STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/04/2022	
	ROVIDER OR SUPPLIER LIFF HEALTH & REHABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE I BEND, IN 46619		
(X4) ID PREFIX TAG F 0000	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00366448, IN00371389, IN00372741 and IN00375599. Complaint IN00366448 - Unsubstantiated due to lack of evidence. Complaint IN00371389 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00372741 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00375599 - Substantiated. Federal/state deficiencies related to the allegations are cited at F657 and F758. Survey dates: March 29, 30, 31, & April 1, 4, 2022 Facility number: 013420 Provider number: 155831 AIM number: 201293620 Census Bed Type: SNF: 92 Total: 92 Census Payor Type: Medicare: 6 Medicaid: 68 Other: 18 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation or execution of this plan of correction does a constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepare and executed solely because is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Annual Survey on April 4, 2022. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing the provider is in substantial compliance.	he ed e it f eed	

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

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/04/2022		
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
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F 0570 SS=D Bldg. 00	§483.10(f)(10)(vi) security. The facility must potherwise provide the Secretary, to a personal funds of the facility. Based on interview failed to ensure the sufficient to cover the account on a daily be had the potential to facility. Finding includes: During an interview the Business Office Bond amount was \$ was \$113,947.90. During an interview the Business Office was not high enough resident fund and which was sufficient fund and which was sufficiently used by the indicated,"Our factor provides self-instof all resident's personal facility. 1. The facil guarantee the protest self-instof all resident's personal facility. 1. The facil guarantee the protest self-instof all resident's personal facility. 1. The facil guarantee the protest self-instof all resident's personal facility. 1. The facil guarantee the protest self-instof all resident's personal facility. 1. The facil guarantee the protest self-instof all resident's personal facility. 1. The facil guarantee the protest self-instof all resident's personal facility. 1. The facil guarantee the protest self-instof all resident's personal facility. 1. The facil guarantee the protest self-instof all resident's personal facility. 1. The facil guarantee the protest self-instof all resident's personal facility. 1. The facil guarantee the protest self-instof all resident's personal facility.	pleted on 4/12/22. Trity of Personal Funds Assurance of financial Furchase a surety bond, or assurance satisfactory to assure the security of all residents deposited with and record review, the facility Surety Bond amount was the Resident's personal fund the pasis. This deficient practice effect 91 of 91 residents in the Assurance of review, the facility Surety Bond amount was the Resident's personal fund the pasis. This deficient practice effect 91 of 91 residents in the Assurance of review, the facility Surety Bond amount was the Resident's personal fund to assure the surety and the resident funds Assurance of financial Trity of Personal Funds Trity of all residents in the Trity of all residents in the Trity of Alm., manager indicated the amount the and would not cover the ould have to be increased. Trity of Personal Funds Trity of all residents in the Trity of Alm., manager indicated the surety and the resident funds Trity of Alm., manager indicated the amount the and would not cover the ould have to be increased. Trity of Personal Funds Trity of Alm. Trity of Alm. Trity	F 0:	570	F 570 – Surety Bond-Security Personal Funds 1. What corrective action will be accomplished for tho residents found to have been affected by the deficient practice? A bond in the proper amount to ensure resident true funds has been obtained. 2. How other residents having the potential to be affected by the same deficien practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this practice. 3. What measures will be put into place and what systemic changes will be mat to ensure that the deficient practice does not reoccur. Resident Trust Fund balance will be checked week BOM to ensure the bond in place	nt d l	05/01/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155831	B. W	NG		04/04/	2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	3. The purpose of guarantee that the falosses occurring from hold, safeguard, marresident's funds (i.e.	Ethe surety bond is to acility will pay the resident of many failure by the facility to mage, and account for the losses occurring as a result negligence, incompetence or			is sufficient to cover the amount funds being held. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qualit assurance program will be printo place. ED and BOM will monitor the resident trust fund monthly during reconciliation to ensure appropriate bond coverage in inplace. 5. By what date the systemic changes for each deficiency will be completed. May 1, 2022	ty ut or	
F 0580 SS=D Bldg. 00	§483.10(g)(14) No (i) A facility must in resident; consult w physician; and not her authority, the r when there is- (A) An accident in- results in injury an requiring physician (B) A significant ch physical, mental, of (that is, a deterioral psychosocial statu- conditions or clinic (C) A need to alter	(Injury/Decline/Room, etc.) Itification of Changes. Inmediately inform the with the resident's ify, consistent with his or resident representative(s) It wolving the resident which d has the potential for intervention; Inange in the resident's or psychosocial status ation in health, mental, or is in either life-threatening is in either life-threatening is treatment significantly discontinue an existing					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI		f .		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155831	B. W.	ING		04/04/	2022
	PROVIDER OR SUPPLIEF	: HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE I BEND, IN 46619		
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PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	consequences, or of treatment); or (D) A decision to the resident from the §483.15(c)(1)(ii). (ii) When making (g)(14)(i) of this seemsure that all pering §483.15(c)(2) is upon request to the (iii) The facility muresident and the reany, when there is (A) A change in reassignment as spoor (B) (10) (iv) The facility murbale the addression of representative(s).	transfer or discharge the facility as specified in notification under paragraph ection, the facility must rtinent information specified a available and provided ne physician. Ust also promptly notify the esident representative, if second or roommate ectified in §483.10(e)(6); or esident rights under Federal gulations as specified in of this section. Ust record and periodically as (mailing and email) and the resident must disclose in its ment its physical uding the various locations composite distinct part, the policies that apply to tween its different locations					
	Based on observation review the facility fand responsible particles skin condition and of	on, interview, and record failed to notify the physician ty of the residents change in obtain a treatment for one of d for skin integrity. (Resident	F 0:	580	What corrective action(s) will accomplished for those reside found to have been affected b deficient practice? • The Physician was notified or resident # 38's impaired skin integrity and treatment orders	ents y the	05/01/2022

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STATEMEN	T OF DEFICIENCIES	CIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155831	B. WI	ING		04/04/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			/ESTERN AVENUE		
BRIARCI	IFF HFAI TH & RF	HABILITATION CENTER			BEND, IN 46619		
		, Blen, mon demen			1 2 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	Finding Includes:				were obtained.		
	A -1::1	-:					
		view was completed, on 3/31/22			How will you identify other		
		idicated Resident 38's			residents having the potential		
	-	but were not limited to: s, retention of urine, major			be affected by the same defici		
		s, chronic embolism, and			practice and what corrective a will be taken?	Clion	
	_	veins of right lower extremity,				_	
		•			All residents in the facility have the potential to be affected by	3	
	and dementia without behavioral disturbances The record indicated the resident was admitted on				alleged deficient practice		
	12/28/2021.				Full house skin sweep		
	12/28/2021.				completed with any new or		
	An Admission MDS (Minimum Data Set)				abnormal assessments reporte	ed	
	assessment, dated 1/15/2022, indicated Resident				to the Physician.	Cu	
		nterview for Mental Status)			lo trio i riyololari.		
		ognition. And it indicated he			What measures will be put into)	
		ssist with activities of daily			place or what systemic changes		
	living.	Ž			you will make to ensure that th		
					deficient practice does not rec		
	On 4/1/2022 at 8:35	5 A.M., the progress notes, care			All licensed staff will be in		
	plan, orders, and sk	in assessments were reviewed			serviced on policy related to		
	for 3/31/2022 and n	o documentation about the			Notification of changes with		
	wound was found fi	rom the previous day.			emphasis on when to notify the	е	
					physician and documentation	of	
	_	v on 4/01/2022 at 8:47 A.M.,			notification of the physician.		
	,	ctical Nurse) 18 indicated she					
	-	orning he has a new skin tear			How the corrective action (s) v	vill	
	to the elbow.				be monitored to ensure the		
		1/1/2022			deficient practice will not recur	,	
	-	v on 4/1/2022 at 11:03 A.M., the			i.e., what quality assurance		
	_	indicated she finds out about			program will be put into place?		
		ges by reading the 24- hour			DON/ Designee will "complet	ie	
	_	ber puts a skin sheet in her box,			change of condition audit" to		
	or they call and not	ny ner.			ensure that MD was notified for		
	Duning on intermi	v on 4/1/2022 at 11:15 A.M., the			change of conditions and that		
					notification is documented.	v E	
	_	s indicated that she should as well as the Physician and			Audit will be completed daily		
		•			weekly x 4 weeks, bi-monthly		
	responsible party at	pout a new pressure area.			months, monthly for 6 and the		
			1		quarterly to encompass all shi	เเร	I

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00		SURVEY LETED -/2022	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 0584 SS=E Bldg. 00	provided a policy ti Workforce Togethe Changes, dated July policy was the one of The policy indicated notify the resident a representative and helegate of changes status in order to obtreatment and moniresident's rights to rand care preference and record any new medical record. 6. Utranscribe, and implement and supplement states of the policy of the physical layour resident independing the policy of the p	in the resident's condition or tain orders for appropriate toring and promote the make choices about treatment is. 3. Document the notification orders in the resident's Update the resident's care plan, ement the provider's orders" ortable/Homelike nvironment. a right to a safe, clean, omelike environment, mited to receiving ports for daily living safely.		until continued complimaintained for 2 consquarters. • The results of these be reviewed by the Cooverseen by the ED. I 95% is not achieved a plan will be developed compliance.	ecutive audits will QI committee If threshold of an action		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/04/2022	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	services necessar orderly, and comformation of the services in expension of the services in good condition of the services of the services in a service of the services of the	in bed and bath linens that ion; ate closet space in each specified in §483.90 (e)(2) quate and comfortable areas; afortable and safe and safe are facilities initially certified and safe are of 71 to 81°F; and are of 71 to 81°F; and are maintenance of a levels. In interview and record failed to ensure a clean aintained related to bugs in a mone resident room, bugs in 4 and a dirty ice machine oom observed for	F 0584	F 584 – Safe/Clean/Comfortable/Horike Environment 1. What corrective action will be accomplished for the residents found to have bee affected by the deficient practice? The dead bugs found in light coverings in room 301 has been removed. The dead bugs found in light covering on hall 300 hav been removed. The filters on the ice machine in the main dining has have been cleaned and are freedom.	n(s) use n the ave n the e

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	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		155831	B. W	ING		04/04/2	022
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		IL	DATE	
	front of the machine	e and a build up a white			dust. The machine has been		
substance along the rim on the top of the				cleaned and is free of calcium			
	machine.				buildup.		
		4/4/2022 - 11 40 4 3 5					
	_	y, on 4/4/2022 at 11:48 A.M.,			2. How other residents		
		ndicated the bugs should not			having the potential to be		
	be in fights and the	ice machine was dirty.			affected by the same deficient		
	On 4/42022 at 1.55	P.M., the Director of			practice will be identified and		
		led a print out from TELS,			what corrective action(s) will be taken.	'	
	_	ted this is what the facility			· All residents in the facili	tv	
uses for the ice machine and indicated he had no				have the potential to be affect	-		
	policy on cleaning the lights. The print out, "Ice				by dead bugs in the light fixtur		
		d" Check air-filter (if] , 3		
	present). 1. Check t	hat air filter is correctly			3. What measures will be		
	installed. 2 Replace	filter as needed. Clean Coils. 1.			put into place and what		
	Shut off unit. 2. Rea	move panel cover to expose			systemic changes will be ma	ide	
		rush to remove lint and dirt			to ensure that the deficient		
	-	er coil. 4. Use air compressor			practice does not recur.		
		t/dust buildup. 5. Vacuum			· A facility wide audit has	I	
	condenser area to re				been conducted to ensure tha		
		Clean and wipe down			light fixtures are free of dead b	- I	
	exterior"				A preventative maintenance to a large transfer and the maintenance transfer and tra		
	2 1 10(f)				task to investigate the potential		
	3.1-19(f)				presence of and elimination of dead bugs has been added to		
					master PM schedule.		
					A preventative maintenance	ance	
					task to investigate the potentia	I	
					presence of calcium buildup a		
					elimination of said buildup has		
					been added to master PM		
					schedule		
					4. How the corrective		
					action(s) will be monitored to		
					ensure the deficient practice		
					will not recur, i.e., what quali	-	
					assurance program will be p	ut	
			1		into place.		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/04/2022
	PROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				Maintenance/Designee will complete room rounds as we hallway rounds observing for bugs in light fixtures or visible signs of calcium buildup on it machine daily using daily aud checklist daily x 5 days, week 4 weeks, Monthly x 2 months quarterly thereafter until compliance is maintained for least two consecutive quarterly resented at the QAPI Comm Monthly for review for compliand follow up. 5. By what date the systemic changes for each deficiency will be completed. May 1, 2022	dead e e e e dit kly x and at es II be nittee ance
F 0637 SS=D Bldg. 00	Chg §483.20(b)(2)(ii) No facility determines determined, that the change in the resistant change or improvement in will not normally reintervention by standard disease-interventions, that than one area of the and requires intervention of the car	nere has been a significant dent's physical or mental rpose of this section, a e" means a major decline the resident's status that esolve itself without further off or by implementing related clinical has an impact on more the resident's health status, disciplinary review or	F 0637	What corrective action(s) wil	lbe 05/01/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/04/2022 155831 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE **BRIARCLIFF HEALTH & REHABILITATION CENTER** SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE interview, the facility failed to ensure a significant accomplished for those residents change in condition MDS (Minimum Data Set) found to have been affected by the assessment was completed following the initiation deficient practice? of hospice care for 1 of 23 residents whose MDS's · This had been identified by were reviewed. (Resident 31) facility prior to survey and Resident 31 had significant Findings include: change MDS assessment completed on 3/24/2022 A clinical record review was completed on How will you identify other 3/31/2022 at 11:47 A.M. Resident 31's diagnoses residents having the potential to included, but were not limited to: chronic be affected by the same deficient obstructive pulmonary disease, anxiety, chronic practice and what corrective action pain and chronic respiratory failure. will be taken? All residents in the facility that A current physician's order, dated 1/26/2022, have been added or removed from indicated Resident 31 was admitted to [name of hospice have the potential to be hospice] care on 1/26/2022. affected by alleged deficient practice During an interview, on 3/31/2022 at 12:17 P.M., Audit completed to ensure that LPN (Licensed Practical Nurse) 15 indicated a all residents that meet the criteria significant change MDS assessment had not been for significant change related to completed and should have been when she was hospice in the last year have had admitted into hospice care. LPN 15 indicated she significant change assessment uses the RAI (Resident Assessment Instrument) completed and no further residents manual. identified What measures will be put into 3.1-31(d)(1)place or what systemic changes you will make to ensure that the deficient practice does not recur? • New MDS coordinator in place at facility. Education Provided to MDS/ IDT team on criteria for significant change assessments to be implemented. 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? • MDS/ Designee will Sign Change

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	•	E SURVEY LETED 1/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER	502	EET ADDRESS, CITY, STATE, ZIP COI 4 WESTERN AVENUE JTH BEND, IN 46619	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmi Assessments §483.20(f) Automa requirement- §483.20(f)(1) Enco after a facility com assessment, a faci following informati facility: (i) Admission asses (ii) Annual assess (iii) Significant cha assessments. (iv) Quarterly revie (v) A subset of iter transfer, reentry, o (vi) Background (fi there is no admiss §483.20(f)(2) Trans	atting Resident ated data processing adding data. Within 7 days pletes a resident's allity must encode the on for each resident in the assment. ment updates. ange in status aw assessments. ans upon a resident's alischarge, and death. ace-sheet) information, if	TAG	for Hospice Resident Au ensure that residents that criteria for significant charan MDS initiated. • Audit will be completed 4 weeks, monthly x 6 an quarterly to encompass a until continued complian maintained for 2 consect quarters. • The results of these au be reviewed by the CQI overseen by the ED. If the 95% is not achieved an aplan will be developed to compliance.	at meet ange have I weekly x d then all shifts ce is utive dits will committee nreshold of action	DATE

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	OF OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831			(X3) DATE SURVEY COMPLETED 04/04/2022	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD WESTERN AVENUE H BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
140	assessment, a factransmitting to the for each resident of format that conformat that conformat that conformat sand data of passes standardizand the State.	cility must be capable of CMS System information contained in the MDS in a ms to standard record dictionaries, and that teed edits defined by CMS	TAU		DATE	
	Within 14 days aft resident's assessr electronically trans and complete MD including the follow (i)Admission asse (ii) Annual assess (iii) Significant chat (iv) Significant corrassessment. (v) Significant corrassessment. (vi) Quarterly revie (vii) A subset of ite	ssment. ment. ange in status assessment. rection of prior full rection of prior quarterly				
	(viii) Background (an initial transmiss resident that does assessment. §483.20(f)(4) Data	(face-sheet) information, for sion of MDS data on not have an admission a format. The facility must e format specified by CMS				
	or, for a State whi approved by CMS the State and app Based on record rev failed to transmit a	ch has an alternate RAI , in the format specified by roved by CMS. view and interview, the facility timely MDS (Minimum Data 1 of 1 resident reviewed for	F 0640	F 640- Transmitting Residen Assessments What corrective action(s) wi be accomplished for those residents found to have bee	П	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		00	(X3) DATE SURVEY COMPLETED 04/04/2022		
	PROVIDER OR SUPPLIEI LIFF HEALTH & RE	REHABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	A record review on indicated Resident assessment comple with return not anti 12/28/21. The asses CMS' QIES Assess Processing system. During an interview LPN (Licensed Pra MDS data should has According to the R Assessment Instrumshould be submitted plus 14 calendar data on 4/4/2022 at 2:00 policy entitled, "Ele MDS". The policy assessments and disare completed and facility's MDS infoin accordance with	1.4/4/2022 at 8:44 A.M., 1 had a Quarterly MDS ted on 11/3/2021. A discharge cipated was completed on ssment was not transmitted to ment Submission and 1. v on 4/4/2022 at 10:39 A.M., 1. ctical Nurse) 15 indicated the 1. ave been transmitted. 1. AI manual (Resident 1. nent) a discharge summary 1. d within the Discharge Date 1. vys. 1. P.M., the DON provide the 1. ectronic Transmission of the 1. indicated, "All MDS 1. scharge and reentry records 1. electronically encoded into our 1. rmation system and transmitted 1. current OBRA (Omnibus 1. ion Act) regulations governing		practice? Resident 1 has had MDS transmitted How will you identify other residents having the potenti to be affected by the same deficient practice and what corrective action will be take All residents in the facility h the potential to be affected to alleged deficient practice Audit completed to ens that all other MDS have been transmitted and no further assessments identified as mis transmission. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? New MDS coordinator in place at facility. Education Provided to MDS/ IDT team of criteria for submitting assessments timely. How the corrective action (s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be p into place? MDS/ Designee will "complete MDS Transmission audit" to ensure that residents have had MDS transmitted pe CMS/RAI standard. Audit will be completed weekly x 4 weeks, monthly x 6 and then quarterly to encomp	al en? ave by ure ssing nto in n) the er 6

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/04/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) COMPLETION DATE
				all shifts until continued compliance is maintained for consecutive quarters. The results of these will be reviewed by the CQ committee overseen by the threshold of 95% is not act an action plan will be deverensure compliance.	audits II EED. If nieved loped to
F 0656 SS=D Bldg. 00	§483.21(b) Compi §483.21(b)(1) The implement a compounce of care plan for each the resident rights and §483.10(c)(3) objectives and time resident's medical psychosocial need comprehensive as comprehensive can following - (i) The services the	n, nursing, and mental and the sthat are identified in the sessment. The serie plan must describe the at are to be furnished to the resident's highest		![if !supportAnnotations]	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVOO11 Facility ID: 013420

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		155831	B. WI	NG _		04/04	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			/ESTERN AVENUE		
BRIARCI	IEE HEAI TH & RE	HABILITATION CENTER			BEND, IN 46619		
BINIARO		CHABIETATION GENTER		00011			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	-being as required under					
	§483.24, §483.25						
	, , , , , , , , , , , , , , , , , , ,	hat would otherwise be					
	I	83.24, §483.25 or §483.40					
	•	ed due to the resident's					
	exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)						
	(6).	. d					
	1 ' ' ' '	ed services or specialized					
		ices the nursing facility will					
	provide as a resul						
		s. If a facility disagrees with PASARR, it must indicate					
	I -	resident's medical record.					
		with the resident and the					
	resident's represe						
		goals for admission and					
	desired outcomes	- -					
		preference and potential for					
	1 ' '	Facilities must document					
	1	ent's desire to return to the					
		ssessed and any referrals					
	I	gencies and/or other					
	1	es, for this purpose.					
		ns in the comprehensive					
	1 ' '	ropriate, in accordance with					
		set forth in paragraph (c) of					
	this section.	, 0 , (-)					
		on, interview and record	F 06	556	What corrective action(s) will be	эе	06/01/2022
		failed to ensure comprehensive			accomplished for those reside		
	care plans for falls,	and weight loss were in place			found to have been affected b		
	for 2 out of 3 reside	ents reviewed for care plans.			deficient practice?	•	
	(Resident 29 & 38))			IDT team reviewed resident:	38	
					and compressive care plan wa	as	
	Findings include:				reviewed including care plan f	or	
					falls.		
	A clinical record	d review was completed, on			IDT team reviewed resident:	29	
		1., and indicated Resident 38's			and comprehensive care plan	was	
	1 -	, but were not limited to:			reviewed including care plan f	or	
	delusional disorder	s, retention of urine, major			weight loss.		

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Event ID:

CVOO11 Facility ID: 013420

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STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	ETED	
		155831	B. W	ING		04/04/2	2022	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			/ESTERN AVENUE			
DDIADC		EHABILITATION CENTER			BEND, IN 46619			
BRIARC	LIFF HEALTH & RE	ENABILITATION CENTER		30011	1 BEND, IN 400 19			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	depressive disorder	rs, chronic embolism, and			How will you identify other			
	thrombosis of deep	veins of right lower extremity,			residents having the potential	to		
	and dementia with	out behavioral disturbances.			be affected by the same defic	ient		
					practice and what corrective a	ection		
	During an interview	w on 4/4/2022 at 9:02 A.M., the			will be taken?			
	MDS Nurse indicated that everyone should have				All residents in the facility hav	e		
	a fall care plan or a	n at risk for falls and he did not			the potential to be affected by			
	have one.				alleged deficient practice			
	2. A record review	of Resident 29 was completed			Facility to complete audit of a	all		
	on 3/31/2022 at 8:2	29 A.M., diagnosis included, but			resident's care plans conducte	ed to		
	were not limited to	: end stage renal disease,			ensure accuracy, facility will a	udit		
	hypertension and a	trial fibrillation.			10 Resident Care plans week	ly x		
					4 and 5 residents Care plans			
	A 5-day Medicare	MDS (Minimum Data Set)			weekly until 100% of Residen	t		
	Assessment, dated	3/18/2022, indicated that			care plans reviewed.			
	Resident 29 had A	BIMS (Brief Interview Mental						
	Status) of no cogni	tive impairment. Resident 29			What measures will be put into	0		
	required supervision	n with set up for eating, had			place or what systemic chang	es		
	no dental issues and	d hade weight loss of 5			you will make to ensure that the	ne		
	percent or more in	the last month or loss of 10			deficient practice does not rec	cur?		
	percent or more in	last 6 months.			• IDT in-serviced on the MDS			
					assessment process and their	r role		
	Resident 29 was ou	nt of the building for surgery			including use of CARE PLAN			
	from 2/24/2022-3/1	11/2022.			Review sheet to ensure all are	∍as		
					are addressed			
	_	indicated a weight on			Audits Tool "Comprehensive	;		
		2 pounds, on 2/4/2022 of 195.4			Care Plan Audit Tool" will be			
	1 -	22 of 183.4 pounds, and on			completed for all new admissi	ons		
		pounds. A review of the			to ensure completion within 2	1		
	weights indicated a	loss of 22.3 pounds or 11.14			days of the date of admission	or 7		
	percent in three mo	onths and 18.4 pounds or 9.42			days after the ARD to ensure			
	percent on one mor	nth.			accuracy of assessments, Ca	re		
					plans, and Coding.			
	•	ndicated Resident 29 received a			Audit Tool "Comprehensive			
	-	drate diet with supplements of			Plan Audit Tool" will be compl	eted		
	Nepro 237 ml twice	e a day and a health shake 4			as part of all resident Quarterl	y		
	ounces with meals.				and annual assessments or u	pon		
					change of condition to ensure			
	A Care Plan for sig	mificant weight loss or			accuracy of MDS and Care Pl			
	nutritional needs co	ould not be located during			within 7 days of the ARD.			

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	LETED
		155831	B. W	ING		04/04	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			/ESTERN AVENUE		
BRIARCI	LIFF HEALTH & RF	HABILITATION CENTER			BEND, IN 46619		
	· ·				, .		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	record review.	R LSC IDENTIFYING INFORMATION		TAG	bli ellici)		DATE
	record review.						
	During on intervious	v on 3/31/2022 at 10:59 A.M.,			How the corrective action (s) to be monitored to ensure the	WIII	
	_	she would call the MDS			deficient practice will not recu	r	
		t the care plan for weight loss			i.e., what quality assurance	Ι,	
	and nutritional need				program will be put into place	2	
	ana naminonai nece				MDS/ Designee will complet		
	A nutritional care n	A nutritional care plan was provided on 3/31/2022 at 11:36 A.M. The care plan was canceled on			Comprehensive Care Plan Au		
	•				Tool will be completed for all		
	3/9/2022.	•			admissions to ensure complete		
					within 21 days of the date of		
	During an interviev	v on 3/31/2022 at 11:42 A.M.,			admission or 7 days after the	ARD	
	the DON indicated	the care plan provided was not			to ensure accuracy of		
	an active care plan	and the nutritional care plan			assessments, Care plans, and	b	
	had not been update	ed.			Coding.		
					Audit Tool "Comprehensive	Care	
		P.M., the DON provide the			Plan Audit Tool" will be compl	eted	
		re Planning -Interdisciplinary			as part of all resident Quarterl	-	
		indicated, "Our facility's Care			and annual assessments or u	-	
	-	plinary Team is responsible for			change of condition to ensure		
	the development of				accuracy of MDS and Care Pl	ans	
	_	e plan for each resident. 1. A			within 7 days of the ARD.	_	
	_	e plan for each resident is			Audit will be completed daily		
	_	even (7) days of completion of			weekly x 4 weeks, bi-monthly		
	the resident assessn	nent (MDS)			months, monthly for 6 and the		
	3.1-35(a)				quarterly to encompass all shi until continued compliance is	แร	
	3.1-33(a)				maintained for 2 consecutive		
					quarters.		
					The results of these audits was a second to the secon	/ill	
					be reviewed by the CQI comm		
					overseen by the ED. If threshold		
					95% is not achieved an action		
					plan will be developed to ensu		
					compliance.		
F 0657	483.21(b)(2)(i)-(iii						
SS=D	Care Plan Timing						
Bldg. 00	§483.21(b) Comp	rehensive Care Plans					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		lì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED 04/04/2022	
		155831	B. Wl	DN		04/04/	2022
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE		
BRIARCI	LIFF HEALTH & RE	HABILITATION CENTER			BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		omprehensive care plan					
	must be-	in 7 days after completion					
		nin 7 days after completion					
	of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to						
	(A) The attending						
	, ,	urse with responsibility for					
	the resident.	•					
	(C) A nurse aide v	with responsibility for the					
	resident.						
	` '	food and nutrition services					
	staff.						
	(E) To the extent						
		e resident and the resident's					
	, , ,	An explanation must be					
		dent's medical record if the					
		e resident and their resident determined not practicable					
	-	ent of the resident's care					
	plan.	of the resident's care					
	•	iate staff or professionals in					
		ermined by the resident's					
		ested by the resident.					
	(iii)Reviewed and	revised by the					
	interdisciplinary te	eam after each assessment,					
	including both the	comprehensive and					
	quarterly review a						
		view, observation and	F 06	557	What corrective action(s) will be		05/01/2022
		ty failed to revise/update			accomplished for those reside		
	_	for fall interventions,			found to have been affected b	y the	
		rentions, refusal of insulin, and			deficient practice?		
	_	a new pressure ulcer for 3 of			Resident 5 has had care plan		
		care plans were reviewed.			reviewed and updated to refle	CT	
	(Resident 56, 5 and	. 38)			current interventions, person centered care, refusals, and		
	Findings include:				preferences • Resident 56 had care plan		
	1. During an intervi	iew, on 3/29/2022 at 10:00 A.M.,			reviewed and updated to refle	ct	
		ed she had a fall recently and			current interventions person		

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL		
		155831	B. WI	ING		04/04/	2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	ROVIDER OR SUPPLIER	8			/ESTERN AVENUE			
BRIARCI	IFF HEALTH & RE	HABILITATION CENTER		SOUTH	I BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	` ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE	
	broke her nose and	busted her lip.			centered care refusals and			
	A 1' ' 1 1				preferences			
		view was completed on			Resident 38 had care plan			
		.M., Resident 56's diagnoses			reviewed and updated to refle	Ct		
		included, but were not limited to: anxiety, diabetes, functional quadriplegia and depression.			current interventions, person			
	diabetes, functional	quadriplegia and depression.			centered care refusals and			
	A Quartarly MDS (Minimum Data Set)			preferences			
		/25/2022, indicated the			How will you identify other	t-a		
	· · · · · · · · · · · · · · · · · · ·	ally supervision for bed			residents having the potential be affected by the same defici			
	-	dressing, toilet use and eating.			practice and what corrective a			
	modifity, transfers,	dressing, tonet use and eating.			will be taken?	Clion		
	Δ Nurse's Note dat	red 1/3/2022 at 2:00 A.M.,			All residents in the facility have	2		
		56 had an unwitnessed fall in			the potential to be affected by			
		ent was attempting to			alleged deficient practice			
		nroom with the walker and loss			Facility to complete audit of a	ااد		
		forward. Resident 56 received a			resident's care plans conducte			
	_	per lip and had reported she			ensure care plans are reviewe			
	was light headed.	per up una nua reperteu ene			and updated to reflect current			
					interventions, person centered			
	A current care plan.	, dated 9/28/2021, indicated			care, refusals and preferences			
	-	risk for falls related to impaired			facility will audit 10 Resident 0			
	mobility/balance, as	_			plans weekly x 4 and 5 reside			
	-	anxiety medication use,			Care plans weekly until 100%			
	history of falls, pai				Resident care plans reviewed			
	compression.	-						
					What measures will be put into)		
	Interventions include	led, but were not limited to:			place or what systemic change			
	encourage to ask fo	r assistance when attempting			you will make to ensure that the			
	to do activities that	require to bend over when in			deficient practice does not rec	ur?		
	the wheelchair, mor	nitor psychotropic medications			• IDT in-serviced on the Care			
	for side effects and	report to physician, do not			Planning Process with empha	sis		
		shower, anticipate and meet			on their role including use of I	DT		
		ep area free from clutter, spills,			CARE PLAN Review sheet to			
		oper lightening, keep call light			ensure all areas are addresse	d.		
		ently used items within reach,			IDT in-serviced on Clinical			
	and complete fall ri	sk assessment per facility			Morning Meeting process with			
	protocol.				emphasis on their role includir	ng		
					identifying changes that requir	e		
	A Nurse's Note, dat	ed 1/4/2022 at 9:08 A.M			care plan updates			

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155831	B. W	ING		04/04/	2022
NAME OF F	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD		
					ESTERN AVENUE		
BRIARCI	_IFF HEALTH & RE	HABILITATION CENTER		SOUTH	I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	,	Interdisciplinary Team) had met			Audit Tool "Comprehensive (Tool "C		
		nt's fall on 1/3/2022 that			Plan Audit Tool" will be comple		
		r to the emergency room. The			as part of all resident Quarterl	-	
		subdural hematoma and a			and annual assessments or up		
	_	osable sutures to her upper			change of condition to ensure		
		oorted that she believes she she got up in the early			accuracy of MDS and Care PI	ans	
					How the corrective action (s) v	azill	
	_	morning hours to toilet self. The interventions were for neuro checks to continue, therapy			be monitored to ensure the	WIII	
		ostatic blood pressure			deficient practice will not recui	r	
	checks.	iosiane biood pressure			i.e., what quality assurance	',	
	checks.				program will be put into place	?	
	The care plan lacke	d the intervention of			Audit Tool "Comprehensive (
	_	essures to prevent further			Plan Audit Tool" will be complete		
	falls.	1			as part of all resident Quarterl		
					and annual assessments or u	-	
	During an interview	y, on 4/4/2022 at 1:55 P.M., the			change of condition to ensure		
	_	indicated the care plan had			accuracy of MDS and Care PI		
	_	ter the fall and did not know if			within 7 days of the ARD.		
	the orthostatic bloo	d pressures were completed.			DON/ designee will complete	9	
					"Clinical Meeting Audit" to ens	ure	
	A current care plan	, dated 10/8/2021, indicated			that all items discussed in clin	ical	
	Resident 56 had a b	ehavioral problem related to			meeting have been appropriat	tely	
	hallucinations, i.e. s	staff members are outside her			care planned.		
		ointing laser lights in her room,			Audit will be completed daily	x 5,	
	1	es, and false allegations			weekly x 4 weeks, bi-monthly		
		entions included, but were not			months, monthly for 6 and the		
		rs to provided opportunity for			quarterly to encompass all shi	fts	
	1 ~	and attention. Stop and talk			until continued compliance is		
	_	sing by. Remove from			maintained for 2 consecutive		
		alternate location as needed.			quarters.		
		of activities that is of interest			• The results of these audits w		
	and accommodates	residents status.			be reviewed by the CQI comm		
	D	4/04/2022 4 10 46 4 35			overseen by the ED. If thresho		
	~	v, on 4/04/2022 at 10:46 A.M.,			95% is not achieved an action		
		lirector indicated the care plans			plan will be developed to ensu	ıre	
		ntered and did not have			compliance.		
		ic to the hallucinations and or					
		rd review of Resident 5 was 2022 at 11:11 A.M., diagnosis					
1	i completed on 5/31/.	2022 at 11.11 A.W. Waynosis			•		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/04/2022	
	PROVIDER OR SUPPLIEF	HABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD /ESTERN AVENUE I BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION	
	· ·	not limited to: diabetes mellitus cer and nondisplaced fracture r of right femur.				
	Assessment, dated 3 Resident 5 had a BI Status) score indica impairment. Reside assistance with two mobility, transferring a recent surgery req	Minimum Data Set) 3/13/2022, indicated that MS (Brief Interview Mental ting severe cognitive nt 5 required extensive staff members for bed ng and toileting. Resident 5 had uiring an SNF (Skilled Nursing epair of fracture including the				
	administration of In	r, dated 10/21/22, indicated sulin Glargine Solution 100 cutaneously at bedtime.				
	Record) indicated R sugar testing and In administration 16 ti in January 2022, 16 times in March 202 documentation of 4	AR (Medication Administration desident 5 had refused blood sulin Glargine Solution mes in December 2021, 10 times times in February 2022, and 16 2. Resident 5 had blood sugar 65 on 12/12/2021, 442 on 12/25/2021 and 446 on 3/7/2022.				
	through March 202	wed from December 2021 2, had no documentation of on of Insulin Glargine Solution ng refusal.				
	has diabetes mellitusigns or symptoms. Interventions include ordered by doctor. I effects and effective	o/21/2021 indicated Resident 5 is and will be free from any of hyperglycemia. ded, "Diabetes medication as Monitor/document for side eness". The Care Plan had no Resident 5 had refused				

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII		00	COMPL		
		155831	B. WIN	G		04/04/	2022	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD			
		HABILITATION CENTER	l		ESTERN AVENUE BEND, IN 46619			
BRIARCI	IFF HEALIH & KE	HABILITATION CENTER		30016	DEND, IN 40019			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL	P.	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION asulin Glargine Solution and		TAG			DATE	
	blood sugar testing.							
	During an interview on 4/4/2022 at 11:00 A.M., LPN 15 indicated Resident 5 should have a care							
	1 ~	sal of medication and the						
	pnysician should be	e notified of refusals.						
	A Nurses' Note on	11/29/2021 at 9:55 A.M.,						
		/29 ED (Executive Director) and						
		Nursing) were notified by						
	_	sident fell in his room. Nursing						
		ead to toe, pain and skin						
		s were received from MD for						
		s managed. As per MD order (Emergency Room) for						
		report received from hospital						
	_	stain a fracture right side hip.						
	[Resident 5] remain	as in the hospital for treatment						
	at this time"							
	0 2/2/2022 . 5 4/2	- D. K						
		5 P.M., indicated Resident 5 is hip surgery on February 8,						
	2022.	mp surgery on reordary 8,						
	On 2/12/2022 at 5:3	33 A.M., indicated "Staff						
	1 -	ter that resident was on floor.						
		to res room. Resident observed						
	, , ,	s right-side legs point towards						
		ir behind his headThis r neuro (neurological)						
		c/o (complained of) pain						
		n pain scale of 0-10. [Physician						
		ordered to send res to ER for						
	eval and treatment.	"						
	0. 2/10/2022 / 4.2	10 A M (1) (1) D (1)						
		39 A.M., indicated "Resident to bedpain to R leg"						
	Tourid on Hoor flext	to bedpain to K leg						
	A Nurses' Note on 2	2/21/2022 at 11:09 a.m.,						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED		
		155831	B. W	ING	_	04/04	/2022		
NAME OF P	PROVIDER OR SUPPLIE	R.			ADDRESS, CITY, STATE, ZIP COD				
		EHABILITATION CENTER			ESTERN AVENUE I BEND, IN 46619				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE		COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		t to review residents fall on							
	_	M INTERVENTION: Fall mat							
	placed on floor nex	at to bed"							
	A review of Nurses	s' Notes indicated an IDT							
		Interdisciplinary Team) meeting did not occur for							
	1 ` •	n 11/27/2021 and 2/12/2022 to							
		ons to prevent further falls.							
	A Physician Proore	ess Note on 2/18/2022 at 9:51							
		This is an 82-year-old male.							
		dmission to the facility. He was							
	~	2/12-2/16 s/p (status post) fall in							
	1 -	ound to have a right hip							
	fracture and UTI as	nd is s/p repair with							
	[physician's name]	He had a fall with a fracture to							
	that hip in Novemb	per 2021 as well"							
	A Care Plan on 10/	[21/2021, indicated [Resident 5]							
		nd has a history of falls and							
		ot sustain serious injury from							
		ntative interventions were							
	_	that occurred on 11/27/2021							
	and 2/12/2022.								
	During an interviev	w on 4/4/2022 at 10:48 A.M.,							
	_	she is involved with IDT							
		interventions to prevent falls							
	"	placed in the care plan.							
	During an internet	y on 4/4/2022 of 11.20 A B.F. 41.							
	_	w on 4/4/2022 at 11:20 A.M., the							
		Γ meets the next morning after a day or the weekend and							
		d be placed for a new fall.							
	mici ventions snout	a de piacea foi a fiew fait.							
		0 P.M., the DON provide the							
		are Planning -Interdisciplinary							
		indicated, "Our facility's Care							
		plinary Team is responsible for							
	the development of	f an individualized							

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	ULTIPLE CO UILDING	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED	
		155831	B. W	ING		04/04/	/2022
	PROVIDER OR SUPPLIER	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION e plan for each resident. 1. A		TAG	DEFICIENCY)		DATE
	-	e plan for each resident is					
	•	even (7) days of completion of					
	the resident assessm	nent (MDS)"3. A clinical					
		completed, on 3/31/22 at 1:40					
		the Resident 38's diagnoses					
		ncluded, but were not limited to: delusional lisorders, retention of urine, major depressive lisorders, chronic embolism, and thrombosis of					
	· ·	lower extremity, and dementia					
	without behavioral	disturbances					
		4/1/2022 - 11.50 + 3.5 - 1					
	_	on 4/1/2022 at 11:59 A.M., the ed that she has been helping					
		s. If a new pressure area was					
	-	put in right away by the nurse					
	-	sure area and the next morning					
	it is reviewed by the	e IDT in the morning meeting					
	and revised if neede	ed.					
	On 4/1/2022 at 1:33	3 P.M., the Director of Nursing					
		tled, "Goals and Objectives,					
		April 2009, and indicated the					
		currently used by the facility.					
		d "5. Goals and objectives or revised: a. When there has					
		hange in the resident's					
	condition"	2					
	This Federal tag rel	ates to complaint IN00375599.					
	3.1-35(d)(2)(b)(e)						
F 0658	483.21(b)(3)(i)						
SS=D		Meet Professional					
Bldg. 00	Standards						
	- , , , ,	mprehensive Care Plans					
		ided or arranged by the					
	care plan, must-	d by the comprehensive					
	oare plan, must-						I

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155831	B. W	NG		04/04/2022	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u></u>	_
NAME OF I	PROVIDER OR SUPPLIE	R			/ESTERN AVENUE		
BDIVDC		EHABILITATION CENTER			BEND, IN 46619		
BNIANG	LIFF HEALTH & NE	ENABILITATION CENTER		30011	1 BEIND, IN 400 19		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	_
		nal standards of quality.					
		on, record review and	F 00	658	658- Services Provided Meet	<u>t</u> 05/01/2022	
		ity failed to follow the five			Professional Standards		
	_	n administration for 4 of 7			What corrective action(s) will	11	
		residents observed for medication administration.			be accomplished for those		
	(Resident 6, 25, 38	& 81)			residents found to have been	n	
					affected by the deficient		
	Finding includes:				practice?		
					· LPN 18 removed from		
	_	ion on 4/1/2022 at 7:46 A.M.,			schedule pending education a	ınd	
		bass on the 700 hall, LPN			training. LPN 18 Completed		
		Nurse)18 was observed			Medication Administration		
		medication for Resident 6			education and had supervised	d med	
		the medication being			pass administration completed	l l	
		MAR (Medication			successfully before returning	to	
	Administration Red	cord) for accuracy.			the floor to pass medications.		
					· Residents 6,25,38 and	81	
		18 was observed opening			were not affected		
	_	ion for Resident 25 and			How will you identify other		
	_	ral inhalant without verifying			residents having the potential	al	
	<u> </u>	stered medications with the			to be affected by the same		
	MAR.				deficient practice and what		
					corrective action will be take	••••	
		118 was observed opening			All residents in the facility ha		
	_	ion and placing in a medication			the potential to be affected by	y	
		ng the accuracy of the			alleged deficient practice		
		ne MAR. These medications			· LPN 18 removed from		
		to be administered but placed			schedule pending education a	ınd	
		cart without identifying			training. LPN 18 Completed		
	resident informatio	n.			Medication Administration		
					education and had supervised		
		1 18 was observed opening			pass administration completed		
	1 -	ion for Resident 38 without			successfully before returning	l l	
		lication being administered to			the floor to pass medications.		
	the MAR.						
		444000			What measures will be put in	ito	
		w on 4/1/2022 at 8:43 A.M., LPN			place or what systemic		
		re right to medication pass			changes you will make to		
		cation, dose, route, and time)			ensure that the deficient		
	and indicated the n	nedication packets should be	- 1		practice does not recur?	ĺ	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A PUBLISHED OF COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155831	A. BUILDING 00 COMPLETED B. WING 04/04/2022				
		100001	D. WI	_		04/04/	ZUZZ
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE		
BRIARCL	LIFF HEALTH & RE	HABILITATION CENTER			BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	checked against the	R LSC IDENTIFYING INFORMATION MAD (Medication		TAG	· All Licenses staff		DATE
	Administration Rec				in-serviced on the 5 rights of		
	110	era) for accuracy .			medication with emphasis on		
	On 4/4/2022 at 2:00	P.M., the DON provide the			comparing medication being		
		ministering Medications". The			administered to MAR		
	policy indicated, ".						
	_	nedication checks the label			Harris Maria a sumur et a esta esta esta esta esta esta esta		
		o verify the right resident, right osage, right time and right			How the corrective action (s) will be monitored to ensure t		
	_	lministration before giving the			deficient practice will not	iiie	
	medication"	animistration before giving the			recur, i.e., what quality		
					assurance program will be p	ut	
	3.1-35(g)(1)				into place?		
					· DON/ designee will		
					complete medication pass		
					observations/ audits to ensure	;	
					compliance. · Audit will be completed		
					daily x 5, weekly x 4 weeks,		
					bi-monthly for 2 months, mont	hly	
					for 6 and then quarterly to	,	
					encompass all shifts until		
					continued compliance is		
					maintained for 2 consecutive		
					quarters. The results of these aud	dite	
					will be reviewed by the CQI	uito	
					committee overseen by the EI	D. If	
					threshold of 95% is not achiev		
					an action plan will be develope	ed to	
					ensure compliance.		
					[EK1]Nood desumentation of	hor	
					[EK1]Need documentation of training for POC binder	i i c i	
					Training for 1 00 billion		
					[EK2]Education for Nurses ar	nd	
					QMAs		
			1		I		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/04/2022
	ROVIDER OR SUPPLIE	R EHABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Quality Indicator: Medication Pass Compliance = # of yes responses x 100 Percentage of Compliance Signature of Assessor/Date: X = Yes 0 = No Criteria/Questions Residents Comments 1 2 3 4 5 6 7 8 9 10 Hand Hygiene Preformed prion handling medication(s) and after administering medication(s) if resident contact was necessarial.	r to ter

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		JLTIPLE CO IILDING	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THIS I ETHIN	or coluction.	155831	B. WI		<u></u>	04/04/	
	PROVIDER OR SUPPLIEF	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					The correct medication was administered to the resident.		
					The correct dose was administered to the resident		
					Medication administered with a physician's order	a	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/04/2022	
	ROVIDER OR SUPPLIE	R EHABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD /ESTERN AVENUE I BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Medications administered as ordered (e.g., before, after, or food such as antacids).	r with
				Medications administered bef the expiration date on the lab	
				Medications administered to t	he
				resident via the correct route	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED B. WING 04/04/2022				
		155831	B. W			04/04/	2022
	PROVIDER OR SUPPLIER	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE I BEND, IN 46619		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDER'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Medication held and physician notified in the presence of an adverse effect, such as signs bleeding or abnormal lab resu with anticoagulants Checked pulse and/or blood pressure prior to administering medications when indicated/ordered	of Its	
					Staff ensured medications were administered to the resident (eleft medications at bedside).	_	

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	F OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/04/2022
	ROVIDER OR SUPPLIE	R EHABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE
				Resident was properly post to receive medications (e.g of the bed is elevated at an of 30-45°).	ı., head
				Resident was properly information the medications being administered	rmed of
				Medication cart was locked unattended in resident care	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>00</u> CC) DATE SURVEY COMPLETED	
		155831	B. WIN			04/04/	
	PROVIDER OR SUPPLIER	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
					If a controlled medication was administered, make sure the count in the cart matches the count in the facility's reconcile records. Insulin suspensions - "mix" or "roll" the suspension without creating air bubbles.		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/04/2022
	ROVIDER OR SUPPLIE	R EHABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE I BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Shake a drug product that is labeled "shake well," such as Dilantin Elixir.	
				5 Rights of Medication Administration were followed Right Patient, Right Medicatio Right Dose, Right Route Righ Time)	n,
				Nurse Compared MAR to MEDICATIONS	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/04/2022	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE	
BRIARCL	.IFF HEALTH & RE	HABILITATION CENTER		H BEND, IN 46619	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
				Compliance: Count only yes boxes for Total # of complete boxes For any quest that does not apply to specific quality indicators use N/A and not count in completed boxes Trends Identified:	d iion ii do

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Event ID:

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PRINTED: 05/11/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(x3) date survey completed 04/04/2022	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene; Based on observation review, the facility removal of facial hardon activities of dail Findings include: 1. A clinical record 3/31/2022 at 3:15 P diagnoses included, 2 diabetes, chronic	ad for Dependent Residents esident who is unable to of daily living receives the s to maintain good g, and personal and oral on, interview and record failed to provide assistance for air for 2 of 2 residents reviewed y living. (Resident 25 & 38) Treview was completed on .M., and indicated Resident 25's but were not limited to: type obstructive pulmonary on, chronic kidney disease	F 0677	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice? • Residents 25 and 38 were provided with ADL care related facial hair How will you identify other residents having the potential to be affected by the same deficient practice and what corrective active and will be taken?	nts y the d to to ent

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155831	B. W	ING		04/04/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			ESTERN AVENUE		
BRIARCI	LIFF HEALTH & RE	HABILITATION CENTER			I BEND, IN 46619		
(IVA) ID	CID OLL DV	CT A TEN CENTE OF DEFICIENCIE			, I		(ME)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		dism, hyperlipidemia, and		TAG			DATE
		vioral disturbances.			All residents in the facility have	е	
	dementia with bena	violal disturbances.			the potential to be affected by alleged deficient practice		
	On 3/29/22 at 12:20	P.M., observed Resident in			Audit completed of residents	in	
		or lunch and had a lot of facial			the facility and all with facial h		
	hair on her chin.	or runeri and had a for or racial			offered ADL care.	ali	
	nun on ner enni.				officied ADE care.		
	During an observati	ion and interview, on 3/30/22			What measures will be put into	o	
	_	lent 25 indicated she wishes			place or what systemic change		
	someone would brin	ng in a razor and shave her			you will make to ensure that th	ne	
	facial hair because	it is so embarrassing.			deficient practice does not rec	ur?	
					Staff in servicing conducted		
	A review of Reside	nt 25's activity of daily living			related to ADL care for depend	dent	
	care plan indicated	she requires supervision by			resident, utilizing the ADL poli-	су	
	_	onal hygiene and oral care and			with emphasis on facial hair.		
	limited assistance b	y one staff with					
	bathing/showering.						
					How the corrective action (s) v	vill	
	_	on 4/1/2022 at 9:37 A.M., the			be monitored to ensure the		
		ated staff should ask resident's			deficient practice will not recur	-,	
	-	haved, and she should have			i.e., what quality assurance		
	been shaved.				program will be put into place?		
					DON/ designee will complete	;	
		l review was completed, on			ADL care Audits to monitor		
		I., and indicated Resident 38's			residents ADL status including	J	
		but were not limited to:			facial hair	_	
		s, retention of urine, major			Audit will be completed daily		
	_	s, chronic embolism, and			weekly x 4 weeks, bi-monthly		
	_	veins of right lower extremity,			months, monthly for 6 and the		
	and dementia witho	out behavioral disturbances			quarterly to encompass all shi	fts	
	An Admi MD	S (Minimum Data S-t)			until continued compliance is		
		S (Minimum Data Set)			maintained for 2 consecutive		
		/15/2022, indicated Resident			quarters. • The results of these audits w	.:II	
	•	interview for Mental Status) impaired cognition.					
	score or 0, severery	mpaneu cogmuon.			be reviewed by the CQI commoverseen by the ED. If threshop		
	On 3/29/2022 at 10	:29 A.M., observed lying in bed			95% is not achieved an action		
		eks, chin and above the lip.			plan will be developed to ensu		
		, Jimi and above the lip.			compliance.		
	On 3/30/22 at 9:25	A.M., observed the resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		r í	a. building <u>00</u>			(X3) DATE SURVEY COMPLETED 04/04/2022	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	50)24 WE	DDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAU	lying in bed, he is unshaved, his facial hair is resembling the beginnings of a beard, hair looks greasy and unkept. During an interview on 3/31/22 at 9:30 A.M., the Director of Nursing indicated that the resident is difficult to shave but he should be shaved.		1A	d			DATE
	Nursing provided a Daily Living (ADL 2018, and indicated currently used by th " Residents who a activities of daily li the services necessa grooming and perso Appropriate care an residents who are u independently, with and in accordance v appropriate support	230 A.M., the Director of policy titled, "Activities of s), Supporting", dated March the policy was the one are facility. The policy indicated are unable to carry out wing independently will receive ary to maintain good nutrition, and and oral hygiene. 2. d services will be provided for mable to carry out ADLs at the consent of the resident with the plan of care, including and assistance with a.					
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of Quality of care is a applies to all treat facility residents. I comprehensive as facility must ensur treatment and car professional stand	a fundamental principle that ment and care provided to Based on the sessment of a resident, the te that residents receive in accordance with lards of practice, the erson-centered care plan,					
			F 0684		What corrective action(s) will be	е	05/01/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/04/2022 155831 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE **BRIARCLIFF HEALTH & REHABILITATION CENTER** SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on record review and interview, the facility accomplished for those residents failed to complete physician ordered dressing found to have been affected by the changes for a non-pressure wound in 1 of 2 deficient practice? residents reviewed for non-pressure wounds. • Resident 80 skin tear was (Resident 80). assessed, and no abnormal findings noted. Residents skin Finding includes: tear continues to heal as expected. A clinical record review was completed on How will you identify other 4/1/2022 and indicated that resident 80's residents having the potential to diagnoses included, but were not limited to: be affected by the same deficient dementia, type II diabetes, depression, and practice and what corrective action cellulitis. will be taken? All residents in the facility have A nurse note, dated 3/25/2022 at 12:24 P.M., the potential to be affected by indicated resident 80 was seen by the wound alleged deficient practice doctor for skin issues on the right and left lower • TAR audit completed to legs. New orders were given for treatment. determine any additional missing treatments for last 30 days Current physicians orders dated 3/25/2022 stated • Full house skin sweep to cleanse the left and right lower leg, cover with completed calcium alginate (wound treatment), and wrap with What measures will be put into gauze daily for wound healing. place or what systemic changes you will make to ensure that the A Treatment Administration Record (TAR) dated deficient practice does not recur? March 2022, indicated these treatments were not All Licensed nursing staff completed on 3/28/2022. in-serviced Quality of Care and treatment with emphasis on During an interview on 4/4/2022 at 11:07 A.M., documentation of completed LPN (Licensed Practical Nurse) 22 indicated that nursing services such as signing the dressing changes should be documented of EMAR/ETAR daily on the TAR by a check mark. A blank space · All Licensed nursing staff in indicated that it was not done or documented. serviced on utilizing PCC for EMAR/ETAR and utilizing reports A non-pressure wound care policy was requested to ensure that task are completed but not provided. each shift 3.1-37(a) How the corrective action (s) will

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

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f ´		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155831	A. BU B. W	UILDING	00	COMPL 04/04/	
		100001	D. W			04/04/	2 022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE		
BRIARCL	LIFF HEALTH & RE	HABILITATION CENTER		SOUTH BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	be monitored to ensure the		DATE
					deficient practice will not recu		
					i.e., what quality assurance	,	
					program will be put into place?	?	
					DON/ designee will complete	;	
					Quality of Care related to		
					Treatment Audit to include		
					monitoring of EMAR/ETAR • Audit will be completed daily	v 5	
					weekly x 4 weeks, bi-monthly		
					months, monthly for 6 and the		
					quarterly to encompass all shi	fts	
					until continued compliance is		
					maintained for 2 consecutive		
					quarters. • The results of these audits w	ill	
					be reviewed by the CQI comm		
					overseen by the ED. If thresho		
					95% is not achieved an action		
					plan will be developed to ensu	ire	
					compliance.		
F 0686	483.25(b)(1)(i)(ii)						
SS=G		Prevent/Heal Pressure					
Bldg. 00	Ulcer						
	§483.25(b) Skin Ir						
	§483.25(b)(1) Pre						
		prehensive assessment of ility must ensure that-					
		ives care, consistent with					
	` '	ards of practice, to prevent					
		nd does not develop					
	•	nless the individual's clinical					
		rates that they were					
	unavoidable; and	processor ulcare					
	· ·	pressure ulcers receives ent and services, consistent					
		standards of practice, to					
		prevent infection and prevent					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155831	B. W	ING		04/04/	/2022
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			/ESTERN AVENUE		
BBIVB€I	IFF HEAI TH & DE	EHABILITATION CENTER			BEND, IN 46619		
DIVIANCE	-ii i iilaliii a Re	LIABILITATION CENTER		30011	, DEMD, IN 40019		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	new ulcers from d	. •					
		on, interview and record	F 00	586	What corrective action(s) will be		05/01/2022
	review the facility f	-			accomplished for those reside		
		event the development of a			found to have been affected b	y the	
		at risk for one out of one			deficient practice?		
		for skin integrity. (Resident			Resident 38 will continue to I	be	
	38)				evaluated for healing and	_	
	Finding in the de				appropriate treatment modality	У	
	Finding includes:				weekly by the wound care		
	A clinical record re	wiew was completed on 2/21/22			physician. Resident 38 will		
	A clinical record review was completed, on 3/31/22 at 1:40 P.M., and indicated Resident 38's				continue with low- air loss	aata	
		, but were not limited to:			mattress, pressure reducing b as ordered and care planned.	oots	
		s, retention of urine, major			Heels Up device was added to		
		rs, chronic embolism, and			residents' orders and care pla		
	_	veins of right lower extremity,			Resident 38 had footboard	11.	
	_	out behavioral disturbances.			removed and LAL mattress pu	ımn	
		ed the resident was admitted on			was relocated to side of the be	-	
	12/28/2021.	a the resident was admitted on			How other residents having th		
	12/20/2021.				potential to be affected by the	C	
	An Admission MD	S (Minimum Data Set)			same deficient practice will be	1	
		1/15/2022, indicated Resident			identified and what corrective	•	
		nterview for Mental Status)			action(s) will be taken?		
	•	cognition and he needed			All residents in the facility have	e	
		th activities of daily living.			the potential to be affected by		
		, ,			alleged deficient practice		
	A Braden Assessme	ent, dated 12/28/2021,			• Full house skin sweep		
		sk for pressure areas with a			completed with any new or		
	score of 16.	•			abnormal assessments report	ed	
					to the Physician.		
	On 3/30/2022 at 9:2	25 A.M., observed the Resident			Audit completed of all reside	nts	
		bed eating breakfast, his feet			to ensure all who are at risk fo		
	were bare with no b	poots in place, and his right			skin breakdown have preventa	ative	
	foot had an black as	nd red area on the edge/			interventions in place and that		
	plantar area of the f	foot.			interventions are listed in Care	•	
					plan and Kardex		
	On 3/31/2022 at 9:2	22 A.M., observed the resident			Nursing staff educated on		
	lying in bed with so	ocks on his feet, no boots in			Nursing staff in-serviced on		
	place, and right for	ot against the foot board of the			preventative wound care with		
	bed.				emphasis importance of placir	na	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ſ ′	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155831	B. W	ING		04/04	/2022
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t			/ESTERN AVENUE		
BRIARCI	IFF HEALTH & RE	HABILITATION CENTER		SOUTH	H BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					skin preventative interventions	8	
	1	y, on 3/31/2022 at 10:01 A.M.,			such as floating heels and		
		rsing Assistant) 16 indicated he			pressure relieving boots.		
		and she's getting him up			Nursing staff educated on us		
	1	think he has any other skin			Kardex / pocket care plan and		
	issues except the ar	ea on the bottom.			what interventions are listed a	nd in	
	<u> </u>	2/21/2022 / 12 15 1 35			place for each resident		
	_	y, on 3/31/2022 at 10:15 A.M.,					
		rse) 12, indicated he only had			What measures will be put into		
	the area on his sacri	um and bruising on his arms.			place or what systemic chang		
	.	2/21/2022 . 10.20 . 15			you will make to ensure that the		
		y, on 3/31/2022 at 10:20 A.M.,			deficient practice does not rec	ur?	
	RN (Registered Nurse) 12 indicated the skin is				Nursing staff in-serviced on		
	1	the nurse, she indicated it will			preventative wound care per p	oolicy	
	pop up in the Medic				with emphasis importance of		
		ord and a skin assessment is			placing skin preventative		
	form is filled out.				interventions such as floating		
	0 2/21/2022 / 10	56 436 1 14 121			heels and pressure relieving b		
		:56 AM., observed the RN			Nursing staff educated on us		
		12 remove Resident 38's socks			Kardex and what interventions	s are	
		s eschar on the right side and			listed and in place for each		
		and ball of left foot looks like			resident		
		ng in bed may have been			DON /designee will validate		
	_	v air loss machine and the foot			treatments continue to be		
		l was palpated by nurse and			completed as ordered and		
	she indicated the ne blanchable.	el was soft and mushy but			pressure relieving devices are	: IU	
	oranchable.				place.	,	
	A Physician Onder	dated 3/20/2022 indicated			Wound team to make weekly rounds an residents identified.		
		dated 3/29/2022, indicated bed, every shift for prevention.			rounds on residents identified	WILII	
	Hoat heels while in	oca, every sum for prevention.			skin impairment to ensure treatments continue to be		
	A Physician Order	dated 3/29/2022, indicated				200	
	1 .	elieving boots as tolerated			completed per order and device		
	every shift.	cheving boots as tolerated			are in place for prevention of s		
	every sinit.				breakdown, notify Physicians changes are needed and that		
	A Physician Order	dated 3/39/2022, indicated low			plan of care is current/up-date		
		eck placement and function of			needed.	u as	
		y shift. Set to resident comfort					
	every shift.	y smit. Set to resident connoct			DON/designee will conduct rounds each shift to ensure		
	every sinit.				rounds each shift to ensure	a	
i e	1				T DIEVERBANCE DIESSUIE FENEVIN	LI.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155831	B. WI	NG _		04/04/	/2022
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ESTERN AVENUE		
BRI∆RCI	IFF HFAI TH & PF	HABILITATION CENTER			I BEND, IN 46619		
אואוטו	III IILALIII & NE			55011	, DEND, IN 70018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	v, on 3/31/2022 at 11:26 A.M.,			devices are in place per plan o	of	
	, -	rse) 12 indicated he should			care.		
	have boots on his fe	eet.					
					How the corrective action (s) v	vill	
	_	v, on 3/31/2022 at 11:21 A.M.,			be monitored to ensure the		
		rsing Assistant) 16, Indicated			deficient practice will not recui	۲,	
	_	putting boots on him. She			i.e., what quality assurance	_	
		ok for some boots but none			program will be put into place?	?	
	were found in the ro	oom.			DON/designee will conduct		
	A G Pl 1	2/10/2022 : 1: 1			rounds each shift to ensure		
		2/10/2022, indicated			preventative pressure relieving	-	
	intervention boots to bilateral feet at all times				devices are in place per plan o	of	
	when in bed to prot	ect heels.			care.		
		2/10/2022 : 1: 1			Wound team to make weekly		
		2/10/2022, indicated			rounds on residents identified	with	
		nattress- set at resident comfort			skin impairment to ensure		
	level.				treatments continue to be		
	0 4/1/2022 + 10.2	20 A M. (1 D. (CN .			completed per order and device		
		20 A.M., the Director of Nursing			are in place for prevention of s		
		tled, "Prevention of Skin			breakdown, notify Physicians		
	-	ted July 2017, and indicated one currently used by the			changes are needed and that		
		indicated "The purpose of			plan of care is current/up-date	d as	
		provide information regarding			needed. • The DON/Designee is		
	_	n ulcer/injury risk factors and			responsible for the completion	of	
		ecific risk factors. 3. Inspect			the Skin/ Wound Audit weekly		
	-	pasis when performing or			4 weeks, bi-monthly for 2 mon		
		onal care or ADLs. a. Identify			monthly for 6 and then quarter		
		ping pressure injuries. For			encompass all shifts until	ly to	
		kin, inspect for changes in skin			continued compliance is		
		and consistency, b. inspect			maintained for 2 consecutive		
	_	rum, heels, elbows, etc)"			quarters.		
	, F(5000)	, , , , , , , , , , , , , , , , , , , ,			The results of these audits w	rill	
	3.1-40				be reviewed by the CQI comm		
					overseen by the ED. If thresho		
					95% is not achieved an action		
					plan will be developed to ensu		
					compliance.		
					,		

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Event ID: CVOO11 Facility ID: 013420

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	IDENTIFICATION NUMBER	A. BUILDIN	G <u>00</u>	(X3) DATE SURVEY COMPLETED	
	155831	B. WING		04/04/2022	
		502	STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619		
SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
*			CROSS-REFERENCED TO THE APPRO	PRIATE	
	LSC IDENTIFYING INFORMATION	TAC	DEFICIENCY	DATE	
, , , , ,					
Hazards/Supervisi §483.25(d) Accide The facility must e §483.25(d)(1) The remains as free of possible; and	nts. nsure that - resident environment accident hazards as is				
- ' ' ' '					
to prevent accident Based on record reversalled to prevent injuresidents reviewed for	its. iew and interview, the facility uries from falls for 1 of 4	F 0689	What corrective action(s) was accomplished for those restound to have been affected deficient practice?	idents d by the	
3/31/2022 at 11:11 A.M., diagnosis included, b were not limited to: diabetes mellitus type 2, prostate cancer and nondisplaced fracture of greater trochanter of right femur. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/13/2022, indicated that Resident 5 had a BIMS (Brief Interview Menta Status) score indicating severe cognitive impairment. Resident 5 required extensive assistance with two staff members for bed mobility, transferring and toileting. Resident 5 a recent surgery requiring an SNF (Skilled Nur Facility) stay and repair of fracture including the hip. A Nurses' Note on 11/29/2021 at 9:55 A.M.,			completed, all resident interventions were reviewe care plan was updated. How will you identify other residents having the potent be affected by the same depractice and what corrective will be taken? All residents in the facility have the potential to be affected alleged deficient practice • An Audit of resident falls completed for last 60 days fall events reviewed to ensign IDT note was written, and on plan was updated with intervention. What measures will be put place or what systemic charyou will make to ensure the deficient practice does not	d, and tial to eficient e action have by and all ure that care into anges at the recur?	
	SUMMARY S (EACH DEFICIENCE REGULATORY OR 483.25(d)(1)(2) Free of Accident Hazards/Supervisi §483.25(d) Accide The facility must e §483.25(d)(1) The remains as free of possible; and §483.25(d)(2)Each adequate supervisi to prevent accident Based on record rev failed to prevent injuresidents reviewed for Finding includes: A record review of 13/31/2022 at 11:11 A were not limited to: prostate cancer and greater trochanter of A Quarterly MDS (1) Assessment, dated 3 Resident 5 had a BI Status) score indicat impairment. Resider assistance with two mobility, transferrin a recent surgery req Facility) stay and re hip. A Nurses' Note on 1 indicated "On 11/ DON (Director of N nursing staff that resident resi	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 record review and interview, the facility failed to prevent injuries from falls for 1 of 4 residents reviewed for accidents. (Resident 5) Finding includes: A record review of Resident 5 was completed on 3/31/2022 at 11:11 A.M., diagnosis included, but were not limited to: diabetes mellitus type 2, prostate cancer and nondisplaced fracture of greater trochanter of right femur. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/13/2022, indicated that Resident 5 had a BIMS (Brief Interview Mental Status) score indicating severe cognitive impairment. Resident 5 required extensive assistance with two staff members for bed mobility, transferring and toileting. Resident 5 had a recent surgery requiring an SNF (Skilled Nursing Facility) stay and repair of fracture including the hip. A Nurses' Note on 11/29/2021 at 9:55 A.M., indicated "On 11/29 ED (Executive Director) and	IFF HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §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 record review and interview, the facility failed to prevent injuries from falls for 1 of 4 residents reviewed for accidents. (Resident 5) Finding includes: A record review of Resident 5 was completed on 3/31/2022 at 11:11 A.M., diagnosis included, but were not limited to: diabetes mellitus type 2, prostate cancer and nondisplaced fracture of greater trochanter of right femur. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/13/2022, indicated that Resident 5 had a BIMS (Brief Interview Mental Status) score indicating severe cognitive impairment. Resident 5 required extensive assistance with two staff members for bed mobility, transferring and toileting. Resident 5 had a recent surgery requiring an SNF (Skilled Nursing Facility) stay and repair of fracture including the hip. A Nurses' Note on 11/29/2021 at 9:55 A.M., indicated "On 11/29 ED (Executive Director) and DON (Director of Nursing) were notified by nursing staff that resident fell in his room. Nursing	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) (1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(1) The resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to prevent injuries from falls for 1 of 4 residents reviewed for accidents. (Resident 5) A record review of Resident 5 was completed on 3/31/2022 at 11:11 A.M., diagnosis included, but were not limited to: diabetes mellitus type 2, prostate cancer and nondisplaced fracture of greater trochanter of right femur. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/13/2022, indicated that Resident 5 had a BIMS (Brief Interview Mental Status) score indicating severe cognitive impairment. Resident 5 required extensive assistance with two staff members for bed mobility, transferring and toileting. Resident 5 had a recent surgery requiring an SNF (Skilled Nursing Facility) stay and repair of fracture including the hip. A Nurses' Note on 11/29/2021 at 9:55 A.M., indicated "On 11/29 ED (Executive Director) and DON (Director of Nursing) were notified by nursing staff that resident fell in his room. Nursing	

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Event ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155831	B. W	'ING		04/04/	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	S.			ESTERN AVENUE		
BRIARCL	.IFF HEALTH & RE	HABILITATION CENTER			I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
	assessments. Orders	s were received from MD for			review and Care Plan Updates	S.	
	X-Ray and pain wa	s managed. As per MD order			All falls will be reviewed by the		
	resident sent to ER	(Emergency Room) for			IDT team the following busine		
	evaluation. As per r	eport received from hospital			day as part of the daily clinical		
	[Resident 5] did sus	stain a fracture right side hip.			meeting to determine root cau		
	[Resident 5] remain	s in the hospital for treatment			and other possible intervention	ns to	
	at this time"				prevent future falls. Care plan	s will	
					be updated as appropriate.		
	On 2/2/2022 at 5:45	P.M., indicated Resident 5 is			DON/Designee will conduct		
	scheduled for right	hip surgery on February 8,			rounds weekly to ensure fall		
	2022.				interventions are implemented	l per	
					plan of care		
	On 2/12/2022 at 5:33 A.M., indicated " Staff						
	reported to this writ	er that resident was on floor.					
	This writer rushed t	o res room. Resident observed			How the corrective action (s) v	vill	
	on floor lying on hi	s right-side legs point towards			be monitored to ensure the		
		ir behind his headThis			deficient practice will not recui	۲,	
		r neuro (neurological)			i.e., what quality assurance		
		c/o (complained of) pain			program will be put into place?	?	
		n pain scale of 0-10. [Physician			 DON/ designee will complete 	e the	
	_	ordered to send res to ER for			Fall Management audit tool		
	eval and treatment.	"			 Audit will be completed daily 		
					weekly x 4 weeks, bi-monthly		
		9 A.M., indicated "Resident			months, monthly for 6 and the		
	found on floor next	to bedpain to R leg"			quarterly to encompass all shi	fts	
					until continued compliance is		
		:09 a.m., indicated "IDT			maintained for 2 consecutive		
		eam) met to review residents			quarters.		
	_	:30 A.M INTERVENTION:			The results of these audits w		
	Fall mat placed on t	floor next to bed"			be reviewed by the CQI comm		
					overseen by the ED. If thresho		
		'Notes indicated an IDT			95% is not achieved an action		
	_	our for falls documented on			plan will be developed to ensu	ire	
		2/2022 to develop interventions			compliance.		
	to prevent further fa	IIIS.					
	A Physician Progre	ss Note, on 2/18/2022 at 9:51					
	P.M., indicated " This is an 82-year-old male						
		Imission to the facility. He was					
	-	/12-2/16 s/p (status post) fall in					
	_	• • • •	I				I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/04/2022	
	PROVIDER OR SUPPLIER	HABILITATION CENTER		5024 W	DDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	fracture and UTI an	He had a fall with a fracture to					
	is at risk for falls an [Resident 5] will no fall. No new preven	21/2021, indicated [Resident 5] d has a history of falls and t sustain serious injury from tative interventions were that occurred on 11/27/2021					
	LPN (Licensed Practinvolved with IDT)	vent falls should have been					
	the DON indicated after a fall unless or	y, on 4/4/2022 at 11:20 A.M., IDT meets the next morning a a Friday or the weekend and the placed for a new fall.					
	policy entitled, "Fal The policy indicated evaluations and cur- interventions related risks and causes to the from falling and to from falling. 5. If fal interventions, staff	P.M., the DON provide the ls and Fall Risk, Managing". d., "Based on previous rent data, the staff will identify d to the resident's specific try to prevent the resident try to minimize complications alling recurs despite initial will implement additional or ons, or indicate why the current elevant"					
F 0690	3.1-45(a)(1) 483.25(e)(1)-(3)						
SS=D Bldg. 00		ontinence, Catheter, UTI inence.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		A. BU	A. BUILDING <u>00</u> C			3) DATE SURVEY COMPLETED 04/04/2022	
	PROVIDER OR SUPPLIEF	L HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i.c	DATE
	§483.25(e)(1) The resident who is comprehensive as soon as possibilitial condition of catheterization is (iii) A resident who receives appropriate to prevent urinary restore comprehensive as comprehensive as ensure that unless the resident who an indwelling catheter one is assessed for as soon as possibilitial condition of catheterization is (iii) A resident who receives appropriate to prevent urinary restore continence §483.25(e)(3) For incontinence, bas comprehensive as	e facility must ensure that ontinent of bladder and on receives services and nation continence unless his dition is or becomes such not possible to maintain. The resident with urinary end on the resident's essessment, the facility must enters the facility without eter is not catheterized nat's clinical condition at catheterization was enters the facility with an or or subsequently receives or removal of the catheter ele unless the resident's demonstrates that					
	1	propriate treatment and					
		e as much normal bowel					
	interview, the facili orders for a Foley c reviewed for urinar	on, record review and ty failed to obtain physician atheter for 1 of 2 residents y catheters. (Resident 54)	F 06	590	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice? Resident 4's physician orders	nts y the s	05/01/2022
	Finding includes:				were reviewed and all appropr	iate	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/04/2022 155831 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **5024 WESTERN AVENUE BRIARCLIFF HEALTH & REHABILITATION CENTER** SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Foley Catheter orders A record review of Resident 54 was completed on implemented including when to 3/30/2022 at 1:44 P.M., diagnosis included, but change the Foley catheter/ were not limited to: stage 4 pressure ulcer to right drainage system buttock, osteomyelitis, and acute kidney injury. How will you identify other residents having the potential to A Quarterly MDS (Minimum Data Set) be affected by the same deficient Assessment, dated 3/22/2022, indicated that practice and what corrective action Resident 54 had a BIMS (Brief Interview Mental will be taken? Status) score indicating no cognitive impairment All residents in the facility with and had an indwelling catheter. Catheters have the potential to be affected by alleged deficient Physician's Orders, on 2/17/2022, indicated practice catheter care every shift and record catheter An Audit of residents with output every shift. No physician orders indicated catheters to ensure that all when to change the Foley catheter or drainage residents have all appropriate system. Foley Catheter orders implemented including when to A Care Plan, on 12/13/21, indicated Resident 54 change the Foley catheter/ had a urinary catheter and catheter care and drainage system treatment per current MD orders. What measures will be put into place or what systemic changes During an interview, on 4/4/2022 at 11:24 A.M., you will make to ensure that the the DON (Director of Nursing) indicated the Foley deficient practice does not recur? catheter is not changed on routine basis unless • IDT was educated on Foley the catheter needs changed. She indicated the Catheter Maintenance Orders and bags are changed weekly on Sundays by the third shift nurse. She indicated an order should be Nursing staff educated on Foley written for changing the Foley catheter when Catheter Maintenance orders and needed and changing of the drainage bag system care weekly. • IDT will review all new admissions in clinical meeting for On 4/4/2022 at 12:15 P.M., a policy was requested catheters and ensure that all for Foley catheters A policy was not provided. Foley Catheter Maintenance orders are implemented 3.1-41(a) • IDT will review all new MD orders in clinical meeting for new catheters and ensure that all Foley Catheter Maintenance

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orders are implemented

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		A. BUILDING B. WING	00	COMPLETED 04/04/2022	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD /ESTERN AVENUE I BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydratio	n Status Maintenance		How the corrective action (s) be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place • DON/ designee will complete Catheter audit tool to ensure all residents have necessary catheter orders • Audit will be completed daily weekly x 4 weeks, bi-monthly months, monthly for 6 and the quarterly to encompass all shuntil continued compliance is maintained for 2 consecutive quarters. • The results of these audits we reviewed by the CQI commoverseen by the ED. If thresh 95% is not achieved an action plan will be developed to ensuronments.	r, ? e the that x x 5, for 2 en iifts vill nittee old of
Bldg. 00	§483.25(g) Assisto (Includes naso-ga tubes, both percut gastrostomy and μ jejunostomy, and	n Status Maintenance ed nutrition and hydration. stric and gastrostomy caneous endoscopic percutaneous endoscopic enteral fluids). Based on a thensive assessment, the te that a resident-			
	· .	ntains acceptable ritional status, such as			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		` ′				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00		COMPLETED	
		155831	B. WI	NG		04/04	/2022	
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	resident's clinical that this is not pos preferences indical §483.25(g)(2) Is o							
	§483.25(g)(3) Is of when there is a numbealth care provided Based on record revision failed to provide the of 2 residents review hemodialysis (HD) Finding includes: A clinical record resident record resident and the stage renal disease, delusional disorder. A current order indirective double protective double protective double protective double protective and stage renal disease. A nutrition note data indicated a diet recorder at breakfast. During an observation resident 71's lunched carrots, a piece of figure. The meal tick diet tray and listed mayonnaise, carrots.	offered a therapeutic diet attritional problem and the der orders a therapeutic diet. View and interview, the facility is ordered therapeutic diet for 1 wed for nutrition with treatment. (Resident 71). View completed on 4/1/2022 at teed that residents 71's but were not limited to: end anxiety, depression, and dieated resident 71 should in a breakfast and lunch for ease. Just 3/2/2022 at 2:19 P.M., commendation for double and lunch. Just 3/2/2022 at 11:53 A.M., tray was noted to include fries, ish on a bun, pudding, and teet on the tray indicated a renal baked fish on a bun, s, corn, fruit, and a fruit drink.	F 06	592	What corrective action(s) will I accomplished for those reside found to have been affected by deficient practice? Resident 71 was not affected alleged deficient practice. How will you identify other residents having the potential be affected by the same deficient practice and what corrective a will be taken? All residents in the facility with Catheters have the potential to affected by alleged deficient practice An Audit of all resident's diet orders completed to ensure the diet orders are accurate and undate on tray cards being serve from kitchen What measures will be put into place or what systemic change you will make to ensure that the deficient practice does not reconstructed. Dietary Staff educated on tray card updating and accuracy. IDT will review all new MD or in clinical meeting and apparent.	ents by the d by to ient action o be dist up to ed o es ne cur? ay rders	05/01/2022	
	The notes section of and milk only for or	f the tray ticket listed: coffee			in clinical meeting and ensure	that		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/04/2022		
	PROVIDER OR SUPPLIE			5024 W	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	dietary manager in mean two servings and if double prote	4/1/2022 at 1:35 P.M., the dicated double protein would of the protein portion of meal, in is ordered, the ticket should in" in the notes section.			completed. How the corrective action (s) be monitored to ensure the deficient practice will not recuire., what quality assurance program will be put into place. Dietary Manager / designee complete the Tray Card Audit to ensure that all residents hancessary catheter orders. Audit will be completed daily weekly x 4 weeks, bi-monthly months, monthly for 6 and the quarterly to encompass all shuntil continued compliance is maintained for 2 consecutive quarters. The results of these audits we reviewed by the CQI compoverseen by the ED. If thresh 95% is not achieved an action plan will be developed to enscompliance.	y will tool ave / x 5, for 2 en ifts	
F 0693 SS=D Bldg. 00	§483.25(g)(4)-(5) (Includes naso-ga tubes, both percu gastrostomy and jejunostomy, and resident's compre facility must ensu §483.25(g)(4) A r to eat enough alco fed by enteral me	gmt/Restore Eating Skills Enteral Nutrition astric and gastrostomy taneous endoscopic percutaneous endoscopic enteral fluids). Based on a chensive assessment, the re that a resident- esident who has been able one or with assistance is not thods unless the resident's demonstrates that enteral					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	ETED
		155831	B. W	ING		04/04/	2022
	PROVIDER OR SUPPLIER	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	feeding was clinicated to by the						
	means receives the and services to receive the and services to receive the and services to receive the analysis and to enteral feeding incomplete the aspiration pneumodehydration, metanasal-pharyngeal Based on observation review, the facility was labeled with its initialed for one out tube feeding manage. On 3/29/2022 at 2:5 with light brown liquid not labeled winitials. On 3/30/2022 at 9:3 with light brown liquid not labeled winitials. During an interview Director of Nursing feeding bags should a date, time, and initials.	on, interview and record failed to ensure a feeding bag a contents, time, date, and a one resident reviewed for rement. (Resident 242) 66 P.M., observed two bags one quid and the other with clear with contents, date, time, or 83 A.M., observed two bags one quid and the other with clear with contents, time, date, or 9 on 4/1/2022 at 9:43 A.M., the gindicated that the tube 1 be labeled with the contents	F 00	593	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice? Resident 242 did not have a negative outcome related to the alleged deficient practice Resident 242 enteral feeding bags were replaced and dated How will you identify other residents having the potential be affected by the same deficipractice and what corrective awill be taken? All residents in the facility with enteral tubes have the potential be affected by alleged deficient practice An Audit of residents with entubes completed to ensure that residents have all appropriate enteral orders and that bags a labeled and dated What measures will be put into place or what systemic change you will make to ensure that the deficient practice does not receive Licensed Nursing Staff were educated on appropriate enteral	nts y the to ent ction al to t teral t all re es ee ur?	05/01/2022

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PRINTED: 05/11/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 04/04/2022
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER	5024	ET ADDRESS, CITY, STATE, ZIP COD 4 WESTERN AVENUE JTH BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				feeding maintenance with emphasis on labeling and data bags/ feeding • Angel Care Representatives educated on checking reside with enteral feedings to ensure that bags/ feeding is labeled dated during rounds • DON to conduct weekly rou to ensure that bags/feeding is labeled and dated appropriate. How the corrective action (s) be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place. • DON/ designee will complete Enteral Feeding audit tool to ensure that all residents have necessary enteral orders and bags/ feeding is labeled appropriately • Audit will be completed daily weekly x 4 weeks, bi-monthly months, monthly for 6 and the quarterly to encompass all shuntil continued compliance is maintained for 2 consecutive quarters. • The results of these audits we be reviewed by the CQI commoverseen by the ED. If thresh 95% is not achieved an action plan will be developed to enscompliance.	s ints re and nds selly will ir, re the e that / x 5, re for 2 en ifts will mittee old of n

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 04/04/2022			ETED		
	PROVIDER OR SUPPLIED	R EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0695	483.25(i)						
SS=D		neostomy Care and					
Bldg. 00	Suctioning						
	. ,, .	ratory care, including					
	1	e and tracheal suctioning.					
	I -	ensure that a resident who					
	needs respiratory	•					
	1	e and tracheal suctioning,					
	1 '	care, consistent with					
		dards of practice, the					
		erson-centered care plan,					
	the residents' goals and preferences, and 483.65 of this subpart.						
	Based on observation, interview and record		FA	(05			05/01/2022
		failed to ensure posting of	F 0	693	What corrective action(s) will be		05/01/2022
		ety signs indicating the use of			accomplished for those reside		
		de necessary respiratory care			found to have been affected b	y trie	
		of 3 residents reviewed for			deficient practice? • Resident 242 did not have a		
	respiratory care. (R				negative outcome related to the		
	respiratory care. (N	resident 31 & 242)			alleged deficient practice	ie	
	Findings include:				Resident 31 did not have a negative outcome related to the	ie	
	1. During an interv	riew, on 3/29/2022 at 11:41 A.M.,			alleged deficient practice		
	Resident 31 indicat	ted she only gets her breathing			Resident 242 had oxygen tul	oing	
	treatments at 9:00 A	A.M. and 9:00 P.M.			and humidification replaced • Resident 31 had oxygen,		
	During an observat	tion, on 3/29/2022 at 11:42			nebulizer tubing equipment an	d	
	A.M., Resident 31'	s oxygen tubing was dated			humidification replaced		
	3/13/2022, and the	water humidification bottle was			How will you identify other		
	undated.				residents having the potential	to	
					be affected by the same defici	ent	
	A clinical record re	eview was completed on			practice and what corrective a	ction	
	3/31/2022 at 11:47	A.M. Resident 31's diagnoses			will be taken?		
	included, but were	not limited to: chronic			All residents in the facility with		
	obstructive pulmor	nary disease, anxiety, chronic			oxygen / nebulizers have the		
	pain and chronic re	espiratory failure.			potential to be affected by alle	ged	
					deficient practice		
		orders, dated 12/31/2021,			An Audit of residents with		
	_	e the oxygen tubing, humidifier,			oxygen or use of nebulizers		
	and equipment and	nebulizer setup every Sunday			completed to ensure that all		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155831	B. W	ING		04/04/	
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					ESTERN AVENUE		
BRIARC	LIFF HEALTH & RE	HABILITATION CENTER		SOUTH	I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	·-	DATE
	night shift, initial and date new equipment				residents have all appropriate		
					orders for routine changing of		
	A current care plan dated, 3/17/2022, indicated				equipment and that all oxygen	and	
	Resident 31 was at risk for respiratory distress.				nebulizer equipment is labeled		
	Interventions included, but were not limited to				dates in residents' rooms.		
	change oxygen tubi	ng nasal canula and humidifier			What measures will be put into)	
	every Sunday.				place or what systemic change		
	'				you will make to ensure that the		
	During an observation, on 3/31/2022 at 2:32 P.M.,				deficient practice does not rec		
	RN (Registered Nurse) 21 indicated the date was				Licensed Nursing Staff were		
	3/13/2022 on the tubing and it had not been				educated on appropriate oxyg		
	changed and the water bottle should have a date				and nebulizer maintenance wi		
	on it.				emphasis on changing, labelir	na.	
	2. A clinical record review was conducted on				and dating the equipment	J,	
	4/1/2022 at 11:00 A	A.M., and indicated Resident			Angel Care Representatives		
		luded, but not limited to: atrial			educated on checking residen		
	_	ia without behavioral			with oxygen or nebulizer		
	· ·	y disorder, benign prostatic			equipment to ensure that labe	lina	
		ate and chronic respiratory			and dating is present during	3	
	failure with hypoxi				rounds		
					DON to conduct weekly roun	ds	
	On 3/29/22 at 3:06	P.M., observed Resident 242 on			to ensure oxygen and nebulize		
		ng and the humidifier bottle			equipment is labeled and date		
		at initials or signage on the			appropriately		
	door to indicate oxy	ygen is in use.			'' '		
	On 3/30/2022 at 9:3	33 A.M., observed oxygen on 3			How the corrective action (s) v	vill	
	L/NC, humidifier w	vater and tubing was undated		be monitored to ensure the			
	and no initial or sig	nage on the door to indicate			deficient practice will not recui	-,	
	oxygen is in use.				i.e., what quality assurance		
					program will be put into place	?	
	A Physician Order,	initiated on 3/25/2022,			DON/ designee will complete		
	indicated change or	xygen tubing, humidifier, and			Respiratory Equipment audit t		
	equipment every Su	anday night shift. Initial and			to ensure that all residents ha		
	date new equipmen	t, every night shift every			necessary respiratory orders,	and	
	Sunday.	· · · · · · · · · · · · · · · · · · ·			that bags/ feeding is labeled		
					appropriately		
	On 4/01/22 at 9:39	A.M., the Director of Nursing			Audit will be completed week	dy x	
		lifier and tubing should be			4 weeks, bi-monthly for 2 mon	•	
	labeled with a date and they are changed every				monthly for 6 and then quarter		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/04/2022	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0698 SS=D Bldg. 00	on 4/1/2022 at 10:2 provided a policy tir (Respiratory Therap dated April 2007, arone currently used by indicated "2. Use humidification per fawith date and initial oxygen tubing cann (7) days, or as needs 3.1-47(a)(6) 483.25(I) Dialysis §483.25(I) Dialysis The facility must erequire dialysis reconsistent with propractice, the comp	10 A.M., Director of Nursing tled, "Departmental by) - Prevention of Infection", and indicated the policy was the by the facility. The policy distilled water for facility protocol. 3. Mark bottle is upon opening. 6. Change the ulae and tubing every seven ed"		encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits v be reviewed by the CQI commoverseen by the ED. If threships is not achieved an action plan will be developed to ensucompliance.	nittee old of
	Based on observation interview, the facility dialysis assessment communication on or residents reviewed (as 59) Findings include: 1. A clinical record completed on 3/31/2 included, but were a disease, hypertension	on, record review and ty failed to complete pre/post and assessment dialysis days for 2 of 2 for dialysis care. (Resident 29 review of Resident 29 was 2022 at 8:29 A.M., diagnosis not limited to: end stage renal on and atrial fibrillation. MDS (Minimum Data Set)	F 0698	What corrective action(s) will accomplished for those reside found to have been affected be deficient practice? • Resident 22 did not have a negative outcome related to the alleged deficient practice • Resident 59 did not have a negative outcome related to the alleged deficient practice. How will you identify other residents having the potential be affected by the same deficient practice and what corrective a will be taken?	ents by the ne to ient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) D) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 CO	COMPLETED
155831 B. WING 04	04/04/2022
OTDEET ADDRESS SITN STATE ZID COD	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD	
5024 WESTERN AVENUE	
BRIARCLIFF HEALTH & REHABILITATION CENTER SOUTH BEND, IN 46619	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
Assessment, dated 3/18/2022, indicated that All residents in the facility that are	,
Resident 29 had A BIMS (Brief Interview Mental receiving dialysis have the	
Status) of no cognitive impairment. Resident 29 potential to be affected by alleged	<u>.</u>
received dialysis. deficient practice	
• An Audit of residents with	
A Physician Order, on 3/11/2022, "Renal dialysis dialysis completed to ensure that	
at [Dialysis Facility] Frequency: Mon, Wed, Fri all residents have a dialysis binder	
with chair time @ (at) 8:10 am" in place with communication forms	
present.	3
Documentation of communication between the • DON/Designee spoke with each	
facility and dialysis center lacked documentation resident's dialysis center related	
on 1/20/2022, 1/21/2022, and 3/21/2022.	
During an interview on 3/31/2022 at 11:40 A.M., communication expectations and requirements were reviewed and	
communication form should be completed daily issues related to dialysis patients	
when attending dialysis. addressed with provider.	
What measures will be put into	
2. During an interview, on 3/29/2022 at 10:31 A.M., place or what systemic changes	
Resident 59 indicated he received dialysis 3 times you will make to ensure that the	
a week. deficient practice does not recur?	
• Licensed Nursing Staff were	
A clinical record review was completed on educated on End Stage Renal	
3/29/2022 at 11:15 A.M., Resident 59's diagnoses Disease Care To include	
included, but were not limited to: end stage renal Post-Dialysis: Nurse to complete	
disease, anxiety, hypertension, seizure disorder the post-dialysis evaluation upon	
and diabetes. return from the dialysis center.	
Any abnormal or unusual	
A Quarterly MDS (Minimum Data Set) occurrence resident reports while	
assessment, dated 2/16/2022, indicated Resident at dialysis center will be reviewed	
59 was receiving dialysis. and reported to the physician if	
necessary. The care of the	
Resident 59's current physician orders, dated resident receiving dialysis services	:S
3/2022, indicated Resident 59 received dialysis 3 will include ongoing	
times a week on Monday, Wednesday and communication, coordination and	
Fridays, and to check permacath site daily and collaboration between the dialysis	;
upon return from dialysis. center and the facility.	
A current care plan, dated 6/1/2021, indicated the	
resident's dialysis was on Monday, Wednesday How the corrective action (s) will	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COMI	E SURVEY PLETED 4/2022
	PROVIDER OR SUPPLIEF	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP WESTERN AVENUE H BEND, IN 46619	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 0757	and Friday at 2:00 I but were not limited between facility and signs and symptoms medications as order Resident 59's dialys indicated there had Communication For January, 1 time in F2022. During an interview the Director of Nurson to been assessed provided the Renal Disease, Card September 2020, and one currently used limicated" Resided disease (ESRD) will currently recognize Education and train specifically: a. The management of ESI prevention and nutranssessment date that resident's condition Signs and symptom and/or complication grafts and fistulas	P.M. Interventions included, Ito: maintain communication It dialysis clinic. Monitor for sof pain and administer ared. Perm-cath site care. Itis communication book been a Dialysis/Observation rm completed 7 times in Tebruary and 2 times in March are are all times in March are are all times in March are are all times in March are		be monitored to ensure deficient practice will i.e., what quality assure program will be put in • DON/ designee will or Dialysis audit tool to eall residents have need dialysis assessments communication forms • Audit will be compleweekly x 4 weeks, bimonths, monthly for 6 quarterly to encompare until continued complimaintained for 2 consiquarters. • The results of these be reviewed by the Converseen by the ED. If 95% is not achieved a plan will be developed compliance.	not recur, irance ito place? complete the ensure that cessary and in place ited daily x 5, monthly for 2 and then ss all shifts iance is secutive audits will QI committee If threshold of an action	
SS=D		Free from Unnecessary				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155831	B. WI	3. WING 04/0			2022
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			5024 W	ESTERN AVENUE		
BRIARCL	IFF HEALTH & RE	HABILITATION CENTER		SOUTH	BEND, IN 46619		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00	Each resident's dr from unnecessary drug is any drug w						
	§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or						
	consequences wh	ne presence of adverse ich indicate the dose d or discontinued; or					
	reasons stated in (5) of this section.	combinations of the paragraphs (d)(1) through					
	failed to ensure residence free from unnecessar	riew and interview, the facility dents' medication regimen was ary medication in 1 of 6 for unnecessary medications.	F 07	757	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice? • Resident 40 did not have a negative outcome related to the	nts y the	05/01/2022
	Finding includes:				alleged deficient practice • MD was notified that resident		
	2:26 P.M., indicated included, but were r disease, epilepsy, de disorder. A current physician	view completed on 3/31/2022 at direction and resident 40's diagnoses not limited to: Alzheimer's ementia, and psychotic order, dated 2/25/2022, 0 should be given tramadol			was receiving tramadol and hat complaints of pain, no new ord were obtained. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective are will be taken?	lers to ent	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155831	B. W	ING		04/04/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			ESTERN AVENUE		
BRIARCI	JIFF HEALTH & RE	HABILITATION CENTER			I BEND, IN 46619		
			1		,	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		CLSC IDENTIFYING INFORMATION cheduled every 12 hours for		TAG		<u> </u>	DATE
	· · · · · · · · · · · · · · · · · · ·	3			All residents on scheduled pai		
		pain. An order dated ed resident 40's pain level			medication in the facility have		
	should be monitored	-			potential to be affected by alle	gea	
	SHOULD DE HIGHHOFE	d every sinit.			deficient practice • Facility to complete audit of a	all .	
	A MAR (Medicatio	n Administration Record),			residents on scheduled pain	ali	
	· ·	indicated all documented pain			medication, facility will audit 1	n l	
		0 were zero, and the tramadol			Residents weekly x 4 and 5		
		en to resident 40 the same			residents weekly until 100% o	f	
	_	was documented as zero.			Resident orders reviewed.	'	
	part pull level				DON/Designee notified MD of	of	
	In an interview, on	4/4/2022 at 11:07 A.M., LPN			audit results.		
		Nurse) 22 indicated the pain			What measures will be put into	,	
	assessment is documented on the MAR, and the				place or what systemic change		
	number is documented is the resident's measured				you will make to ensure that the		
		e pain level is documented, a			deficient practice does not rec		
	*	essment in Advanced			Licensed Nursing Staff were		
	· ·	sed for those residents not able			educated on Medication Thera		
	to communicate. A	zero documented would			policy with emphasis on	-	
	indicate no pain.				assessing residents for pain a	nd	
					appropriateness of medication	۱.	
		ded on 4/4/2022 at 2:00 P.M.,			MD notified of audit results		
		sentative titled, "Medication	related to residents on pain				
		Each resident's medication			medication and pain levels		
	-	de only those medications					
		xisting conditions and address			How the corrective action (s) v	vill	
	significant risks"				be monitored to ensure the		
	2.1.40(.)(1)				deficient practice will not recui	-,	
	3.1-48(a)(4)				i.e., what quality assurance		
					program will be put into place?		
					DON/ designee will complete		
					Unnecessary Medication Pain		
					audit tool to ensure that reside	ents	
					are receiving pain medication		
					appropriately	sII	
					Facility to complete audit of a residents on schoduled pain.	411	
					residents on scheduled pain	n	
					medication, facility will audit 10	U	
					Residents weekly x 4 and 5	f	
					residents weekly until 100% o	ı	

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

PRINTED: 05/11/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		A. BUILDING B. WING	00	COMPLETED 04/04/2022	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Resident orders reviewed. The results of these audits we be reviewed by the CQI commoverseen by the ED. If threshows is not achieved an action plan will be developed to ensuron compliance.	nittee old of
F 0758 SS=D Bldg. 00	Use §483.45(e) Psychology §483.45(c)(3) A pso- drug that affects be with mental process	Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any rain activities associated asses and behavior. These are not limited to, drugs in iories:			
	resident, the facilit §483.45(e)(1) Res psychotropic drugs	_			
	reductions, and be	s receive gradual dose havioral interventions, ntraindicated, in an effort			
	- ',','	idents do not receive s pursuant to a PRN order			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/04/2022 155831 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE **BRIARCLIFF HEALTH & REHABILITATION CENTER** SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility F 0758 What corrective action(s) will be 05/01/2022 failed to complete a gradual dose reduction, failed accomplished for those residents to have proper indication/diagnosis, failed to found to have been affected by the monitor and document side effects of deficient practice? psychotropic medications for 4 of 5 residents • Resident 56 did not have a reviewed for unnecessary medications. (Resident negative outcome related to the 56, 38, 81 and 40) alleged deficient practice and medication was reviewed for GDR. Findings include: • Resident 38 did not have a negative outcome related to the 1. A clinical record review was completed on alleged deficient practice and 3/31/2022 at 3:07 P.M., Resident 56's diagnoses AIMS assessment was included, but were not limited to: anxiety, completed. depression, diabetes and functional quadriplegia. Resident 81 did not have a negative outcome related to the A Quarterly MDS (Minimum Data Set) alleged deficient practice and assessment, dated 2/25/2022, indicated Resident medication was reviewed for GDR. 56 had received antianxiety and antidepressant • Resident 40 did not have a medications. negative outcome related to the alleged deficient practice and side Physician orders, dated 3/2022, indicated the effect monitoring was added for

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PRINTED: 05/11/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	TE SURVEY IPLETED 04/2022
NAME OF	PROVIDER OR SUPPLIEF	.		ET ADDRESS, CITY, STATE, ZIP CO WESTERN AVENUE	D	
BRIARC	LIFF HEALTH & RE	HABILITATION CENTER		TH BEND, IN 46619		
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE ID PROPERTY OF THE PROPERTY O		PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	JULI D DE	COMPLETION
TAG			TAG	DEFICIENCY)		DATE
	resident had received Clonazepam (anticonvulsant) 1 mg (milligram) three times a day for anxiety.			monitoring adverse effe	cts related	
				to medication use.		
				How will you identify oth	ier	
				residents having the pot		
		ress Note, dated 7/1/2021,		be affected by the same	deficient	
	indicated Resident	56 medications included		practice and what correc	ctive action	
	Clonazepam that sta	arted on 1/1/2020. Assessment		will be taken?		
	and Plan: Anxiety d	lisorder. No changes indicated		All residents on psychot	ropic	
	today. Currently therapeutically managing target			medications in the facilit	ly have the	
	symptoms. She refused wanting GDR (Gradual			potential to be affected I	by alleged	
	Dose Reduction). Continue Klonopin			deficient practice		
	(Clonazepam) 1 mg	g by mouth three times a day for		 Facility to complete au 	dit of all	
	anxiety.			residents on psychotrop	oic	
				medications, facility will	review all	
	A Psychiatric Progr	ress Note, dated 12/6/2021,		residents for GDR in bel	havior	
	indicated Resident	56 medications included		management meeting.		
	Clonazepam started	on 1/1/2020. Assessment and		Facility will complete a	udit to	
	Plan: Anxiety disor	der. No changes indicated		ensure that all residents	on	
	today. Currently the	erapeutically managing target		psychotropic medication	าร have	
	symptoms. She refu	sed wanting GDR (Gradual		appropriate AIMS asses	sment	
	Dose Reduction). C	Continue Klonopin		completed.		
	(Clonazepam) 1 mg	by mouth three times a day for		Facility will complete a	udit to	
	anxiety.			ensure that all residents	on	
				psychotropic medication	າs have	
	A Psychotropic Me	dication Evaluation &		appropriate side effect n	nonitoring	
	Behavior Meeting I	Form, dated 10/21/2021,		in place.		
	indicated Resident	56's medication of Clonazepam		What measures will be p	put into	
	1 mg was started or	n 6/20/2020 and documented as		place or what systemic	changes	
	N/A (not applicable	e) under last review date and		you will make to ensure	that the	
	· ·	Gradual Dose Reduction). 1.		deficient practice does r	not recur?	
	describe residents p	sychiatric history and		Licensed Nursing Staff	f were	
	behaviors for medic	eation use: resident 56 has a		educated Physician orde	ers	
	history of crying ou	it, tearfulness, refusing care,		guidelines, with emphas	sis on	
	and self isolation. 2	. List Non-Pharmalogical		following implementation	n of side	
	interventions as car	e planned or attempted and		effect monitoring upon in		
	documented: talk w	rith family and friends, reassure		psychotropic medication		
	her and provide pos	sitive affirmation. 4. Have there		IDT/SSD to be educate		

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been any changes in the function or adverse

reactions to the medications since the last

psychotropic medication evaluation? No

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expectations

If continuation sheet

and GDR Process and

behavior management meeting

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/04/2022	
	PROVIDER OR SUPPLIER LIFF HEALTH & RE	HABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE I BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	documentation. 5. A needed. 6. Behavior Increased, Decreased documentation. Behavior and provide possible and self isolation. No documentation. No documentation assembled and provide manual provide possible date of last GDR (Company) describe residents provide possible documentation. S. A needed. 6. Behavior medicated. Summary of Psychosymmary of finding summary of finding provides and provid	AIMS Score, and Date- not Trends since last assessment: Ed, No changes- No navior meeting committee otropic Medication Use- gs: No documentation. 2. a. ecommendations to attending atrist. Recommend Gradual clude new dosage and mentation. b. Gradual dose amended: include reason as to cated: Circle on and write brief cumentation. Resident is not o documentation. Resident dessment: No documentation. dication Evaluation & form, dated 11/18/2021, 56's medication of Clonazepam a 6/20/2020 and documented as b) under last review date and diradual Dose Reduction). 1. sychiatric history and cation use: resident 56 has a at, tearfulness, refusing care, att, tearfulness, refusing care, b. List Non-Pharmalogical e planned or attempted and ith family and friends, reassure dications since the last ation evaluation? No alms Score, and Date- not at Trends since last assessment:	TAG	How the corrective action (s) be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place • SSD/ designee will complete Unnecessary Psychotropic autool to ensure that residents a receiving pain medication appropriately • Audit will be completed daily weekly x 4 weeks, bi-monthly months, monthly for 6 and the quarterly to encompass all shuntil continued compliance is maintained for 2 consecutive quarters. • The results of these audits who be reviewed by the CQI commoverseen by the ED. If threships is not achieved an action plan will be developed to ensuron compliance.	will r, the dit re x 5, for 2 en efts vill hittee old of

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 04/04/2022						
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	physician or psychic Dose Reduction: Indirections. No docureduction not recommy it is contrainding explanation. No docureduction in the contraint of the contra	atrist. Recommend Gradual clude new dosage and mentation. b. Gradual dose imended: include reason as to cated: Circle on and write brief cumentation. Resident is not o documentation. Resident is not o documentation. Resident is as 60 days. No documentation. If you have a compared to the consideration in the consideration is a consideration in the consideration in						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	e survey pleted 4/2022	
NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			5024 V	ADDRESS, CITY, STATE, ZIP COE VESTERN AVENUE H BEND, IN 46619)	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
IAU	and irritability and a A Physician Order, olanzapine 7.5 mg be disorder with delusi physiological condii On 4/1/2022 at 12:1 provided a form the Healthcare Manage Evaluation & Behavisix months, and ind contraindicated or a and she documents signed the following 1/20/2022, 2/17/202 the behavior meeting Reviewing the recorblank. On 4/4/2022 at 10:2 Director indicated to found anywhere elses should have had a gent attempted since the 9/13/2021. 4. A clinical record 3/31/22 at 1:40 P.M.	dated 9/14/2021, indicated by mouth daily for psychotic cons due to known tion. 5 P.M., the Social Worker by use titled, "Sterling ment Psychotropic Medication wior Meeting Form," for the last icated that they review if a GDR (gradual dose reduction) it on the form. The Physician grevaluations on 12/16/2021, 22 and 3/17/2022 agreeing with lags recommendations. In the Social Service the documentation cannot be and indicated the Resident gradual dose reduction drug was initiated on Treview was completed, on L., and indicated the Resident	IAG			DATE
	delusional disorders depressive disorders thrombosis of deep and dementia witho	aded, but were not limited to: s, retention of urine, major s, chronic embolism, and veins of right lower extremity, ut behavioral disturbances. d the resident was admitted on				
	Service indicated th	202 P.M., the Director of Clinical at an AIMS (Abnormal ment Scale) needs to be done				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/04/2022	
		155831	B. WIN			04/04	12022
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
				1	BEND, IN 10010		T
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	r	REFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1110		n any medication increase and		1110			DATE
	every six months.	,					
	During an interview	v on 3/31/2021 at 12:10 P.M.,					
		Director indicated that he did					
		on admission and should have					
	had one.						
	5 A clinical recor	d review was completed, on					
		I., and indicated the Resident					
		uded but were not limited to:					
	_	s, retention of urine, major					
		rs, chronic embolism, and					
	thrombosis of deep	veins of right lower extremity,					
	and dementia withou	out behavioral disturbances.					
	The record indicate 12/28/2021.	ed the resident was admitted on					
	A Physician Order	dated 1/8/2022, quetiapine					
	-	mg (milligram) give 1 tablet by					
	mouth two times a						
		w on 3/31/2022 at 12:11 P.M.,					
	_	Director indicated that					
		appropriate diagnosis for the					
	antipsychotropic fo	or resident 38.					
	On 4/1/2022 at 9.50	0 A.M., the Social Worker					
		o A.M., the Social worker a policy titled, Tapering					
	-	radual Drug Dose Reduction,"					
		olicy was the one currently					
	_	. The policy indicated "					
	Policy statement 1. After medications are ordered						
	for a resident, the s	taff and practioner shall seek					
	* *	and duration for each					
		o minimizes the risk of adverse					
	-	ll medications shall be					
	•	sible tapering. Tapering that is					
		sychotic medications shall be					
referred to as gradual dose reduction, 3. Residents		ı				I .	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155831	B. W	ING		2022	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE I BEND, IN 46619		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S I		PROVIDER'S PLAN OF CORRECTION	PLAN OF CORRECTION	
PREFIX					(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	dose reductions and	c drugs shall receive gradual behavioral interventions, ntraindicated, in an effort to rugs"					
	This Federal tag rela	ates to complaint IN00375599.					
	3.1-48(a)(6)(b)(1)(2)						
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its-						'
	§483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5 percent (%) for 2 of 7 residents observed during medication pass. Three (3) medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 12 %. The errors involved 2 residents (Resident 25 and 63) in a sample of 7. Findings include:		F 0759		What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice? • Resident 25 did not have a negative outcome related to the alleged deficient practice • Resident 67 did not have a negative outcome related to the alleged deficient practice	nts y the e	05/01/2022
	observed being adm (milligrams), hydral mg, atenolol 50 mg, (micrograms) by mo /salmeterol 100/50 m A review of Resider indicated levothyrous bedtime and after us	nt 25's Physician Orders xine was to be given at se of fluticasone/salmeterol to			How will you identify other residents having the potential be affected by the same deficipractice and what corrective awill be taken? All residents in the facility have the potential to be affected by alleged deficient practice Licensed Nursing Staff were educated on the 5 rights of medication with emphasis on	ent ction	
	rinse the mouth. Resident 25 did not rinse her mouth after use of the inhalant.				comparing medication being administered to MAR and rinsi	na	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831			A. BUILDING 00 B. WING			COMPLETED 04/04/2022	
		100001	D. W			04/04/	2022	
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD			
BRIARCI	IFF HEAI TH & RE	HABILITATION CENTER			VESTERN AVENUE HBEND, IN 46619			
	Т		-		T BEND, IN 40013		1	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
1110	REGUENTORT OF	CESCIDENTI TING IN GRAINTIGH	_	1710	mouth after inhaler use.		DITTE	
	2. On 4/1/2022 at 8	:02 A.M., Resident 63 was						
		ninistered vitamin C 500 mg,			What measures will be put int	0		
	memantine 5 mg, ferrous sulfate 325 mg, and				place or what systemic chang	es		
	acetaminophen 325	mg two tablets.			you will make to ensure that the			
		can be a second			deficient practice does not rec			
		nt 63's Physician Orders			Licensed Nursing Staff were			
		63 was also to receive			educated on the 5 rights of			
	administered.	capsule. These were not			medication with emphasis on comparing medication being			
	aummstereu.				administered to MAR and rins	ina		
	During an interview on 4/1/2022 at 8:43 A.M., LPN (Licensed Practical Nurse) 18 indicated the five right to medication pass (right person, medication,				mouth after inhaler use.	ıııg		
					How the corrective action (s)	vill		
	dose, route, and tim	ne) and indicated the			be monitored to ensure the			
	_	should be checked against the			deficient practice will not recu	۲,		
	•	Administration Record) for			i.e., what quality assurance			
	accuracy.				program will be put into place			
	0 4/4/2022 / 2 0/	DAY of DOME 11 of			DON/ designee will complete			
		P.M., the DON provide the lyerse Consequences and			medication pass observations	/		
		The policy indicated, "5. A			audits to ensure compliance.Audit will be completed daily	v 5		
		is defined as the preparation or			weekly x 4 weeks, bi-monthly			
		rugs or biological which is not			months, monthly for 6 and the			
	in accordance with				quarterly to encompass all shi			
		fications, or accepted			until continued compliance is			
	professional standar	rds and principles of the			maintained for 2 consecutive			
	professional(s) prov	viding services"			quarters.			
					The results of these audits w			
	3.1-48(c)(1)				be reviewed by the CQI comm			
					overseen by the ED. If thresho			
					95% is not achieved an action			
					plan will be developed to ensu compliance.	пС		
					Compilation.			
F 0761	483.45(g)(h)(1)(2)							
SS=D	Label/Store Drugs	and Biologicals	ı				I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155831	B. WI	NG		04/04/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DD14 D01					ESTERN AVENUE		
BRIARCLIFF HEALTH & REHABILITATION CENTER				SOUTH	I BEND, IN 46619		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROWIDER'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
Bldg. 00	§483.45(a) Labelir	ng of Drugs and Biologicals					
ŭ	ισ,	cals used in the facility					
		accordance with currently					
		onal principles, and include					
		cessory and cautionary					
		he expiration date when					
	applicable.	no expiration date mion					
	app						
	§483.45(h) Storag	e of Drugs and Biologicals					
	8/183 /15/h)/1) In a	ccordance with State and					
	. , , ,	facility must store all drugs					
		-					
	and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have						
	access to the keys						
	access to the keys	5.					
	8/18/3 /15/h)/(2) The	facility must provide					
	- ' ' ' '	permanently affixed					
		storage of controlled drugs					
	-	II of the Comprehensive					
		ention and Control Act of					
	_	ugs subject to abuse,					
		acility uses single unit					
	•	ribution systems in which					
		d is minimal and a missing					
	dose can be readi						
		on and interview, the facility	F 03	761	action(s) will be accomplished	for	05/01/2022
		ore gel-based medication and	1 0	01	those residents found to have	101	03/01/2022
		, store eye drops, oral			been affected by the deficient		
		inhalants separately, and have			practice?		
		information on suppositories			1 7	vo 0	
		n carts observed for			No Residents have had a harmonic population outcome related to the		
		(300/400 hall & 500/600 hall)			negative outcome related to the	i C	
	medication storage.	(500/400 Hall & 500/000 Hall)			alleged deficient practice	.	
	Findings include:				Diclofenac gel for resident 69 was bagged and placed in	7	
	r manigs include:				was bagged and placed in		
	1 On 4/1/2022 at 1	16 D.M. the medication cout for			appropriate treatment cart.		
		116 P.M., the medication cart for			Bisacodyl suppositories were removed and disposed of	;	
		s reviewed for proper			removed and disposed of		
	medication storage.	In a drawer of medication cart	1		• 500/600 med cart reorganize	a,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
		IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155831	B. W	ING		04/04/	2022
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8	5024 WESTERN AVENUE				
BRIARCL	IFF HEALTH & RE	HABILITATION CENTER			H BEND, IN 46619		
			1		· [(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	,	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU		Penac sodium gel for Resident 69	+	IAU	and inhalants separated		DATE
		mixed in with Resident 11's			How will you identify other		
		e medication cart had			residents having the potential	to	
		yl suppositories without			be affected by the same defici		
	-	or instruction for use.			practice and what corrective a		
	resident identifiers	or instruction for use.			will be taken?	Clion	
	During an interview	y, on 4/1/2022 at 1:26 P.M., LPN			All residents in the facility have	_	
	-	Nurse) 14 indicated the			the potential to be affected by		
	· ·	d oral medications should not			alleged deficient practice		
	_	or mixed with another			- Facility audited all Medication	n	
	-				carts to ensure that all	''	
	resident's medications and the suppositories should have patient identifiers on the label.				medications and treatments w	ere	
	should have patient identifiers on the laber.				labeled, dated and stored	010	
	2. On 4/1/2022 at 1	:31 P.M., the medication cart for			correctly.		
		s reviewed for proper			Concour,		
		Fluticasone nasal inhalant			What measures will be put into	0	
	_	l inhalants, albuterol oral			place or what systemic change		
	inhalant was mixed				you will make to ensure that the		
		7			deficient practice does not rec		
	During an interview	on 4/1/2022 at 1:44 P.M.,			Licensed Nursing Staff were		
	-	edication Aide) 20 indicated			educated on Medication Stora		
		l inhalants and eye drops			policy	J	
	should be stored sep	parately.			-		
					How the corrective action (s)	will	
	On 4/4/2022 at 2:00	P.M., the DON provide the			be monitored to ensure the		
	policy entitled, "Sto	orage of Medications". The			deficient practice will not recui	۲,	
	policy indicated, ".	2. Drugs and biologicals are			i.e., what quality assurance		
	stored in the packag	ging, containers or other			program will be put into place'	?	
		n which they are received. 10.			DON/ designee will complete	•	
		ns are stored separately from			medication storage audits to		
	•	nt the possibility of mixing			ensure compliance.		
	medications betwee	en residents.			Audit will be completed daily		
					weekly x 4 weeks, bi-monthly		
	3.1-25(j)				months, monthly for 6 and the		
					quarterly to encompass all shi	fts	
					until continued compliance is		
					maintained for 2 consecutive		
					quarters.		
					The results of these audits w		
					be reviewed by the CQI comm	nittee	

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

PRINTED: 05/11/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/04/2022	
NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFEREDED TO THE APPROPRIA TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
					overseen by the ED. If thresho 95% is not achieved an action plan will be developed to ensu compliance.		

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