and did not feel comfortable with that. LPN 5 took a picture of the wound on her cell phone and sent it to the Director of Nursing Services (DNS) to get her</p>		F 0583	<p><b>-by what date the systemic changes for each deficiency will be completed</b> Friday, November 29, 2024</p> <p>Preparation, submission, and implementation of this Plan of Correction does not constitute an admission <b>F 583 Personal Privacy/Confidentiality of Records</b></p> <p><b>-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b> Any and all photos/videos have been deleted.</p> <p><b>-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective</b></p>		11/29/2024	

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	<p>opinion. LPN 5 indicated she did not send the picture to anyone else and deleted the picture off her phone.</p> <p>During an interview with LPN 4 on 11/8/24 at 2:41 p.m., she indicated she did take a video of Resident W and sent it to the DNS. LPN 4 indicated she was working third shift, and Resident W had a total change in condition. The resident was making a snoring sound, breathing weird, hitting himself, banging on his chest, banging on the walls and tore up his bedroom. This was out of character for the resident. LPN 4 indicated she had tried to call the DNS and when she did not answer she video tapped Resident W and sent it to the DNS. LPN 4 indicated she wanted the DNS to understand how serious the situation was. LPN 4 indicated she did not send the video to anyone else, and she deleted it from her cell phone.</p> <p>During an interview with the DNS on 11/12/24 at 12:13 p.m., she indicated the facility previously had the capability to send pictures of wounds via the electronic health record system and they no longer had that option. LPN 5 and LPN 4 did send the DNS a picture and video of residents because the nurses did not feel like the provider was responding appropriately about these situations and wanted my help. The DNS indicated Resident W was delusional and having hallucinations on the video. Resident W was yelling and hitting himself. LPN 4 had called the on-call Nurse Practitioner (NP), and she gave an order for Ativan (anxiety medication), and it did not help Resident W. That was why LPN 4 called her and sent the video to her.</p> <p>The resident photograph policy provided by the Executive Director, on 11/6/24 at 10:20 a.m.,</p>			<p><b>actions will be taken</b> No photos or videos will be taken of any residents for any reason. <b>-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</b> Education provided to nursing staff on all residents' personal privacy. Corrective action to be taken, if needed. <b>-how the corrective action will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place</b> Continued education provided to nursing staff weekly for 1 month, biweekly for 2 months, and monthly for the remainder of the 6 months. The results of these audits are to be reviewed at QAPI x 6 months to track any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis. <b>-by what date the systemic changes for each deficiency will be completed</b> Friday, November 29, 2024</p>			

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F 0689 SS=D Bldg. 00	<p>indicated taking photographs and/or videos of residents was a violation of the residents rights' to privacy and confidentiality.</p> <p>This citation relates to Complaint IN00446364.</p> <p>3.1-3(o)</p> <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices</p> <p>Based on observation, interview, and record review the facility failed to utilize smoking aprons during smoking for safety of the residents as assessed for 3 of 3 residents reviewed for smoking safety (Resident J, Resident Z and Resident BB).</p> <p>Findings include:</p> <p>1. During an observation on 11/7/24 at 11:43 a.m., Resident J was outside smoking with other residents and a staff member. Resident J did not have on a smoking apron.</p> <p>During an interview with Resident J on 11/7/24 at 12:00 p.m., he indicated he did not wear a smoking apron when smoking. Resident J indicated the smoking apron was only for residents who drop things and were not safe during smoking.</p> <p>Review of the record of Resident J, on 11/8/24 at 2:18 p.m., indicated the diagnoses included, but were not limited to, chronic respiratory failure, difficulty walking, chronic obstructive pulmonary disease, diabetes, heart failure and dependence on nicotine.</p> <p>The plan of care for Resident J, dated 7/9/24, indicated the resident was at risk for smoking</p>			F 0689	<p>Preparation, submission, and implementation of this Plan of Correction does not constitute an admission</p> <p><b>F 689 Free of Accident Hazards/Supervision/Devices</b></p> <p><b>-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b> Smoking aprons were provided for 3 of 3 residents.</p> <p><b>-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken</b> A complete audit of assessments conducted for residents that utilize tobacco products to ensure proper safety equipment is being used during designed smoking times.</p> <p><b>-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</b></p>		11/29/2024

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	<p>related injury. The interventions included, but were not limited to, provide a smoking apron while smoking.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident J, dated 8/29/24, indicated the resident was cognitively intact for daily decision making.</p> <p>The smoking and safety assessment for Resident J, dated 10/29/24, indicated the resident was lethargic/falls asleep easily during task or activities. The intervention included, but were not limited to, utilize a smoking apron.</p> <p>2a. During an observation of the designated smoking area, on 11/6/24 at 11:41 a.m., Resident Z and Resident BB were smoking without a smoking apron in place.</p> <p>The clinical record for Resident Z was reviewed on 11/8/24 at 10:46 a.m. The diagnoses for Resident Z included, but were not limited to, flaccid hemiplegia (neurological condition with a loss of voluntary movement in a limb) affecting left non-dominant side, dependence on supplemental oxygen, and vascular disease.</p> <p>An Annual Minimum Data Set (MDS) assessment, dated 9/17/24, indicated Resident Z was cognitively intact and had limited range of motion of upper extremity on one side and utilized a wheelchair for ambulation.</p> <p>A Smoking and Safety assessment provided by the Director of Nursing Services (DNS), on 11/8/24 at 9:30 a.m., indicated Resident Z had limited or no Range of Motion (ROM) in arms or hands and was to utilize a smoking apron.</p> <p>During an interview on 11/7/24 at 1:50 p.m.,</p>			<p><i>Education provided to nursing staff on the proper completion of the Smoking and Safety assessment and the necessary safety equipment needed.</i></p> <p><b><i>-how the corrective action will be monitored to ensure that deficient practice will not recur, I.e., what quality assurance program will be put into place</i></b></p> <p><i>Audits to be conducted of the Smoking and Safety assessment &amp; care plans of 3 residents that utilize smoking tobacco products weekly for 1 month, 2 residents weekly for 1 month, and 1 resident weekly for the remainder of the 6 months. The results of these audits are to be reviewed at QAPI x 6 months to track any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.</i></p> <p><b><i>-by what date the systemic changes for each deficiency will be completed</i></b></p> <p><i>Friday, November 29, 2024</i></p>			



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	<p>Resident Z indicated she occasionally wore a smoking apron and was aware that she was supposed to at all times. Resident Z indicated she had never had any burns while smoking.</p> <p>2b. The clinical record for Resident BB was reviewed on 11/8/24 at 10:47 a.m. The diagnoses included, but were not limited to, essential hypertension, hypothyroidism, and chronic obstructive pulmonary disease (COPD).</p> <p>A Quarterly MDS assessment, dated 10/2/24, indicated Resident BB had moderate cognitive impairment and was wheelchair dependent for mobility.</p> <p>A Smoking and Safety assessment provided by the DNS, on 11/8/24 at 9:30 a.m., indicated Resident BB was to utilize a smoking apron.</p> <p>During an interview on 11/7/24 at 1:46 p.m., Resident BB indicated he would wear a smoking apron every now and then, when "you guys" were here. Resident BB indicated he was aware that he was supposed to utilize a smoking apron at all times while smoking. He indicated he had never been burned while smoking but he had gotten ashes on his clothing that caused burn holes in his clothing.</p> <p>During an interview on 11/6/24 at 11:41 a.m., the DNS indicated the facility does a smoking assessment on all residents who smoke. That assessment assesses their abilities to safely smoke. If a resident triggers for not being able to smoke without a risk, they will trigger for a smoking apron to be worn. If they do not trigger, then they are not required to wear one.</p> <p>A Resident Smoking Policy was provided by the</p>						

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F 0755 SS=D Bldg. 00	<p>Executive Director (ED) on 11/6/24 at 10:20 a.m. The policy indicated the following, "...it is the policy of the facility to provide a self and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents ...6. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all ...10. All safe smoking measures will be documented on each resident's care plan ...."</p> <p>This citation relates to Complaint IN00446364.</p> <p>3.1-45(a)(2)</p> <p>483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records</p> <p>Based on interview and record review, the facility failed to obtain physician orders to crush medications for 3 of 5 residents reviewed for medication administration.</p> <p>Findings include:</p> <p>1. The clinical record for Resident L was reviewed on 11/7/2024 at 1:30 p.m. The medical diagnoses included diabetes.</p> <p>During an interview with Resident L, on 11/6/2024 at 1:15 p.m., they indicated they take their medication crushed since they were admitted to the facility.</p> <p>The physician orders did not reflect an active order to crush medications as needed.</p>			F 0755	<p>Preparation, submission, and implementation of this Plan of Correction does not constitute an admission <b>F 755 Pharmacy Services</b></p> <p><b>-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b> Physician ordered medications to be crushed.</p> <p><b>-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken</b> Physician and pharmacist completed a medication review for</p>		11/29/2024

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	<p>2. The clinical record for Resident O was reviewed on 11/7/2024 at 1:40 p.m. The medical diagnoses included diabetes.</p> <p>The physician orders did not reflect an active order to crush medications as needed.</p> <p>3. The clinical record for Resident P was reviewed on 11/7/2024 at 1:45 p.m. The medical diagnoses included chronic obstructive pulmonary disease.</p> <p>The physician orders did not reflect an active order to crush medications as needed.</p> <p>During a confidential staff interview completed during the survey, the staff member indicated they crush medications based on nursing judgement. Resident L, Resident O, and Resident P take their medications crushed and have since the staff member has worked with them. The staff member verified Resident L, Resident O, and Resident P do not have orders to crush medications.</p> <p>An interview with Registered Nurse (RN) 1, on 11/6/2024 at 1:41 p.m., indicated they had issues with medication not being able to be crushed, but the pharmacy was unaware of the resident taking medications crushed because of not having physician orders when they review medications. RN 1 stated they provided the Director of Nursing Services (DNS) and the Executive Director (ED) with a list of residents that take crushed medications, but no orders have been obtained for those residents.</p> <p>A blank nursing report sheet was provided by the DNS on 11/7/2024 at 2:30 p.m. The document indicated Resident L, Resident O, and Resident P received crushed medications.</p>				<p><i>all residents that required crushed medications.</i></p> <p><b>-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</b></p> <p><i>Education provided to nursing staff on the need for physician's order to crush medications.</i></p> <p><b>-how the corrective action will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p><i>Audits to be conducted of residents that require medications to be crushed; 5 residents weekly for 1 month, 3 residents weekly for 1 month, 1 resident weekly for 1 month, and 1 resident biweekly for the remainder of the 6 months.</i></p> <p><i>The results of these audits are to be reviewed at QAPI x 6 months to track any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.</i></p> <p><b>-by what date the systemic changes for each deficiency will be completed</b></p> <p><i>Friday, November 29, 2024</i></p>		

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

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F 0757 SS=D Bldg. 00	<p>A policy, entitled "Medication Administration", was provided by the ED on 11/6/2024 at 10:20 a.m. The policy indicated, " ...Crush medications as ordered ..."</p> <p>This citation relates to Complaint IN00446364.</p> <p>3.1-25(b)</p> <p>483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs</p> <p>Based on interview and record review the facility failed to follow-up with monitoring and have an indication for use on a one-time order for Ativan (antianxiety medication) for a resident who was experiencing an acute change in condition for 1 of 3 residents reviewed for change in condition (Resident W).</p> <p>Findings include:</p> <p>During an interview with Licensed Practical Nurse (LPN) 4 on 11/8/24 at 2:41 p.m., she indicated she did take a video of Resident W and sent it to the Director of Nursing Services (DNS). LPN 4 indicated she was working third shift, and Resident W had a total change in condition. The resident was making a snoring sound, breathing weird, hitting himself, banging on his chest, banging on the walls and tore up his bedroom, which was out of character for the resident. LPN 4 indicated she had tried to call the DNS and when she did not answer she video tapped Resident W and sent it to the DNS, on 10/18/24 around 2:30 a.m. LPN 4 indicated she wanted the DNS to understand what a serious situation that was. LPN 4 indicated she did not send the video to anyone</p>		F 0757	<p>Preparation, submission, and implementation of this Plan of Correction does not constitute an admission</p> <p><b>F 757 Drug Regimen is Free from Unnecessary Drugs</b></p> <p><b>-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b> Resident no longer resides at the facility.</p> <p><b>-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken</b> Audit conducted of the past 7 days for residents who received a one-time order to ensure the proper indication for use was listed prior to administration, along with the proper follow-up monitoring.</p> <p><b>-what measures will be put into place and what systemic changes will be made to ensure</b></p>		11/29/2024	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>else, and she deleted it from her cell phone.</p> <p>During an interview with the DNS on 11/12/24 at 12:13 p.m., she indicated LPN 4 did send the DNS a video of Resident W because the nurse did not feel like the provider was responding appropriately about the situation and wanted my help. The DNS indicated Resident W was delusional and having hallucinations on the video. Resident W was yelling and hitting himself. LPN 4 had called the on-call Nurse Practitioner (NP), and she gave an order for Ativan (antianxiety medication), and it did not help Resident W. That was why LPN 4 called her and sent the video to her.</p> <p>Review of the record of Resident W, on 11/12/24 at 10:36 a.m., indicated the diagnoses included, but were not limited to, opioid dependence, hypertension, muscle weakness, and fatigue.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 9/30/24, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident did not have hallucinations, delusions, or behaviors.</p> <p>A progress note for Resident W, dated 10/18/24 at 3:32 a.m., indicated the resident had been in his room since early A.M., around 1:30 a.m., with altered mental status. The resident was standing with eyes rolling in the back of his head, laying on the couch halfway, screaming out, stating that someone was going to push him off his bed if he got on it. The resident was beating on his chest and face with his fists, while seemingly being asleep. The resident was "not getting any better, only worse." This nurse sat resident down numerous times to keep him safe and prevent him</p>				<p><b>that the deficient practice does not recur</b></p> <p><i>Education provided to nursing staff to ensure the proper indication for use is listed on all one-time orders, along with follow-up monitoring for one-time orders.</i></p> <p><b>-how the corrective action will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p><i>Audits to be conducted of one-time orders twice weekly for 2 months, once weekly for 2 months, and biweekly for the remainder of the 6 months. The results of these audits are to be reviewed at QAPI x 6 months to track any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.</i></p> <p><b>-by what date the systemic changes for each deficiency will be completed</b></p> <p><i>Friday, November 29, 2024</i></p>		

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	<p>from falling. There was nothing that was helping the situation. The on-call provider was notified, and the DNS was notified.</p> <p>A progress note for Resident W, dated 10/18/24 at 3:37 a.m., indicated the Nurse Practitioner (NP) response was to administer Ativan two milligrams (mg); one dose.</p> <p>The clinical record did not indicate what the Ativan two milligrams was utilized for or indication of follow up if the Ativan was effective or not effective for Resident W.</p> <p>A progress note for Resident W, dated 10/18/24 at 6:52 a.m., indicated the resident was thrashing on the couch uncontrollably, vital signs were normal, and was unable to answer questions appropriately. The writer suspects resident had taken unprescribed medication. The NP was called, and an order was received to send the resident to the emergency room.</p> <p>A progress note for Resident W, dated 10/18/24, indicated since around midnight the resident had been thrashing, yelling, hitting himself, eyes rolling back in head and general disoriented to person, time, and place. The resident had refused care of his cellulitis this past week and could be septic although his vital signs were normal. The resident became very disoriented, combative with staff, and hitting himself. Ativan two mg was given, around 2:00 a.m., with little effect on his demeanor. The resident was experiencing hallucinations and agitation. The resident was disoriented with mental status changes, usually this resident was very kind and respectful and was currently yelling and hitting himself. The resident was unable to answer if he had taken any substance that he was not supposed to or why</p>						

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	<p>his condition suddenly spiraled out of control. The resident was being transported to the emergency room. The progress note was electronically signed by NP 2.</p> <p>A progress note for Resident W, dated 10/18/24 at 7:10 a.m., indicated the fired department was at the facility to transport the resident, NP 2 was in the resident's room as well.</p> <p>The hospital records for Resident W, dated 10/18/24, indicated the resident was admitted to the local hospital with toxic encephalopathy (sudden, severe change in mental function) secondary to cocaine and amphetamine use. The resident had left the long-term care facility yesterday and when he returned, he was altered and confused. The resident remained in the emergency room for several hours, with attempts at metabolizing, but despite this he remained quite sleepy and had to be placed on oxygen. "Given the prolonged period of observation in the emergency department, still without return to baseline I do feel that patient will warrant further inpatient management."</p> <p>The provision of physician ordered services policy provided by the Executive Director, on 11/12/24 at 3:00 p.m., indicated the purpose of this policy was to provide reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality.</p> <p>This citation relates to Complaint IN00446364.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>						

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F 0761 SS=E Bldg. 00	<p>483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals</p> <p>Based on observation and interview, the facility failed to ensure open medication bottles were dated in 2 of 2 medication carts observed for medication storage and four open, un-identified medications laying in medication drawers in 2 of 2 medication carts observed.</p> <p>Findings include:</p> <p>During an observation of Extended Care Unit (ECU) Medication Cart 1 with Registered Nurse (RN) 1, on 11/6/24 at 9:45 a.m., several medication bottles were noted not to have open dates marked on the bottles. Bottles included: one 236 milliliter (ml) Guaifenesin, one 433 ml Enulose, three Polyethylene Glycol 3350 8.3 ounce (oz) bottles, one 473 ml Milk of Magnesia, three 355 ml oral simethicone, one 473 ml Guaifenesin, two Almacone bottles, one 236 ml Dermal Wound Cleanser, and one 10 ml Refresh Optive Advanced. One Fluticasone Propionate inhalation powder was noted to not have a resident label or dates labeled on it. One half of a loose orange oblong pill was laying in the medication drawer.</p> <p>During an interview on 11/6/24 at 9:45 a.m., RN 1 indicated she was unsure where the open pill came from, and it should have been discarded if not used. RN 1 indicated when a new medication bottle is opened, they were to put an open date and expiration date on them.</p> <p>During an observation of the ECU Medication Cart 2 with Licensed Practical Nurse (LPN) 2 on 11/6/24 at 10:00 a.m., one loose blue pill was noted in medication drawer. LPN 2 indicated she was</p>			F 0761	<p>Preparation, submission, and implementation of this Plan of Correction does not constitute an admission <b>F 761 Label/Store Drugs and Biologicals</b></p> <p><b>-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b> Opened, undated medications were removed from the medication cart, disposed of properly, and reordered through pharmacy.</p> <p><b>-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken</b> A review of all four medication carts was conducted and any opened, undated medications were removed, disposed of, and reordered.</p> <p><b>-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</b> Education provided to nursing staff for the need to date all opened medications with open dates and expiration dates.</p> <p><b>-how the corrective action will be monitored to ensure that deficient practice will not recur,</b></p>		11/29/2024



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	<p>unsure who's medication it was or where it came from, and open medications should not be stored in the medication cart. One Albuterol 90 microgram (mcg) inhaler with spacer was noted laying in the bottom drawer with no resident label on it. LPN 2 indicated, she was unsure who the medication belonged to, and it should be labeled. LPN 2 discarded all loose and unidentified medications.</p> <p>During an observation of the ECU Medication Cart 2 with LPN 2 on 11/6/24 at 10:00 a.m., several medication bottles were noted not to have open dates labeled on them. Bottles included: one 473 ml Enulose, four Guaifenesin 473 ml bottles, one Max Tussin 300 ml bottle, one Milk of Magnesia 473 ml bottle, one 8.3 oz. Polyethylene Glycol, and one Potassium Chloride 10% 473 ml bottle. LPN 2 indicated when a bottle was opened, the open date should be recorded on them.</p> <p>During an interview with the Director of Nursing Services (DNS) on 11/8/24 at 1:20 p.m., they indicated nursing puts the open date and the dispose date anytime a new medication bottle is opened. The DNS indicated they keep a binder at the nurses' stations that has what the discard time lengths should be for different medications.</p> <p>A Medication Storage Policy provided by the Executive Director, on 11/6/24 at 11:22 a.m., indicated the following, "...It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations ...8. The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, or deteriorated medications with worn, illegible, or missing labels ...."</p>				<p><b><i>I.e., what quality assurance program will be put into place</i></b> <i>Audits to be conducted of all 4 medication carts weekly for 1 month, 2 random medications carts weekly for 1 month, 1 random medication cart weekly for 1 month, and all medication carts monthly for the remainder of the 6 months. The results of these audits are to be reviewed at QAPI x 6 months to track any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.</i></p> <p><b><i>-by what date the systemic changes for each deficiency will be completed</i></b> <i>Friday, November 29, 2024</i></p>		

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F 0849 SS=D Bldg. 00	<p>This citation relates to Complaint IN00446364.</p> <p>3.1-25(j) 3.1-25(o)</p> <p>483.70(o)(1)-(4) Hospice Services</p> <p>Based on interview and record review, the facility failed to ensure an order and care plan were in place for a resident receiving hospice services for 1 of 3 residents reviewed for hospice. (Resident DD)</p> <p>Findings include:</p> <p>The clinical record for Resident DD was reviewed on 11/6/24 at 1:26 p.m. The diagnoses included, but were not limited to, anxiety disorder, diabetes mellitus, and chronic pain syndrome. Resident DD's hospice binder indicated he was placed on hospice on 9/15/24. The clinical record indicated there was not an order for hospice nor a hospice care plan in the Electronic Health Record (EHR).</p> <p>During an interview with the Director of Nursing Services (DNS) on 11/7/24 at 10:29 a.m., they indicated Resident DD's physician put a one-time order in for a hospice services consult for one day only, then the order fell off the EHR after that day, and an order was not put in after that.</p> <p>An interview with the DNS on 11/8/24 at 10:00 a.m., they indicated the facility recently switched over their care plan library for auditing purposes, on 10/28/24, and all of the old care plans were disappearing.</p>		F 0849	<p>Preparation, submission, and implementation of this Plan of Correction does not constitute an admission</p> <p><b>F 849 Hospice Services</b></p> <p><b>-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b> Hospice orders and care plan updated.</p> <p><b>-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken</b> Audit conducted of all active hospice residents to ensure order placement and care plans are up to date.</p> <p><b>-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</b> Education provided to nursing staff on the need for hospice orders and care plans being up to date.</p>		11/29/2024	

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	<p>A hospice care plan, dated 11/7/24, indicated interventions to coordinate plan of care with hospice services and to obtain physician order and appropriate referral.</p> <p>A Coordination of Hospice Services Policy was provided by the Executive Director (ED) on 11/6/24 at 2:40 p.m. The policy indicated the following, "...the facility and hospice provider will coordinate a plan of care and will implement interventions ...5. The facility will monitor and evaluate the resident's response to the hospice care plans...."</p> <p>This citation relates to Complaint IN00446364.</p> <p>3.1-37(a)</p>				<p><b>-how the corrective action will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p><i>Audit of 3 residents who receive hospice services to be conducted weekly for 1 month, 2 residents weekly for 1 month, 1 resident weekly for 1 month, and 1 resident biweekly for 1 month, then 1 resident monthly for the remainder of the 6 months. The results of these audits are to be reviewed at QAPI x 6 months to track any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.</i></p> <p><b>-by what date the systemic changes for each deficiency will be completed</b></p> <p><i>Friday, November 29, 2024</i></p>		