STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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. Survey dates: July 10, 11, 12 & 13, 2023. Facility number: 000437 Provider number: 155520 AIM number: 100273770 Census Bed Type: NF: 23 SNF/NF: 4 Total: 27 Census Payor Type: Medicare: 2 Medicaid: 20 Other: 5 Total: 27 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 21, 2023.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 2 of 4 residents reviewed for medication administration. (Resident 20, Resident	F 0554	Plan of Correction Response for 554 Residents 20 and 21 were not assessed to determine whether self-administering medications are clinically appropriate for the	08/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Margaret Braun	Administrator	08/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	21) Findings include: 1. On 7/12/23 at 7:37 A.M., LPN (Licensed Practical Nurse) 3 was observed to administer medications for Resident 20 in his room. Medications prepared for administration included, but was not limited to, a Juven packet (nutrition powder) mixed in 8 oz (ounces) of water. LPN 3 handed Resident 20 his medications and left the room before the resident took the Juven. On 7/12/23 at 9:36 A.M., Resident 20's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus with foot ulcer, dysphagia following cerebral infarction, and visual field defects. The most recent significant change MDS (Minimum Data Set) assessment, dated 6/1/23, indicated Resident 20 was cognitively intact and had a diabetic foot ulcer. Current physician orders included, but was not limited to: Juven packet, 1 packet twice daily for wound healing, dated 6/20/23 The clinical record lacked an order for self administration of medications. The clinical record lacked a care plan related to self administration of medications. The clinical record lacked a self administration of medication assessment. 2. On 7/12/23 at 7:44 A.M., LPN 3 was observed to administer medications for Resident 21 in her room. Medications prepared for administration included, but were not limited to, 1 senna 8.6 mg		resident. Therefore, the need to have an order or care plan for self-administering medications for the two residents is not necessary. Under both instances, the nurse observed during the med pass left the room before the residents swallowed or drank their medication and did not confirm the medications were 100% taken. **MONITORING** The Director of Nursing and/or their designee will in-service all Licensed Nursing Personnel on the Policy for “Self-Administration of Medications.” If there are any nurses that are not in-serviced by 8/8/2023, they will be in-serviced before returning to work. To assure that licensed nursing personnel comply with the policy and observe standard medication pass protocol, the D.O.N. and/or their designee will conduct a random medication pass audit weekly for one month, monthly for a quarter, and on a quarterly basis for three quarters. The Director of Nursing assumes responsibility for and ensures compliance. The Administrator is responsible for overall compliance. Any documentation regarding the POC for F554 will be available to the surveyors upon their request. I respectfully request paper compliance regarding F554. Compliance Date: August 8, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	(milligrams) tablet, 1 multivitamin tablet, 1 aspirin 81 mg tablet, 1 oxybutynin 5 mg tablet, 1 clopidogrel 75 mg tablet, 1 amlodipine 5 mg tablet, 1 escitalopram 20 mg tablet, 1 famotidine 20 mg tablet, 1 metformin 1,000 mg tablet, 1 calcium 600 mg plus vitamin d3 800 mg tablet, and 1/2 metoprolol 25 mg tablet. LPN 3 handed Resident 21 the medications in a medication cup and left the room before the resident took the medications. On 7/12/23 at 9:39 A.M., Resident 21's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and major depressive disorder. The most recent annual MDS assessment, dated 5/17/23, indicated Resident 21 was cognitively intact. Current physician orders included, but was not limited to: Senna 8.6 mg, 1 tablet by mouth daily for constipation, dated 5/10/22 Multivitamin, 1 tablet by mouth daily as a supplement, dated 10/13/20 Aspirin EC (enteric-coated) 81 mg, 1 tablet by mouth daily for hypertension, dated 10/13/20 Oxybutynin ER (extended release) 5 mg, 1 tablet by mouth daily for overactive bladder, dated 10/13/20 Clopidogrel 75 mg, 1 tablet by mouth daily for DVT (deep vein thrombosis) prevention, dated 10/13/20 Amlodipine 5 mg, 1 table by mouth daily for hypertension, dated 10/13/20 Escitalopram 20 mg, 1 tablet by mouth daily for depression, dated 10/13/20 Famotidine (an antihistamine and antacid medication) 20 mg, 1 tablet by mouth 2 times daily, dated 5/4/22 Metformin (an anti-diabetic medication) 1,000 mg, 1 tablet by mouth daily, dated 4/18/23		Margaret H. Braun, HFA Administrator Braun's Nursing Home	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	Calcium 600 plus Vitamin D 800, 1 tablet by mouth twice daily as a supplement, dated 10/13/20 Metoprolol tartrate (a beta blocker medication) 25 mg, 1/2 tablet by mouth twice daily, dated 10/13/20 The clinical record lacked an order for self administration of medications. The clinical record lacked a care plan related to self administration of medications. The clinical record lacked a self administration of medication assessment. On 7/12/23 at 9:03 A.M., the ADON (Assistant Director of Nursing) indicated that no one in the facility had a self administration order for medications. She further indicated that medications should not be left at the bedside. On 7/13/23 at 8:14 A.M., a current Self-Administration of Medications policy, undated, indicated "the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident ... The staff and practitioner will document their findings and choice of residents who are able to self-administer medications ... The staff and practitioner will periodically (for example, during quarterly MDS reviews) reevaluate a resident's ability to continue to self-administer medications". 3.1-11(a)			
F 0657 SS=E 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	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 interview and record review, the facility failed to provide quarterly care conferences that included the required interdisciplinary team members for 13 of 16 residents reviewed for quarterly care conferences (Residents 1, 2, 4, 6, 8, 9, 10, 12, 16, 21, 22, 23, 25) and failed to update revisions to care plans for 2 of 2 residents reviewed for care plan revisions (Resident 1, Resident 22). Findings include: 1. During an interview on 7/11/23 at 9:37 A.M.	F 0657	Plan of Correction Response for 657 The facility has reviewed Policies pertaining to Comprehensive Care Plans. The Administration will in-service and educate all administrative personnel on the facilities policy before August 8, 2023. Each resident's chart will be reviewed to assure that the care plan reflects pertinent changes since the MDS consultant was in	08/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), they indicated the social worker was doing quarterly care conferences verbally and over the phone, but failed to document the conferences. During an interview on 7/10/23 at 9:48 A.M., LPN 6 indicated that social services and ADON (Assistant Director of Nursing) will contact the family by call or email. 2. On 7/12/23 at 10:15 A.M., Resident 8's clinical records were reviewed. Resident 8's diagnoses included, but were not limited to, Alzheimer's with late onset, anxiety disorders, delusional disorders, depressive disorders. The most recent quarterly MDS dated 5/10/23 indicated resident has mild cognitive impairment and is totally dependent with assist of 2 for bed mobility, transfers, and toileting, dependent with assist of 1 for eating, and is totally dependent for bathing. Resident 8's clinical record contained handwritten documentation of quarterly care conferences on 2/4/20, 4/24/20, 7/22/20, 10/13/20, 2/9/21 and 1/31/23, plus 1 undated care conference. The documentation indicated the resident and representative were invited but did not attend; the physician did not attend. 3. On 7/12/23 at 9:40 A.M., Resident 9's clinical records were reviewed. Resident 9's diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, diabetes, history of falls, obsessive compulsive disorder. Current quarterly MDS dated 6/7/23 indicated resident has severe cognitive impairment (resident was not able to answer any of the Brief Inventory of Mental Status (BIMS) questions) and requires extensive assistance of 2		the facility on July 19, 2023. This review will be completed before August 5, 2023. **MONITORING** Beginning Monday, July 31, 2023, the Assistant Social Services Designee will review the ARD schedule to assure the care conferences are scheduled and or completed within the required two-week period. This review will occur on a weekly basis for one month, monthly for a quarter, and on a quarterly basis for three quarters. To assure that the new protocol implemented is being followed, the MDS Consultant will audit the process weekly for one month, monthly for a quarter, and quarterly for three quarters. The Director of Nursing and Social Services Designee assumes responsibility for and ensures compliance. The Administrator is responsible for overall compliance. Any documentation regarding the POC for F657 will be available to the surveyors upon their request. I respectfully request paper compliance regarding F657. Compliance Date: August 8, 2023 Margaret H. Braun, HFA Administrator Braun's Nursing Home	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	for bed mobility, transfers, and toileting, extensive assist of 1 for eating, and is totally dependent for bathing. Resident 9's clinical record contained handwritten documentation of quarterly care conferences on 1/14/20, 4/7/20, 7/1/20, 9/22/20, and 12/22/20. The documentation indicated the resident and representative were invited but did not attend; the physician did not attend. Residents 8 and 9 handwritten care conference documentation contained the signature of the same physician but with different handwriting 4. On 7/12/23 at 9:22 A.M., Resident 10's clinical record was reviewed. Resident 10's diagnoses included, but were not limited to, late onset Alzheimer's, vascular dementia, dementia with behaviors, diabetes, depression. The most recent quarterly MDS dated 5/10/23 indicated resident has severe cognitive impairment and requires total assist of 2 for bed mobility, transfers, toileting, total assist of 1 for eating, and is totally dependent for bathing. Resident 10's clinical record contained handwritten documentation of quarterly care conferences on 3/9/20, 6/2/20, 11/24/20, and 3/4/21. The documentation indicated the representative attended on 3/9/20; the physician did not attend. 5. On 7/12/23 at 10:25 A.M., Resident 22's clinical record was reviewed. Resident 22's diagnoses included, but were not limited to, dementia, diabetes, syncope and collapse. The most recent significant change MDS dated 6/7/23 indicated resident has severe cognitive impairment and is totally dependent with assist of 2 for bed mobility,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	transfers, and toileting, totally dependent with assist of 1 for eating, and totally dependent for bathing. Resident 22 was admitted 8/16/22. The clinical record contained handwritten documentation of one quarterly care conference dated 5/22/23. The documentation indicated there was a discussion with resident's husband but he was not noted as having attended. Physician did not attend. During an interview on 7/12/23 at 11:46 A.M., the DON indicated they attempted to perform restorative nursing care for Resident 22, but resident was not capable of doing it. The care plan for restorative nursing is still on the comprehensive care plan, which has not been updated. 6. On 7/11/23 at 9:49 A.M., Resident 1's clinical record was reviewed. Diagnoses included but were not limited to Arteriosclerotic heart disease of the native coronary artery and hyperlipidemia. The most recent quarterly MDS (Minimum Data Set) Assessment dated 4/26/23 indicated Resident 1 was cognitively intact and needed supervision with set up for mobility, transfer, and eating. Progress notes indicated Resident 1 had and unwitnessed falls on 5/19/23 and 6/4/23. The progress note also lacked documentation of an IDT (interdisciplinary team) meeting. The care plan lacked revision of interventions after the falls. During an interview on 7/11/23 at 10:57 A.M., indicated LPN 6 if a resident fell she would assess the resident for injuries, make sure they were not hurt. Take vital signs and do neuro checks per protocol if unwitnessed fall. Then notify family, DON (Director of Nursing) and physician. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	care plan should have interventions updated with each fall. On 7/11/23 at 10:12 A.M., a Care Conference Summary sheet was located on Resident 1's chart and lacked documentation of a care conference for the resident since 3/11/21. During an interview on 7/10/23 at 9:03 A.M., Resident 1 indicated she had no knowledge of attending care plan conference meetings since she had been here. The resident was admitted on 4/3/17. She had never received an invitation for attending a meeting. 7. On 7/11/23 at 8:26 A.M., Resident 23's clinical record was reviewed. Diagnoses included but were not limited to, hypertension and COPD (Chronic Obstructive Pulmonary Disease). The most recent quarterly MDS (Minimum Data Set) Assessment dated 5/31/23 indicated that Resident 23 was cognitively intact and needed supervision with set up for eating and mobility. The chart lacked documentation of Care Conference Summary sheet for resident. During an interview on 7/10/23 at 9:30 A.M., Resident 23 indicated she had never been invited or been to a care conference. During an interview on 7/11/23 at 9:33 A.M., the DON indicated that a care conference summary sheet should be in the chart in front of the care plan. During an interview on 7/11/23 at 9:40 A.M., the DON indicated she was not aware of a Care Conference Summary sheet that documented the care conference date.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	8. On 7/11/23 at 9:24 A.M. Resident 25's clinical record was reviewed. Resident 25 was admitted on 3/23/23. Diagnoses included, but were not limited to, diabetes mellitus, cirrhosis of the liver, and hypertension. The most recent Admission MDS (Minimum Data Set) assessment, dated 3/29/23, indicated resident 25 was cognitively intact and required supervision setup from staff for transferring, eating, and toileting. The clinical record lacked documented care plan conferences from 3/23/23 to 7/11/23. 9. On 7/11/23 at 10:02 A.M. Resident 12's clinical record was reviewed. Resident 12 was admitted on 6/1/17. Diagnoses included, but were not limited to, hemiplegia of left side, epilepsy, and hypertension. The most recent Quarterly MDS assessment, dated 6/21/23, indicated resident 12 was moderately cognitively impaired, and required total assistance with transfers, eating, toileting, and bathing. The clinical record lacked documented care plan conferences between 6/1/17 to 1/21/20, and from 3/12/21 to 7/11/23. 10. On 7/11/23 at 10:27 A.M. Resident 21's clinical record was reviewed. Resident 21 was admitted on 6/30/20. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and depression. The most recent Annual MDS assessment, dated 5/17/23, indicated resident 21 was cognitively intact and was independent for transfers, toileting, and eating. The clinical record lacked documented care plan conferences between 6/30/20 and 5/21/23. 11. On 7/12/23 at 6:48 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	4/20/10. Diagnosis included, but was not limited to, Alzheimer's Disease. The most recent quarterly MDS (Minimum Data Set) assessment, dated 5/31/23, indicated Resident 2 had severe cognitive impairment, required limited assistance of 1 staff for transferring, eating, and toileting, and had delusions. The clinical record lacked documented care plan conferences between 1/5/21 and 5/16/23. 12. On 7/11/23 at 11:04 A.M., Resident 4's clinical record was reviewed. Resident 4 was admitted on 1/10/23. Diagnosis included, but was not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the left nondominant side. The most recent quarterly MDS assessment, dated 4/12/23, indicated Resident 4 had moderate cognitive impairment and required extensive assistance of 2 staff for bed mobility, transferring, and toileting and extensive assistance of 1 staff for eating. The clinical record lacked documented care plan conferences. 13. On 7/11/23 at 10:37 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted on 7/27/10. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, prostate cancer, and dementia. The most recent quarterly MDS assessment, dated 6/14/23, indicated Resident 6 had severe cognitive impairment and required total assistance of 1 staff for eating, toileting, and bathing and total assistance of 2 staff for transferring. The clinical record lacked documented care plan conferences after 12/29/20.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	14. On 7/11/23 at 9:22 A.M., Resident 16's clinical record was reviewed. Resident 16 was admitted on 10/7/19. Diagnosis included, but was not limited to, congestive heart failure. The most recent quarterly MDS assessment, dated 6/7/23, indicated Resident 16 had severe cognitive impairment and required extensive assistance of 1 staff for toileting and was independent with setup assistance from staff for transferring and eating. The clinical record lacked documented care plan conferences after 12/22/20. A current undated policy "Care Conference-Scheduling" was provided by the ADON on 7/12/23 at 8:06 A.M., indicated " ...facility protocol for scheduling a Care Conference by Social Services Director or Designee arranging conferences to the following protocol:... 5) Care conference scheduling follows MDS schedule of ...c) quarterly..." 3.1-35(c)(1)			
F 0727 SS=C 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure a RN (Registered Nurse) worked 8 consecutive hours in the facility on any given day for 2 of 14 days reviewed for nurse staffing. Findings include: The staffing schedules were reviewed from 6/25/23-7/8/23 on 7/13/23 at 9:30 A.M. There was no RN scheduled on 7/3-7/4/23. The RN that was to work was scheduled from 6:30 P.M. to 7:00 A.M. on 7/3/23 but did not work there was no RN coverage for 8 consecutive hours for either day. The DON took a holiday on 7/3/23. She was on call on 7/4/23 but did not work. During an interview on 7/13/23 at 10:00 A.M., the DON indicated she was not able to work on-site due to family problems. During an interview on 7/13/23 at 11:07 A.M., the administrator indicated there was an emergency with the RN who was scheduled to work on 7/3/23 so there was no RN coverage on 7/3/23 and 7/4/23. On 7/13/23 a current undated policy "Staffing" was provided by the ADON at 12:52 A.M., indicated "...the facility provides sufficient numbers of staff...Policy Interpretation and Implementation...3.)...the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week..." 3.1-17(b)(3)	F 0727	Plan of Correction Response for F727 This facility continues to deal with the aftermath of the COVID pandemic in terms of staffing and low census. The Administrator, D.O.N. and A.D.O.N., work daily to achieve the 8 hour of continuous R.N. coverage. To achieve this objective, we have engaged staffing agencies to assist us in bridging this gap. The next two schedules for the periods 8/6/2023 through 8/19/2023 and 8/20/2023 through 9/2/2023 have at least 8 hours of R.N. coverage per day. This is in addition to other scheduled licensed nursing personnel. All management is fully aware of the staffing requirement and understands the Direct of Nursing hours may be included if census is below 61. **MONITORING** The Administrator will continue to monitor this situation daily until an acceptable resolution is achieved. This resolution is for all nursing personnel scheduled, are members of Braun's healthcare team. Any documentation regarding the POC for F727 will be available to the surveyors upon their request. I	08/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
			respectfully request paper compliance regarding F727. Compliance Date: August 6, 2023 Margaret H. Braun, HFA Administrator Braun's Nursing Home	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure completed nurse staffing sheets were posted daily 4 of 4 days during the survey.(7/10/23, 7/11/23, 7/12/23, and 7/13/23) Findings includes: On 7/10/23 at 6:40 A.M., a staffing sheet was observed hanging on a television monitor across from the front desk in lobby dated 7/10/23. The sheet included, but was not limited to the following information: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Assistant). Total number of RN, LPN, and CNA for each shift Total hours of RN, LPN, and CNA for each shift The sheet did not specify which actual hours were worked by each discipline during the specified shift when the total hours were not equal to the number of staff. On 7/11/23 at 8:00 A.M., a staffing sheet was observed hanging on a television monitor across from the front desk in lobby dated 7/11/23. The sheet included, but was not limited to the following information: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Assistant). Total number of RN, LPN, and CNA for each shift.	F 0732	Plan of Correction Response for F732 The Administrators designee is responsible for posting the nurse staffing data. The sheet has been modified to reflect the “actual hours worked by each discipline during the specified shift when the total hours were not equal to the number of staff.” The Administrator will verify the **CORRECTED** schedule is posted weekly for four (4) weeks, monthly for three (3) months and then quarterly for three (3) quarters. The Administrator assumes responsibility for and ensures compliance. Any documentation regarding the POC for F732 will be available to the surveyors upon their request. I respectfully request paper compliance regarding F732. Compliance Date: July 26, 2023 Margaret H. Braun, HFA Administrator	07/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	Total hours of RN, LPN, and CNA for each shift. The sheet did not specify which actual hours were worked by each discipline during the specified shift when the total hours were not equal to the number of staff. On 7/13/23 at 8:30 A.M., the DON provided the staffing sheets for dated 7/10/23, 7/11/23. 7/12/23, and 7/13/23. The sheets included, but was not limited to the following information: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Assistant). Total number of RN, LPN, and CNA for each shift. Total hours of RN, LPN, and CNA for each shift. The sheets did not specify which actual hours were worked by each discipline during the specified shift when the total hours were not equal to the number of staff. During an interview at 2:00 P.M., with the DON(Director of Nursing)and ADON(Assistant Director of Nursing), the ADON indicated the social service assistant fills out the posted nurse staffing form. DON indicated she had never looked at it. DON indicated there may be some posted nurse staffing forms on the computer because they used to do it differently. She will look for a form that will show the posted nurse staffing correctly. On 7/13/23 a current undated policy "Staffing" was provided by the ADON at 12:52 A.M., indicated "...the facility provides sufficient numbers of staff...Policy Interpretation and Implementation...6.(iii) the total number and actual hours worked by the following categories... A)Registered Nurses, B)Licensed Practical Nurses...C) Certified nurses aides..."		Braun's Nursing Home	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on interview and observation, the facility failed to provide each resident with food and drink that is served at a safe and appetizing temperature. Food that was supposed to be served hot was served at below the recommended temperature; food that was supposed to be cold was served above the recommended temperature for 1 of 1 meal trays reviewed for food temperature. Findings include: 1. During an interview with Resident 8 on 7/10/23 at 9:55 A.M., the resident stated "Yuk" when asked about the food. Then she indicated the hot food was served lukewarm. On 7/11/23 at 12:34 P.M., the temperatures were measured on the last food tray that was served on the resident's hall. The temperatures were: Broccoli 126.0 F Baked potato 128.0 F Milk 49.7 F Banana pudding 45.7 F Salad 50.1 F	F 0804	Plan of Correction Response for F804 The administrator, dietary manager and their designee observed the food preparation and delivery process to identify deficient practices that contributed to the food temperatures. The primary factor that contributed to the deficiency was the number of trays on a cart, the way the trays left the kitchen and when they were delivered to the unit. **MONITORING** The Dietary Manager or their designee will audit a total of 8 meals for one week, 5 meals weekly for three weeks, 20 meals monthly for a quarter, and 10 meals quarterly for three quarters. During the monthly resident council meeting, the Activity Director will offer residents in attendance the opportunity to	08/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	2. During an interview on 7/11/23 at 11:22 A.M., the dietary supervisor indicated he takes temps for employee first who eat at 11:30 A.M., then re-checks the food temperatures before the residents eat at 12:00 to 12:15 P.M. During an interview on 7/12/23 at 11:22 A.M., the dietary supervisor indicated most of the food should be 165 degrees Fahrenheit across the board that should be hot. The cold cold should be below 40. The warm zone is 41-135 degrees if food is too warm or cold this is a problem. He indicated he would take the temperature the food 1/2 way through the cooking process and if it is not up to a certain temperature the entry may have to cook longer in order to have the correct temperature. The facility's food temperature policy, undated, indicated that hot food must be served at a minimum of 135 degrees F and cold food must be served at a minimum temperature of 41 degrees F... Foods sent to the units for distribution ... will be transported and delivered to unit storage areas to maintain temperature at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods. 3.1-21(a)(2)		address any food issues. The Administrator assumes responsibility for and ensures compliance. Any documentation regarding the POC for F804 will be available to the surveyors upon their request. I respectfully request paper compliance regarding F804. Compliance Date: August 4, 2023 Margaret H. Braun, HFA Administrator Braun's Nursing Home	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	applicable State and local laws or regulations. (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 and interview, the facility failed to ensure food was stored appropriately in 2 of 2 kitchen observations. Food containers were found not labeled in the the dry storage area and shelving in prep area in the kitchen.(Kitchen) Findings include: On 7/10/23 between 6:45 A.M. and 7:10 A.M., during the initial kitchen tour the following was observed: Spices under silver prep table 1 opened container of garlic bread seasoning with a use by day of 4/17/23 1 opened container of garlic herb seasoning with used by date of 6/23/23 1 opened container of ground nutmeg with a use by date of 5/12/23 1 opened container of onion powder with use by date of 1/15/23 1 opened container of minced onion undated 1 opened container of lemon pepper seasoning undated 1 opened container of garlic salt undated 1 opened container of whole gloves with a use by date 11/2/22	F 0812	Plan of Correction Response for F812 All expired or undated seasoning and spices were removed, destroyed and replaced if applicable. This was completed on 7/12/2023. Once opened, these items are properly dated to reflect one year's usage. All boxes in the dry storage room have been dated to reflect the correct "use by" date. The Dietary Manager or their designee will in-service the dietary staff on the proper method of labeling items in the dietary department. **MONITORING** To assure that the above items continue to be observed. the Dietary Manager or their designee will conduct random audits weekly for one (1) month, monthly for three (3) months and then quarterly for three (3) quarters.	08/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	1 measuring cup covered with plastic wrap of white granular substance undated and unlabeled, which the cook indicated was food thickener.. On 7/10/23 between 7:11 A.M. and 7:35 A.M., during the initial kitchen tour the following was observed: Dry storage room 1 opened box of red onion with no date 1 opened box of yellow onion with no date 1 opened box of white potatoes no date 1 opened bag of mashed potato pearls with use by date of 7/9/23, lacked an open date 1 opened container of Quaker oats with use by date written as 6/28/23, lacked an open During an interview on 7/12/23 at 11:22 A.M. the dietary supervisor went through and replaced the outdated spices and indicated that they were good for 1 year after the opening date on the container. 3.1-21(i)(2) 3.1-21(i)(3)		The Administrator assumes responsibility for and ensures compliance. Any documentation regarding the POC for F812 will be available to the surveyors upon their request. I respectfully request paper compliance regarding F812. Compliance Date: August 8, 2023 Margaret H. Braun, HFA Administrator Braun's Nursing Home	
F 0867 SS=F Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	§483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.			
	Based on interview and record review, the facility failed to complete a Quality Assurance and Performance Improvement Program based on identification, investigation, analysis, and prevention of adverse events in the facility within the past year. The data collection form lacked sufficient detail to identify potential high-risk, high-volume, or problem-prone areas for improvement that were counted under the "other" category of the data collection form. Findings include:	F 0867	Plan of Correction Response for F867 In the past and certainly going forward, the administration has utilized a philosophy of addressing issues, concerns, problems, etc., when they are identified versus waiting for a monthly or quarterly QAPI meeting. During the previous QA/QAPI meetings held in the first and second quarter of 2023, the administrator updated	08/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	During an interview on 7/13/23 at 9:29 A.M. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), they indicated they were not aware of any Performance Improvement Projects occurring at the present time or during the past year. They indicated there was no formal mechanism for staff to report concerns; staff leave notes in the administrators' mailboxes. No QAA committee meeting minutes were available. During a phone call with the administrator on 7/13/23 at 10:51 A.M., the administrator indicated the meeting minutes were at home in her briefcase and she was out of town. During record review of event tracking in 2023, the Quarterly Incident Summary Form and the Quality Assurance Meeting DON reports did not match. For the first quarter of 2023 (January, February, March), The Quarterly Incident Summary Form, undated, indicated 16 falls, 17 infections, and 8 pressure wounds. The report did not indicate if the infections, falls, and pressure wounds were facility-acquired. The Quarterly Quality Assurance Meeting DON Report, undated, indicated 15 falls, 15 infections, and 14 pressure wounds. The report did not indicate if the infections, falls, and pressure wounds were facility-acquired. There were no performance improvement plans related to falls, infections, or pressure wounds. For the second quarter of 2023 (April, May, June), the Quarterly Incident Summary Form, undated, indicated 7 falls, 14 infections, and 1 pressure wound. The report did not indicate if the infections, falls, infections, and pressure wounds were facility-acquired. The Quarterly Quality Assurance Meeting DON Report, undated, indicated 8 falls, 11 infections, and 1 pressure wound. There was no documentation of performance		those present of the following: · New Legionella Water Management Program. · Test results for Legionella bacteria. · Complete replacement of unit 200 roof. · Partial replacement and repair of unit 300 roof. · Timeline and go live date for Point Click Care conversion for the MAR, TAR, and POS. The program was in place, the minutes to substantiate the process weren't available. In fact, multiple QAPI meetings of 2-4 individuals have occurred since the recertification survey was completed on 7/13/2023. Although they are short and quick, a summary of each meeting is recorded. **MONITORING** To be efficient and utilize people's time effectively, the Quality Assurance and QAPI meeting will be combined going forward with the 3rd quarter of 2023. The Administrator assumes responsibility for and ensures compliance. Any documentation regarding the POC for F867 will be available to the surveyors upon their request. I respectfully request paper compliance regarding F867. Compliance Date: August 4, 2023 Margaret H. Braun, HFA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRAUN'S NURSING HOME	909 FIRST AVE EVANSVILLE, IN 47710

(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
	improvement plans to address falls, infections, and/or pressure wounds. The facility Quality Assurance and Performance Improvement (QAPI) Program policy, undated, indicated that performance improvement projects (PIP) are initiated when problems are identified, root cause analysis (RCA) is used to determine whether identified issues are exacerbated by the way care and services are organized or delivered, and the RCA serves as a highly-structured approach to fully understanding the nature of an identified problem, its cause, and the implications of making changes to improve the problem. 3.1-52(b)(2)		Administrator Braun's Nursing Home	