STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(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 the Investigation of Complaints IN00353169, IN00353234, IN00353730, IN00354399 and IN00355536. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00353169- Substantiated. Federal/State deficiencies related to the allegations are cited at F657, F677 and F725. Complaint IN00353234- Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F725. Complaint IN00353730- Substantiated. Federal/State deficiencies related to the allegations are cited at F690 and F725. Complaint IN00354399- Substantiated. Federal/State deficiencies related to the allegations are cited at F657, F689 and F725. Complaint IN00355536- Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F725. Survey dates: June 15, 16, 17, 18, 19, 20, and 21, 2021 Facility number: 012548 Provider number: 155790 AIM number: 201023760 Census Bed Type: SNF/NF: 82 Total: 82	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census Payor Type: Medicare: 8 Medicaid: 56 Other: 18 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 29, 2021.			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment,			

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	including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to revise the plan of care for 2 of 3 residents reviewed for falls. (Resident C and P) Findings include: 1. The record for Resident C was reviewed on 6/15/21 at 12:54 p.m. Diagnosis included, but were not limited to, congestive heart failure, generalized muscle weakness, difficulty walking, communication deficit and arthritis. The progress notes indicated Resident C had sustained falls on 4/18/21 at 4:30 p.m., 4/29/21 at 10:00 p.m. and was found on the floor of his room on 5/01/21 at 4:45 a.m. The resident's admission MDS (minimum data set) assessment, dated 4/20/21, indicated the resident was severely impaired cognitively and required extensive assistance for mobility. Resident C's plan of care, initiated on 4/16/21, indicated the resident was at risk for falls. The goal was for the resident to be without falls through the review date. Documentation was lacking of additional revisions of the resident's plan of care following the resident's fall on 4/18/21.2. The record for Resident P was reviewed on 6/18/21 at 10:30 a.m. Diagnoses included, but were not limited to, convulsions, muscle weakness and dementia. A fall risk assessment, dated 4/04/21, indicated the resident had a diminished safety awareness, was non-ambulatory and required a sit to stand lift for transfers (a mechanical device to facilitate transfer for a resident safely who was not ambulatory).	F 0657	1.F657 – Care plan timing and revision 1.Resident C and P could not be identified due to resident confidentiality 2.All residents who sustain a fall have the potential to be affected by the deficient practice. An audit will be conducted of all falls within the last 30 days to ensure residents care plan has been updated with an appropriate intervention related to the root cause of the fall. 3.IDT team and licensed nurses will be educated on the “Care Plan Overview” policy 4.DON/Clinical Designee will audit falls 7 days per week x 30 days to ensure that residents plan of care has been updated with appropriate intervention related to root cause of fall, then 5 times per week x 30 days, then 3 times per week x 1 month. The DON/Clinical Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations. 5.Date of Compliance: 7-17-21	07/17/2021

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	A fall progress note, dated 5/21/21, indicated the resident crawled out of bed at 12 a.m., in search of food stating he was hungry. A Post Fall Evaluation, dated 5/21/21, indicated the resident had a witnessed fall at 12 a.m., and it occurred in the resident's room. The resident was getting out of bed in search of food. The resident's hunger contributed to his fall. A Care Plan, initiated 10/06/20 and revised 3/03/21, indicated the resident was at risk for falls related to dementia and diminished safety awareness. There were no indication the resident had an actual fall on 5/21/21 and a new intervention was not added to the resident's care plan after the fall. During an interview, on 6/21/21 at 3:00 p.m., the Regional Director of Clinical Operations (RDCO) indicated interventions to the plan of care should have been updated following the falls for Residents C and P. The facility policy and procedure regarding care plans was requested on 6/21/21 at 3:00 p.m. The policy and procedure was not received prior to, or at the time of exit of the facility on 6/21/21 at 5:13 p.m. This Federal Tag relates to complaints IN00353169 and IN00354399. 3.1-35(b)(1) 3.1- 35(d)(2)(A) 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to			

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	carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide the necessary services to 3 of 9 residents reviewed who required assistance with grooming, personal and oral hygiene. (Residents H, L and Q) Findings include: 1. During an interview, on 6/16/21 at 10:40 a.m., Resident H's sister indicated the resident received poor oral hygiene causing her to have oral pain and subsequently had to go to the dentist. The resident also developed new skin concerns related to her skin not being kept dry. Resident H's record was reviewed on 6/16/21 at 8:51 a.m. Diagnoses included, but were not limited to, CVA (stroke), hemiplegia (paralysis on one side of the body) and morbid obesity. A physician's order, dated 6/07/21, indicated to ensure the resident was dry and clean and teeth were brushed every 2 hours. A quarterly admission minimum data set (MDS) assessment, dated 5/17/21, indicated the resident required limited assistance of one for personal hygiene and required extensive assistance of two for bed mobility. She did not have any open pressure skin areas at that time. A care plan, dated 10/7/21, indicated the resident had a self care deficit related to immobility and left hemiplegia. The resident required total assistance with personal hygiene care.	F 0677	1.F677 – ADL Care provided for dependent residents 1.Residents H, L, and Q could not be identified due to resident confidentiality 2.All residents have the potential to be affected by the deficient practice. An audit was done to ensure all residents had personal hygiene needs, including oral care and fingernail care, met. Those identified that required assistance with their nail care, oral care, and personal hygiene needs were assisted and tasks were completed. 3.Staff will be educated on “Nail and Hair Hygiene Services” and “Oral Hygiene” policies. 4.DON/Designee will observe 10 residents for nail care/oral hygiene/personal hygiene weekly x 1 month, then 5 residents weekly x 1 month, then 10 residents monthly x 1 month. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations. 5.Date of Compliance: 7-17-21	07/17/2021

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	A care plan, dated 10/7/21, indicated the resident had physical limitations and required incontinent checks every two hours to include washing, rinsing and drying the perineum. A Skin Grid Pressure documentation, dated 6/7/21, indicated the resident developed a new pressure area to her left thigh which was acquired in the facility. A document, titled "Survey Report Documentation," for 5/2021 and 6/2021 was reviewed, the following dates indicated the resident did not receive any personal hygiene for the 24 hour period: 5/19, 5/23, 6/2, 6/5, 6/6, 6/8 and 6/13. The resident's treatment record for 6/2021 was reviewed. The resident did not receive oral care on 6/13 at 7, 9, and 11 a.m. also at 1 p.m., and she did not receive oral care on 6/15 at 3, 5 or 7 p.m. as ordered by the physician. A progress note, dated 6/10/21 at 11:29 a.m., indicated the resident expressed concerns of tooth pain and a dental appointment was made for 6/11/21. A progress note, dated 6/11/21 at 11:39 a.m., indicated the resident had returned from her dental appointment and had been referred to [name of dentistry] for further treatment. 2. During an interview, on 6/15/21 at 10:15 a.m., Resident L indicated when she asked staff to help her get cleaned up she was told they did not have time and acted inconvenienced. During an interview, on 6/21/21 at 4:00 p.m., the resident indicated she did not get help with her			

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	basic needs like washing her face and brushing her teeth. Her arthritis and weakness made this hard for her to do on her own. The record for Resident L was reviewed on 6/18/21 at 11:15 a.m. Diagnoses included, but were not limited to, morbid obesity, muscle weakness and pain in unspecified limb. A quarterly MDS assessment, dated 5/21/21, indicated the resident required limited assistance and required the physical help of 1 staff. A document, titled "Survey Report Documentation," for 5/2021 and 6/2021 was reviewed, the following dates indicated the resident did not receive any personal hygiene for the 24 hour period: 5/19, 5/23, 6/2, 6/5, 6/6, 6/8 and 6/13. During an interview, on 6/17/21 at 3:22 p.m., the Director of Nursing indicated if care was not documented, then care was not provided. 3. During an observation and interview, on 6/20/21 at 12:05 a.m., Resident Q was lying in his bed, on his stomach, holding his cell phone. His fingernails were long, sharp and had yellow and brown substances under them. He indicated he did not like his fingernails to be long. He got his own clippers because the staff were not trimming his nails, but someone took his clippers. Resident Q's record was reviewed on 6/20/21 at 2:00 p.m. His diagnoses included, but were not limited to, acute respiratory failure, morbid (severe) obesity, diabetes mellitus, heart failure and functional quadriplegia. His admission minimum data set (MDS) assessment, dated 4/01/21, indicated his cognitive			

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	status was intact. He had no delirium, psychosis or behavioral symptoms. He required extensive assistance by two people for personal hygiene. Resident Q's progress note, dated 5/12/21, indicated he refused a shower. There were no other progress notes to reflect he refused assistance with personal hygiene from 5/12/21 to the time of the observation of long nails, 6/20/21. A current facility policy, titled "Nail and Hair Hygiene Services," dated 4/14/17 and provided by the Regional Director of Clinical Operation (RDCO) on 6/21/21 at 5:00 p.m., indicated "...This facility will provide routine care for the resident for hygienic purposes and for the psychosocial well-being of the resident included but not limited to hair hygiene that includes combing, brushing, shampoo, trimming, and simple haircuts. Routine care also includes nail hygiene services including routine trimming, cleaning, and filing. Routine nail hygiene and hair hygiene may be performed in conjunction with bathing or performed separately...d. Daily hand washing will be completed with nail care to include cleaning and trimming or filing of sharp edges to prevent infection and damage to skin from scratching...." A current facility policy, titled "Oral Hygiene," dated 10/31/18 and provided by the Regional Director of Clinical Operations on 6/21/21 at 4:15 p.m., indicated "...It is the policy of this facility to provide resident centered care that needs the psychosocial, physical and emotional needs and concerns of the residents...Mouth care or oral hygiene is part of the daily hygienic care of the resident...." A current facility policy, titled "Routine Care-Bathing hygiene," dated 5/13/2003 and			

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	provided by the Regional Director of Clinical Operations on 6/21/21 at 4:15 p.m., indicated "...the facility will provide routine care for the resident for hygienic purposes and for the psychosocial well-being of the resident including...nail hygiene...trimming, cleaning and filing...." A current facility policy, titled "Routine Resident Care," dated as revised on 4/6/16 and provided by the Regional Director of Clinical Operations on 6/21/21 at 4:15 p.m., indicated "...routine resident care: care that is not necessarily medically necessary or clinically based but necessary for quality of life promoting dignity and independence as appropriate...Routine care by nursing assistant includes...assisting or provides for personal care..." This Federal Tag relates to complaints IN00353169 and IN00355536. 3.1-38(a)(3)(E) 3.1-38(b)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision for 1 of 3 residents reviewed with falls	F 0689	1.F689 – Free of Accident Hazards/Supervision/Devices 1.Residents C and R could not	07/17/2021

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	(Resident C) and failed to ensure the environment was free of accident hazards when medications were left at the bedside of 1 randomly observed resident. (Resident R). Findings include: 1. During a review of police case reports, on 6/15/21 at 3:20 p.m., the report indicated on 5/01/21, while on routine patrol in the city, an officer was dispatched at approximately 3:48 a.m., to the facility. The report indicated the officer observed Resident C from the common hallway, through the resident's open room door, lying on the floor on his back with his feet on the bed. The report stated there was significant blood about the bed linen and floor. Resident C's hospital gown exposed his genitals, which appeared to be covered in blood. Resident C's right hand was also wrapped and appeared to be bleeding. Medics from the FD arrived on-scene to begin assessing and treating Resident C. The medic advised they had a run on Resident C earlier in the day and resident was transported to a local hospital, by ambulance for treatment. The record for Resident C was reviewed on 6/15/21 at 12:54 p.m. Diagnosis included, but were not limited to, generalized muscle weakness, difficulty walking, communication deficit and arthritis. The Facility progress notes indicated the following: On 4/16/21 at 5:17 a.m., the resident was admitted at 10 p.m. He tried getting out of bed on several occasions and succeeded once. The facility had to have a HA [hospitality aide] sit with him for several hours until he fell asleep.		be identified due to resident confidentiality. 2.All residents have the potential to be affected by the deficient practices. An audit will be conducted of all falls within the last 30 days to ensure residents care plan has been updated with an appropriate intervention related to the root cause of the fall. An audit was done to ensure all residents had their care planned fall interventions in place and that no medications were left at bedside. 3.All nursing staff were educated on “Care Plan Overview” and “Medication Administration” policies. 4.The IDT will complete room rounds 5 times per week for 30 days to validate fall interventions in place and no medications left at bedside, then three times a week for 30 days, then twice a month for 2 months. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations. 5.Date of Compliance: 7-17-21	

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On 4/18/21 at 4:30 p.m., the resident fell in his room trying to get out of the wheelchair. He fell onto his right side and had a skin tear to right hand. The fall was witnessed.

On 4/19/21 at 10:22 a.m., the Nurse Practitioner's assessment indicated his walk was shuffled and unsteady. His overall judgement and insight was impaired.

On 4/29/21 at 10:47 p.m., the resident had an unwitnessed fall in his room trying to ambulate. He received a skin tear and bruising to his right forearm. He complained of pain to the area.

The progress notes indicated the resident's physician was notified and orders were received to send the resident to the emergency room for an x-ray of the right forearm, to evaluate and treat. Documentation in the notes indicated 911 was notified, however no notes were observed of the resident leaving the facility or results of the evaluation, with regard to injuries sustained in his fall.

The progress notes indicated the resident was evaluated by the Nurse Practitioner (NP) on 4/30/21 at 8:58 a.m., and indicated the following:

The nurse alerted the NP the patient had a sign of stroke. He appeared to have more weakness to his right side with a slight droopy to the right side of his face. He was unable to repeat words, disoriented, agitated and combative. He was sent to the ER [emergency room] for further evaluation.

The progress notes continued with the following:

On 5/01/21 at 7:09 a.m., at approximately 4:00 a.m.,

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	the resident was discovered on the floor at bedside by an officer passing by the resident's room. Bleeding was noted by the CNA to the left arm where there was already a previous bandage. The EMT was already present at the time and requested paperwork be prepared to transport the resident to the local hospital due to the bleeding noted. The resident was confused and unable to explain what happened at that time. A "Fall Follow Up - V2" assessment, dated 4/29/21 at 8:47 p.m., indicated the date of the fall was 04/29/21. The interventions put in place to help prevent future falls was for the resident to be advised to ask for assistance. Resident C's plan of care, initiated on 4/16/21, indicated the resident was at risk for falls. The goal was for the resident to be without falls through the review date. Documentation was lacking of revisions to the interventions following the falls on 4/18/21 and 4/29/21. The only revision or addition to interventions to the plan of care was observed to be dated 4/16/21. The intervention indicated "Resident to sit in wheel chair at nurses station during waking hours." The facility's policy and procedure regarding falls was requested on 6/21/2021 at 3:44 p.m. The Regional Director of Clinical Operations (RDCO) indicated the facility did not have a fall policy and procedure.2. During an observation, on 6/19/21 at 11:45 p.m., Resident R was lying on his side in his bed. Two staff members were at his bedside. Six pills were on his bedside table in a pill dispenser cup. One of staff members asked the resident if he wanted to take the pills. The resident said he would, but he needed assistance. The staff member then lifted the pill dispenser cup to his mouth and poured the six pills into his mouth.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 6/19/21 at 11:48 p.m., the staff member who poured the medications into Resident R's mouth indicated she was a CNA (CNA 3). She was neither a nurse nor a Qualified Medication Aide (QMA). She had taken the QMA class but was waiting for her license to come through. The pills on Resident R's bedside table were left there by the QMA who left at 10:00 p.m. Resident R's record was reviewed on 6/21/21 at 10:05 a.m. Diagnoses included, but were not limited to, embolism and thrombosis (blood clots) of the lower extremities, hypertensive heart disease, benign prostatic hyperplasia (enlarged prostate), hyperlipidemia (elevated cholesterol), dysphasia (difficulty swallowing), and gastroesophageal reflux disease (GERD, a condition in which stomach contents rise up into the esophagus). Resident R's electronic medication record indicated the following medications were administered on 6/19/21: One, 2.5 milligram (mg) tablet of midodrine for hypotension, scheduled for 9:00 p.m. One, 20 mg tablet of simvastatin to treat high cholesterol, scheduled for 8:00 p.m. One, 25 mg tablet of metoprolol tartrate for hypertension, scheduled for 8:00 p.m. One, 2.5 mg tablet of Eliquis to prevent blood clots, scheduled for 8:00 p.m. One, 100 mg tablet of docusate sodium for constipation, scheduled for 8:00 p.m.			

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	Two, 0.4 mg capsules of tamsulosin to treat benign prostatic hyperplasia (enlarged prostate), scheduled for 9:00 p.m. Resident R's quarterly minimum data set (MDS) assessment, dated 4/30/21, indicated he had a moderately impaired cognitive status. He required supervision by one person for eating. Resident R's care plan, dated 6/16/21, reflected the following. He had GERD. Interventions included, but were not limited to, observing for coughing or choking while lying down, regurgitation, and swallowing problems. He had impaired cognition/dementia and needed supervision/assistance with decision making. He had assistance with daily living (ADL) self-care performance deficit and required staff participation to eat. During an interview, on 6/19/21 at 11:50 a.m., Licensed Practical Nurse (LPN) 14 indicated the pills at Resident R's bedside were left by the QMA who left at 10:00 p.m. Per the charting, on the electronic medication administration record (eMAR), the following seven pills were dispensed by the QMA from the previous shift: one tablet of midodrine, one tablet of simvastatin, one tablet of metoprolol tartrate, one tablet of Eliquis, one tablet of docusate sodium, and two capsules of tamsulosin. She did not know why only six pills were in the dispenser cup at the resident's bedside. She suggested he may have declined one of the pills but was unable to tell which one. She indicated the pills should not have been left at his bedside and the CNA should not have administered the medications. During an interview, on 6/20/21 at 12:15 a.m., the Regional Director of Clinical Operations (RDCO)			

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	indicated QMAs should stay at the bedside to observe residents taking their medications if the resident had not been assessed to be able to self-administer medications. Resident R had neither been assessed nor had a physician's order to be appropriate to self-administer medications. CNAs could not administer medications. A current facility policy, titled "Medication Administration," dated 12/14/17 and provided by the RDCO on 6/21/21 at 11:15 a.m., indicated "...e. Licensed or authorized personnel may administer prescribed medication...m. Do not administer medications prepared by others...o. Medications must be poured just prior to administering per resident ...w. Never leave medications unattended...bb. Remain with resident until the medication is swallowed. cc. Do not leave medication at bedside...." This Federal tag relates to Complaints IN00354399 and IN00353234. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-			

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	(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to have an appropriate indication for the use of an indwelling Foley catheter for 1 of 2 residents reviewed for indwelling catheters. (Resident E) Finding includes: The record for Resident E was reviewed on 6/15/21 at 2:00 p.m. Diagnoses included, but were not limited to, over active bladder, morbid obesity and recurrent UTI (urinary tract infection). A physician's order, dated 5/07/21, indicated to place an anchored indwelling urinary (Foley) catheter for wound care/healing. An Admission Skin Evaluation, dated 5/07/21,	F 0690	1.F690 – Bowel/Bladder Incontinence, Catheter, UTI 1.Resident E could not be identified due to resident confidentiality. 2.All residents with an indwelling catheter have the potential to be affected by the deficient practice. An audit will be completed to ensure all residents with an indwelling catheter have an appropriate diagnosis. Any resident noted without an appropriate diagnosis will be seen by physician to determine appropriate diagnosis or to get an order to remove indwelling	07/17/2021

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	indicated the only skin alteration/pressure area was to the resident's chest. A Nurse Practitioner (NP) progress note, dated 5/10/21, indicated the resident requested a Foley catheter to be placed due to her constant bowel and bladder incontinence. The NP ordered a Foley catheter to be placed for wound healing. A care plan, dated 5/17/21, indicated the resident had an indwelling catheter related to impaired skin integrity. During an interview, with the NP on 6/15/21 at 1:00 p.m., she indicated she ordered a Foley catheter to be placed primarily because the staff was unable to get to the resident enough to change her and keep her dry, for wound healing. During an interview, on 6/17/21 at 11:00 a.m., Resident E indicated a Foley catheter was placed to keep her dry because the nursing staff was not checking and changing her enough. During an interview, on 6/21/21 at 3:27 p.m., the Regional Director of Clinical Operations indicated this was not a correct indication or an appropriate order for the use of a Foley catheter for Resident E. This Federal Tag relates to Complaints IN00353730. 3.1-41(a)(1)		catheter. 3.All licensed nurses will be educated on appropriate diagnosis for indwelling catheters and ensuring that resident has appropriate diagnosis. 4.DON/Clinical Designee will audit indwelling Foley catheters 7 days per week x 30 days to ensure that resident has an appropriate diagnosis for the indwelling Foley catheter, then 5 times per week x 30 days, then 3 times per week x 1 month. The DON/Clinical Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations. 5.Date of Compliance: 7-17-21	
F 0725 SS=J Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills			

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	sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview and record review, the facility failed to have sufficient staff with the appropriate competencies and skills sets to provide nursing care to residents to ensure their safety and care needs were met. Multiple residents called 911 to the facility during the night shift to seek help in care needs and while the police were at the facility, they observed the lack of available staff to ensure safety and medical needs were addressed. The police department had been called a minimum of 13 times since 4/01/21. Residents, family and staff interviews indicated a lack of staff to provide personal and medical care. (Resident B, C, N, M, E and Q)	F 0725	Immediate Jeopardy Removal Revision Preventative measures and treatments for Insufficient Staffing Dear ISDH, This letter and attached documentation constitute a credible allegation by Bridgewater Healthcare Center that the immediacy of the allegations identified by the ISDH. Accordingly the facility requests that you accept this information as the basis to return to conduct an immediate follow up survey to	07/17/2021

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	The immediate jeopardy began on 5/01/21 when insufficient staff were observed by the local police and 911 Emergency Medical Technician (EMT) services. The Executive Director (ED), Director of Nurses (DON) and Regional Director of Clinical Services (RDOC) were notified of the immediate jeopardy at 5:04 p.m., on 06/17/21. The immediate jeopardy was removed on 06/21/21, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During an interview, on 6/15/21 at 2:45 p.m., a detective from the Police Department (PD) indicated he had multiple complaints from residents calling 911 for service in the facility. The detective spoke at length regarding his concern for the residents of the facility. During an interview, on 6/17/21 at 11:22 a.m., the detective indicated since 4/01/21, the police had been dispatched a "minimum" of 13 times to the facility. He had never encountered a situation like this before. He feared for the residents' safety. 1. Officer case reports, received and reviewed from the detective on 6/15/2021 at 3:00 p.m., indicated the following: On 6/14/21, the police responded to a "Sick Person/Specific Diagnosis" call. A resident called the police due to not receiving their medications. When the police spoke to the resident, she indicated she also called the facility number and had reached a nurse and finally received her medications right before the officers arrived. The officers noted a clear liquid puddle under the		remove the immediate jeopardy. While the facility does not necessarily agree that all of the allegations set forth in deficiencies are accurate, the facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. 1. Resident B had minor injury and was provided care at the hospital on 5/1/21, and no longer resides at the facility. No other residents have sustained harm while residing at the facility. Resident A, who called the police on the night of 5/1/2021 during the night has a history of disorientation and cognitive communication deficit. Resident A has been free from injury and harm throughout stay at facility. Resident A's care plan has been revised to address her continual need to call the police when her care needs are not met to her satisfaction. Resident C no longer has a Foley catheter and no further allergic reactions have been noted related to the iodine based product. New admissions will be placed on hold and re-evaluated daily.	

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	resident's bed. The resident indicated it was urine. As the officers were leaving the facility, they were flagged down by a family member who indicated the resident who called the police had been screaming for approximately one hour and the level of care at the facility was poor. The officers noted she appeared concerned for the residents. On 6/13/21, the police responded to an abuse/neglect incident at the facility. A resident on the 5000 wing had called dispatch to report she was not receiving proper treatment. The officers arrived as a staff member was in the process of exiting the building. The officers explained why they were there, and the staff pointed the officers to the wing they needed and exited the building. When they arrived at the nurses' station, a staff member was not there. A non-verbal resident was at the nursing station, holding a piece of paper which stated his mouth was hurting and he needed his medication. The officer sat at the nurses' station for "5-10 minutes" before a Certified Nurse Aide (CNA) arrived. They advised the CNA why they were there, and they were trying to get the gentleman at the nurses' station and the resident who called the police some help. The CNA told the officers she was the only person on the wing, and she would "get to them when she could." The report noted the CNA seemed very irritated and agitated. The officers then made their way to check the resident who called dispatch. The resident indicated to the officers she needed changed, had been in the same clothes the last 6-7 hours and she was soiled. She was thirsty and had not had water in a while. She indicated to the officers, when she told the CNA on the wing what she needed, the CNA told her she was "tired and was not going to overwork herself." Unable to find a nurse on the wing, the officers proceeded to another wing. He		The facility will increase oversight and supervision on evenings, nights, and weekends to ensure staff are meeting the care needs of the residents. The staffing schedule will be reviewed by the Regional/Divisional staff with the Administrator, DON, Human Resources manager, and staffing coordinator, to validate appropriate staffing numbers and identify the distribution of staff based on resident needs. An assessment has been completed to determine the best staffing pattern according to the facility layout. The facility Medical Director has been notified of ongoing plan. 2.All residents have the potential to be affected. The facility has implemented a recruiting initiative for licensed nurses, QMAs, and C.N.A.s. The facility is employing agency staff to maintain appropriate staffing numbers. The facility will also offer pick-up bonuses for staff. The facility is implementing increased oversight on evenings,	

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	explained the situation to the staff on the other wing and another CNA volunteered to come help the residents. While walking with the officers, the CNA indicated the facility cannot keep employees, employees were constantly calling in and the patients were not receiving the proper care they needed. Before the officers left the building, the nurse for the 5000 unit approached the officers. The nurse told the officers, she did her best to provide care to the residents but there were way more residents than nurses and CNAs. The quality of the employees hired was also an issue. She sent an employee home this night due to her continuing to fall asleep on the job. On 5/17/21, a resident's family member contacted the police department to report she felt her family member was being neglected, she was contacting the Indiana Department of Health and was transferring her family member to another facility. The police department notified the Adult Protective Services. On 5/01/21, while on routine patrol in the city, an officer was dispatched at approximately 3:48 a.m., to the facility, in reference to a welfare check. The complainant, Resident B, contacted communications requesting police assistance. As the officer looked throughout the hallways for a member of the facility staff, he was unable to locate any nurse or other employee in the area. There were audible call button notifications sounding at the nursing station, and at least two rooms had flashing lights outside indicating the occupants may need to speak with staff. As he began looking into open doors to see if a nursing staff member was attending to another resident, he observed a white male, identified as Resident C, laying on the floor on his back with his feet on the bed. There was significant blood about the		nights, and weekends. An audit will be conducted with all interviewable residents to ensure their care needs are being met and residents identified as non-interviewable will have their responsible party interviewed. Any identified concerns will be addressed and the physician and family will be notified with their care plan updated accordingly. 3.All licensed nurses and QMAs will be in-serviced on answering call lights, incontinence care, skin management, allergies, and catheters. All staff will be in-serviced on answering call lights and allergies. Regional Director of Operations will educate ED, HRM, and DON on daily staffing review and ensuring adequate staffing levels scheduled to meet resident's needs. 4.The staffing schedule will be reviewed daily with the Administrator, DON, Human Resources manager, staffing coordinator, and Regional Director of Operations to validate appropriate staffing numbers and identify the distribution of staff based on resident needs no less than 3 months. Weekend staffing will be reviewed	

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	bed linen and floor. Resident C's hospital gown exposed his genitals, which appeared to be covered in blood. Resident C's right hand was also wrapped and appeared to be bleeding. He continued his efforts to locate a nurse, until it became clear he would not locate one faster than the Fire Department (FD) assistance could be summoned. Medics from the FD arrived on-scene to begin assessing and treating Resident C. The medic advised they had run on Resident C earlier in the day and he was being transported to a local hospital, by ambulance for treatment. The Fire Department report, dated 5/1/21, indicated upon arrival EMTs were not greeted by staff and no staff were to be found. EMTs were called by the police department after they found the Resident C on the ground. The resident was found wearing a tank top with no bottoms on, only a sheet on the bed, no blanket. The resident had dried blood on his penis and fresh blood coming from from gauze wrapped around his right elbow. The EMTs had ran on this resident earlier in the day for a suspected stroke. They began looking for staff and when they eventually found staff they advised they needed paperwork for Resident C as they were transporting him to the hospital. Staff was not able to provide any information on the resident. After several minute of waiting, staff provided paperwork for the resident. During an interview with Resident C's family, on 6/15/21 at 11:33 a.m., the family member indicated they had been contacted by the police department to inform them Resident C had been found on the floor of his room and had been taken to the hospital. The family member indicated during the conversation with the officer at the time of the notification, the officer told the family "it took		every Friday to ensure weekend coverage is appropriate this will be an on-going facility process. If daily staffing review determines staffing is not adequate according to the tool they will call current employees that are not scheduled for shift pick up. If no coverage can be obtained the nurse manager on call will assist with coverage and will be required to come to facility to provide direct care support. A Nursing Manager on-call schedule will be developed to include off shift hours and support will be provided for direct care staff when needed due to census fluctuations, report offs, and acuity changes according. The Nurse Manager on call schedule will be posted for direct care staff availability. ED, DON, Staffing coordinator will review night shift staffing daily to ensure sufficient staff according to current acuity and initiate Nurse Manager on-call support, if indicated. Resident needs (showering, toileting, restorative, ect) will be validated by the completion of 10 Resident interviews/observations per week and reviewed during weekly QA meeting with discussion on improvements needed and corrective action	

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	them 7 minutes to get someone to let them into the facility and 20 minutes to find any staff." The family member indicated the facility notified them around 7:00 a.m., the resident had been sent to the emergency room for treatment. They further indicated Resident C was "never the same" and passed away sometime in early June 2021. Resident C's medical record was reviewed on 6/15/21 at 3:30 p.m. Diagnoses included, but were not limited to, kidney failure, chronic obstructive pulmonary disorder (obstructive lung disease), atrial fibrillation (abnormal heart rhythm), cognitive communication deficit and aphasia (inability to comprehend or formulate language), muscle weakness and difficulty walking. He resided on the 5000 unit. Resident C's progress notes indicated the following: On 5/01/21 at 5:29 a.m., EMTs (Emergency Medical Technician) made the decision to take Resident C to the ED (emergency department), they were on site for another patient with behavioral issues and noted this patient had fallen and was bleeding. On 5/01/21 at 7:09 a.m., at approximately 4:00 a.m., the resident was discovered on the floor at bedside by an officer passing by the resident's room. Bleeding was noted by the CNA to the left arm where there was already a previous bandage. The EMT was already present at the time and requested paperwork be prepared to transport the resident to the local hospital due to the bleeding noted. The resident was confused and unable to explain what happened at that time. 2. During an interview, on 6/17/21 at 10:53 a.m., a		needed, if applicable. A Manager on Duty schedule will be maintained to ensure a manger is in facility 7 days per week and rounds will be completed to review Resident Care and any concerns will be escalated to Executive Director. The Manager on duty schedule will be posted for direct care staff to reference. The results of these audits will be reviewed during weekly QA meeting. Nurse staff interviews will be conducted to identify staffing concerns and recommendations weekly and will be reviewed at a weekly Ad Hoc QAPI meeting with the IDT. DON/Designee will audit through interviews/observation that nursing staff is aware of how to validate resident allergies 2 x weekly for 1 month, then 3 x monthly x 2 months. All findings will be reported to the QAPI committee monthly and the QAPI committee will determine when compliance is achieved or if ongoing monitoring is achieved.	

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	family member of Resident N indicated they stayed with the resident "24/7" because they felt there was "not enough staff" and staff who were working were not "knowledgeable" enough to care for their family member. The family member indicated staff routinely came to the resident's room, turned off the call light and never came back. The family member indicated, on one occasion, the family was being assisted to dress Resident N after being incontinent of liquid stool. There was liquid stool on the floor, however the staff member instructed the family member to assist the resident to stand. She felt the resident would slip and fall and refused to assist the resident to stand until the liquid stool was cleaned from the floor. Resident N's record was reviewed 6/18/21 at 11:32 a.m. Diagnoses included, but were not limited to, mild cognitive impairment, history of urinary tract infections, difficulty walking and communication deficit. Resident N resided on the 5000 unit. 3. During an interview, on 6/16/2021 at 10:20 a.m., Resident M, an alert and oriented resident, indicated she had been at the facility for a "long time" and had moved to the 5000 unit about "2-3 months ago." When questioned, Resident M indicated she was scheduled to receive a shower twice a week. She was unable to shower herself because she felt unsteady in the bathroom due to the tile floor. Resident M indicated, at some point in time in the recent past, she had been assisted by staff to the shower, given towels and toiletries and told to take her own shower because there wasn't enough staff to assist her. The resident indicated she refused and now only took one shower a week. Resident M's record was reviewed on 6/18/21 at			

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	11:00 a.m. Diagnoses included, but were not limited to, asthma, chronic kidney disease, muscle weakness, unsteadiness on feet and chronic pain syndrome. Resident M resided on the 5000 unit. 4. During an interview, on 6/17/21 at 11:10 a.m., a resident's family member who wished to remain anonymous, indicated on the evening of 6/12/21 at around 6:00 p.m. to 7:00 p.m., the family member observed five nursing staff standing at the nursing station on unit 5000. The family member indicated there were "at least 4 call lights blinking" down the hallway on the outside of the resident rooms, with an audible alarm heard to be sounding in the vicinity of the nursing station. Staff were talking and laughing and none of the staff members were observed to answer the call lights. The family member was disturbed by this. The same family member also indicated, during the night of 5/01/21 at around 4:00 a.m., she observed the police to be in the facility. The family member stated a resident could be heard "screaming from her room down the hall" and the family member told the police officer the resident had been "screaming for help for about two hours" prior to their arrival. This family had also pulled their family member's call light before in an attempt to receive assistance for the resident to be taken to the bathroom. This family member stated on at least one occasion, a staff member came to the room, turned the light off and stated she would have to get someone to assist her. The family member indicated, after a long period of time, the CNA came back to the room and stated she was unable to find anyone to assist her.5. Resident E's record was reviewed on 6/15/21 at 2:00 p.m. Diagnoses included, but were not limited to, overactive bladder, morbid obesity and lymphedema (swelling in an arm or leg from lymph fluid buildup). Resident E resided on the 5000 unit.			

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An Admission Skin Evaluation, dated 5/07/21, indicated the only skin alteration/pressure area was to her chest.

A physician's order, dated 5/07/21, indicated to place an anchored indwelling urinary (Foley) catheter for wound care/healing.

A Nurse Practitioner (NP) progress note, dated 5/10/21, indicated the resident was admitted with wounds on her buttocks. The resident requested a Foley catheter be placed due to her constant bowel and bladder incontinence. The NP ordered a Foley catheter to be placed for wound healing.

An Admission Record, an Order Summary, and a Medication Administration Record for Resident E indicated the resident had an allergy to Iodine compounds.

A progress note, written by the Medical Director, on 5/11/21 at 12:39 p.m., indicated Resident E had a Foley catheter in place. She had an allergy to iodine and betadine (a form of iodine) was used to insert the catheter. The resident complained of vaginal itching and Benadryl (a medication used to treat itching) 25 milligrams two times a day as needed was ordered.

A nursing progress note, dated 5/13/21 at 4:01 p.m., indicated the resident had blood in her urine.

A NP progress note, dated 5/17/21 at 11:33 a.m., indicated the resident's catheter was "discontinued due to her unresolved/persistent pain on her insertion area."

A progress note, written by the Medical Director, on 5/18/21 at 12:40 p.m., indicated the resident

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	"had a Foley catheter inserted but now it has been removed due to continued discomfort." A progress note, written by the Medical Director, on 5/26/21 at 6:23 p.m., indicated the resident was still reporting some vaginal and lower abdominal discomfort. The resident had a Foley catheter inserted and betadine was used, the resident reported she had an iodine allergy. During an interview, with the NP, the resident and spouse present, on 6/15/21 at 1:00 p.m., the NP indicated she ordered a Foley catheter to be placed primarily because the staff was unable to get to the resident enough to change her and keep her dry, for wound healing. During an interview, on 6/15/21 at 12:30 p.m., Resident E indicated she had a Foley catheter in place before. The nurse used betadine and she was allergic to iodine compounds and she immediately felt discomfort. During an interview, on 6/17/21 at 11:00 a.m., Resident E indicated a Foley catheter was placed to keep her dry because the nursing staff was not checking and changing her enough. As soon as the Foley catheter was inserted, she immediately felt itching at the site externally and pain internally. She told the nurse right away and asked her "what she used to clean her with" the nurse indicated to her betadine, she immediately told her "what, I am allergic to Iodine." She had pain the entire time the catheter was inserted and on the fourth day she developed blood in her urine. During an interview, on 6/15/21 at 12:30 p.m., Resident E indicated she needed to be checked and changed at least every two hours because			

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	she urinated a lot. There were times she was only changed when she got up in the morning before she was transferred to her chair and then not again till she is put back in bed in the evening. The resident, at that time, was noted to have a urine smell. During an interview, on 6/17/21 at 11:00 a.m., with a Resident E and spouse, the resident indicated yesterday she was changed in the morning and the next time she was changed was not until 4:00 p.m., when she was put back in her bed. She was not changed during the night and when she woke up in the morning, her brief, sheets, and bed mattress were completely saturated with urine. She had never refused to be changed and she had put her call light on several times telling the staff she was wet and needed to be changed. She was told they have a list of residents to clean up and change and there were resident's higher on the list and they will get to her. 6. During an interview, on 6/20/21 at 12:00 a.m., an anonymous nurse indicated a resident on the 2000 unit, Resident Q, called police because he said he was having a seizure. The nurse who was working that night and was the only nurse assigned to both the 2000 and 3000 units. She did not get to speak to the police while they were there for Resident Q because the nurse was on the 3000 unit caring for residents with gastrostomies (g-tubes) and intravenous (IV) medications. It was not unusual for one nurse to be assigned two units or to work with no CNAs. The nurse became tearful when she described she had complained to a corporate person about inadequate staffing. The corporate person told her they did not know what to say other than they would pray. When the nurse asked the corporate person what she should do if someone coded (required CPR), the			

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	person offered no answer. During an interview, on 6/20/21 at 12:05 a.m., Resident Q indicated they often had only one nurse for all the units, and one aide for all units on the night shift (10:00 p.m. to 6:00 a.m.). Sometimes he used the stopwatch feature of his phone to time how long it took staff to respond to his call light. It was not unusual to wait an hour and a half. He had urinary and bowel accidents in bed waiting for help. He could hear other residents calling out for help. He heard a lady screaming for help because she had fallen. One night, he was brought back to the facility by ambulance around 2:00 a.m. The ambulance people banged on the door and pushed the alarm to try to get someone to open the doors while he waited in the ambulance. They were not able to get into the facility until 4:00 a.m., when a staff member leaving the facility let them in. When he got into bed, laying on his stomach, talking to a family member on the phone, he got a feeling in his left leg and left arm. He said "Aunty, I think I'm going to have a seizure." Then his right arm shot one way and his leg another. He started holding onto his bed rail. His Aunt called 911. Resident Q used his call light and screamed at the top of his lungs, but no one came. His Aunt called the facility, but no one answered. When the fire department arrived, he could hear them banging on the door. There were no aides or nurses at the nurses' station because they did not have enough people to work. When they got him to the hospital and put him in the medical bed, the seizure went out of control. Resident Q was observed to have long, sharp fingernails with yellow and brown substances under the nails. The resident indicated he got his own nail clippers because staff were not trimming his nails and then someone took his clippers.			

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	The Fire Department report, dated 4/30/21, indicated they responded on an emergent seizure call. Resident Q called 911 himself after staff did not respond to his call light. The EMTs looked around the unit the resident was on and could not locate staff. Resident Q's medical record was reviewed on 6/20/21 at 2:00 p.m. Diagnoses included, but were not limited to, stroke, heart failure, renal insufficiency, diabetes mellitus, epilepsy, throat cancer, tracheostomy status, morbid (severe) obesity and quadriplegia. His admission minimum data set (MDS) assessment, dated 04/01/21, indicated his cognitive status was intact. He had no delirium, psychosis or behavioral symptoms. He required extensive assistance by one person for bed mobility and toileting, and extensive assistance by two people for transfers and personal hygiene. He did not walk. He was frequently incontinent of urine and bowel. Resident Q's progress note, dated 5/22/21 at 10:01 p.m., indicated the resident called the nurse to the room stating he was having seizure activity. The nurse received an order to send him to the Emergency Room. A progress note, dated 5/23/21 at 3:58 a.m., documented he returned to the facility from the Emergency Room with an order to increase his Keppra (anti-epileptic). Resident Q's care plan, dated 4/27/21, documented he had activities of daily living self-care performance deficits related to diabetes, congestive heart failure, obesity and respiratory failure. He required assistance with grooming,			

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	dressing, bathing, and locomotion and extensive staff participation to use the toilet. 7. A Fire department report, dated 5/5/21, indicated they received a call from a resident who wanted her blankets removed. Dispatch was unable to reach the facility. They went to the residents room. At this time, the resident indicated she felt the staff were verbally abusive. They activated the call button for the nurse. The nurse arrived a little over 10 minutes after they arrived at the facility. The nurse advised she just started her shift and did not know the resident. The nurse told the resident if she felt she was being abused to report it to the day shift. The nurse indicated she could not stay and talk because she had to get back to her computer. They advised the resident to call back if needed and if it was emergent to call 911. A Fire department report, dated 5/12/21, indicated they were dispatched for a resident who had a fall. There was no one at the nursing home to give them information on the resident. A Fire department report, dated 5/30/21, indicated they were dispatched for a call directly from a resident who was upset she could not get a nurse to respond to her call light since last night. Upon arrival to the hospital, the hospital nurse advised they did not receive a prior report from the nursing home regarding the resident. A special note section indicated while the fire department was at the facility at no time did nursing come to the residents room to provide any information although EMTs spoke to them saying hello and informing them why they were there. No paperwork besides the general information sheet was provided. EMTs were able to pull medications, history and allergies from previously			

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	running on this resident. They did ask the facility for DNR paperwork, history and medication list however it was not provided. All the residents belongings were taken with her except for her robe which could not be located due to the resident requested to not return to the facility. A Fire department report, dated 6/5/21, indicated they were dispatched due to a fall. Upon arrival staff pointed them to the room they needed. Staff did not come to the room to help move the resident or ask questions. During transport a brown pill was found on the floor. On the way out, staff was notified they found a pill and placed it on the bedside table. They were delayed on the scene for 20 minutes waiting on paperwork During an interview, on 6/16/21 at 5:15 a.m., QMA (Qualified Medication Aide) 1 indicated it was "not normal" for there to be 3 CNA's on the 5000 unit. There were times when there was only 1 CNA on the 2000 unit and 1 CNA on 5000 unit. She added both units were extremely demanding with many residents requiring assistance with their personal care. QMA 1 indicated aides were unable to turn and reposition residents and change all incontinent residents on these units. When questioned what happens if an employee calls in, the QMA stated the facility tried to replace the staff person, but sometimes are unable to find a replacement so they end up working short staffed and do the best they can. During an interview, on 6/16/21 at 5:30 a.m., CNA 3 indicated she worked the night shift and was concerned with staffing. She typically worked with 1 nurse and sometimes with one other CNA but more often it was just a nurse and herself. She indicated she could not give all the care the way she should "she is one person." Staffing tonight,			

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	was an exception and she didn't know why there were 3 aides scheduled on one floor. She tried to check and change incontinent residents every 2 hours but sometimes when she was by herself she could not do it and the residents would not get the care they deserve. During an interview, on 6/16/21 at 5:53 a.m., an anonymous staff member indicated "the amount of CNA's that worked tonight was very unusual." Normally she worked with only 1 CNA on nights. She indicated she had made a complaint to the State Department of Health 2 different times in the past for staffing related concerns. The residents are not getting the care they should be because there was not enough staff to answer the call lights and do the care which was needed. She often did not feel safe and did not feel the residents were safe. She had seen an increase in pressure wounds because they were not able to turn and change the resident's as often as they should be. During an interview, on 6/16/21 at 5:57 a.m., QMA 5 indicated she worked night shift with a nurse and 1 other aide but sometimes it was just herself and a nurse. She had to work much harder and often the residents did not receive the care they should because the facility had been under-staffed. Recently it had gotten worse and things were not good. During an interview, on 6/16/21 at 6:00 a.m., CNA 6 indicated she had worked mostly on the day shift. She had decreased her hours because the facility had been so under-staffed, she had not been able to give the care she wanted to and the care the residents deserve. The weekends are "horrible" there have been times when she was the only aid for the whole floor and she could not			

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	get all the call lights which go off. During an interview, on 6/17/21 at 11:30 a.m., Licensed Practical Nurse (LPN) 2 indicated there was an LPN, a QMA and 3 aides working today. This was not the typical amount of staff scheduled on day shift, but since "the State" had been in the facility they have had more staff scheduled to work than usual. She also indicated the lack of staffing was affecting patient care in a negative way. During an interview, on 6/19/21 at 11:18 p.m., QMA 1 indicated she was at the facility when the police arrived for a resident on the 5000 unit. She was working in another unit and let them in. She did not know where the staff were on the 5000 unit when the police came and indicated there had been staffing issues. During an interview, on 6/19/21 at 11:35 a.m., CNA 3 indicated, when police were called, it was usually by a resident on the 5000 unit, Resident B. Police would check on Resident B and then come find one of us. The last time the police were there, there was a staffing issue. There wasn't enough staff, and the staff who were working in the 5000 unit couldn't be found. Call lights were not being answered. During an interview, on 6/18/21 at 9:45 a.m., the Staff Scheduler indicated she tried to staff night shifts as follows: 3 nurses for 3 units (1 per unit), and 5 to 6 CNAs, accounting for her PPD (per patient day) budget based on census. She indicated her goal was for 2.5 PPD, with a budget/goal of .58 Registered Nurses (RNs), .987 LPNs, .1 QMAs, and 1.95 CNAs per day. The PPD was calculated as follows: resident census, multiplied by the PPD (2.5) and then divided by			

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	hours of staff (nurse hours were 8 hours per shift and CNA hours were 7.5 hours per shift. During an interview, on 6/18/21 at 10:05 a.m., the Regional Director of Clinical Services indicated the budgeted PPD was 3.66, and the budget was .5 PPD for RNs total in a 24-hour period. The scheduler may be using a different number because she did not schedule unit managers or the Infection Preventionist nurses. Nurse managers provided patient care, the IP nurse did not. The budgeted PPD was .5 RN, .83 LPN, .1 QMA, and 2.008 CNA. The facility's daily staffing sheet, posted at the front of the facility for public view and dated 4/30/21, indicated the census was 85. The public posting indicated the following staff worked during the time police responded to a 911 call (5/01/21 at 3:49 a.m.): 0 RNs, 3 LPNs and 5 CNAs from 10:00 p.m. on 4/30/21 to 6:00 a.m. on 5/01/21. The facility's Daily Schedule, dated 4/30/21, indicated the following staff were scheduled to work on the night of 4/30/21 to the morning of 5/01/21: 2 LPNs, 1 agency nurse, and 6 CNAs. Only one nurse was scheduled to cover the 2000 and 3000 halls. The facility's Time Detail reflected the following staff clocked in to work on the night of 4/30/21 to the morning of 5/01/21: 2 LPNs, 1 QMA, and 2 CNAs (1 less nurse and 3 less CNAs than were publicly posted and/or scheduled to work). The facility's daily staffing sheet, dated 6/12/21, indicated the census was 82. The public posting indicated the following staff worked during the time Resident B alleged to police she did not receive proper care (the evening shift of 6/12/21): 0 RNs, 5 LPNs, and 7 CNAs from 2:00 p.m. to 10:00			

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	p.m. The facility's Daily Schedule, dated 6/12/21, indicated 2 LPNs, 3 QMAs, and 7 CNAs were scheduled to work from 10:00 p.m. on 6/12/21 from 2:00 p.m. to 10:00 p.m. The facility's Time Detail reflected the following staff clocked in to work during that time: 3 QMAs, 3 CNAs, and 2 Hospitality Aides. Agency staff sign-in sheets dated 6/12/21 reflected 1 LPN, 1 QMA, and 3 CNAs also worked. (There was only one nurse in the facility, 4 nurses less than were posted and/or scheduled to work). The facility's public daily staffing sheet indicated the following staff worked during the time police responded to a 911 call at the facility (6/13/21 at 3:02 a.m.): 2 RNs, 1 LPN, and 6 CNAs from 6/12/21 at 10:00 p.m. to 6/13/21 at 6:00 a.m., for a census of 82. The facility's Daily Schedule dated 6/12/21 indicated 2 RNs, 1 LPN, 1 QMA, and 5 CNAs were scheduled to work on 6/12/21 from 10:00 p.m. to 6/13/21 at 6:00 a.m. The facility's Time Detail reflected the following staff clocked in to work during that time: 2 RNs, 1 LPN, 1 QMA, and 3 CNAs. The agency sign-in sheets dated 6/12/21 reflected 1 nurse and 3 additional CNAs worked. The facility's public daily staffing sheet, dated 6/13/21, indicated the census was 81. The public posting indicated the following staff worked during a time police responded to a 911 call (6/14/21 at 5:40 a.m.): 2 RNs, 1 LPN, and 5 CNAs worked on 6/13/21 from 10:00 p.m. to 6/14/21 at 6:00 a.m. The facility's Daily Schedule dated 6/13/21 indicated 2 RNs, 1 QMA, and 4 CNAs were scheduled to work on 6/13/21 from 10:00 p.m. to 6/14/21 at 6:00 a.m.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	06/21/2021

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	The facility's Time Detail reflected the following staff clocked in to work during that time: 2 RNs, 1 QMA, and 3 CNAs. The agency sign-in sheets dated 6/13/21 reflected 1 additional CNA worked. (One less nurse and 1 less CNA than were posted and/or scheduled to work). The facility's Resident Matrix, dated 6/15/21, documented the following impact on resident acuity (level of care): 17 residents with Alzheimer's or dementia, 1 resident receiving nutrition by feeding tube, 3 residents on hospice, 4 residents with a urinary catheter, 1 resident with a tracheostomy, 3 residents with pressure ulcers, 4 residents with falls, and 7 residents on transmission-based precautions, and 4 with unplanned weight loss. The current Facility's Assessment Tool, dated November 2019 to October 2020, provided by the Clinical Support Director on 6/21/21 at 10:45 a.m., reflected the average daily census was 80 residents. The total number needed or average or range of staff included, but was not limited to: - 18 licensed nurses providing di rect care per day- 26 nurses aides per day and 2 restorative aides per dayThe facility's publicly posted staffing sheets for the days/times police were called to the facility reflected the following. - On 4/30/21, there were a total of 12 nurses (96 hours, 6 less nurses than required by the Facility's Assessment Tool), and 18 CNAs (135 hours, 10 CNAs less than required by the Facility Assessment Tool).-On 6/12/21, there were a total of 13 nurses (104 hours, 5 less than required by the Facility's			

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	Assessment Tool), and 21 CNAs (157.5 hours, 7 less than required by the Facility Assessment Tool).-On 6/13/21, there were 12 nurses (96 hours, 6 nurses less than required by the Facility Assessment Tool, and 17 CNAs (127.5 hours, 11 CNAs less than required by the Facility Assessment Tool). A policy, titled "Resident Allergy," dated 3/01/16 and provided by the Corporate Nurse Consultant on 06/18/2021 at 9:49 a.m., indicated "...Definition: Allergy: a medical condition that causes an abnormal hypersensitive reaction of the body to a previously known allergen introduced by...skin contact. Allergic reactions are often manifested by itching...skin rash..."The immediate jeopardy, that began on 5/01/21, was removed on 6/21/21, when the facility completed the following. An assessment was completed to determine the best staffing pattern according to facility layout. The facility increased oversight and supervision on evenings, nights, and weekends to ensure staff were meeting the care needs of the residents. The facility implemented a recruiting initiative for licenses nurses, QMAs and CNAs; offered pick-up bonuses; and employed agency staff. An audit was conducted with all interviewable residents and the responsible parties of non-interviewable residents to ensure care needs were met. Licensed nurses and			

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	QMAs were in-serviced on answering call lights, incontinence care, skin management, allergies, and catheters. All remaining staff were in-serviced on answering call lights and allergies. Daily staffing schedules were reviewed/audited by the Administrator, DON, Human Resources manager, staffing coordinator, and Regional Director of Operations to validate appropriate staffing numbers and identify the distribution of staff based on resident needs. Nursing Manager On-Call and Manager on Duty schedules were developed and implemented. This Federal Tag relates to complaints IN00353234, IN00353169, IN00353730, IN00355536 and IN00354399. 3.1-17(a)			