STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 00 B. WING	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

(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 IN00387850 and IN00387135. Complaint IN00387850 - Unsubstantiated. Did not occur. Complaint IN00387135 - Substantiated. Federal/State deficiencies related to the allegations are cited at F773. Survey dates: August 16 & 17, 2022 Facility number: 013420 Provider number: 155831 AIM number: 201293620 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 4 Medicaid: 67 Other: 13 Total: 84 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 8/18/22.	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly.	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse			

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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	specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on interview and record review, the facility failed to ensure results, from physician ordered lab work, were completed with results in the resident's chart and reported to the physician. (Resident D) Finding includes: On 8/17/22 at 12:10 P.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, anxiety, schizoaffective disorder, pain disorder, repeated falls and osteoporosis. Progress Note, dated 6/23/22 at 8:46 A.M., indicated "...Resident lethargic with decreased appetite. One episode of emesis and loose stools. Denies pain/discomfort. Dr. [name of physician] notified. Order for STAT [immediately] CBC with diff [Complete Blood Count with Differential] CMP [Comprehensive Metabolic Panel] and UA [Urinalysis C&S [Culture & Sensitivity] received...." A form titled "Report View", dated 6/23/22 at 1:20 P.M., indicated the lab staff had been to the facility and completed the following labs: CBC with Differential, and a CMP. An untitled form from the lab indicated the lab work was collected on 6/23/22 and received by the	F 0773	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** This resident no longer resides in the facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents that reside in the facility have the potential to be affected by this alleged deficient practice. An audit of physician ordered lab work, for the past 30 days, will be completed to ensure all were completed with results in the resident's chart and reported to the physician. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** All nurses were educated on correct procedure and policy for physician ordered lab work for residents. DNS and/or designee will review all new orders for new	09/03/2022

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	lab on 6/23/22 at 9:08 P.M. The form had the results of the CBC with Differential and Urinalysis, however the CMP results were missing. During an interview, on 8/17/22 at 2:58 P.M., the Director of Nursing (DON) indicated she had contacted the lab and the CMP blood tube was defective and therefore the facility never got any results and the lab failed to contact the facility regarding the need to have the resident's blood redrawn. On 8/17/22 at 3:55 P.M., the DON provided a policy titled, "Laboratory and Diagnostic Services", dated November 2017 and reviewed July 2021, and indicated the policy was the one currently used by the facility. The policy indicated "...6. The facility will:...D. File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory...." This Federal tag relates to complaint IN00387135. 3.1-49(f)(1)(4)		lab reports daily in morning meeting. DNS and/or designee will ensure that all new lab orders have been completed, results received, results placed in resident's chart, and results reported to the physician. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** DNS and/or designee will complete weekly audits of all new lab orders X 4 weeks, bi-monthly X 2 and monthly X 4 months. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	