STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155062	A. BUILDING 00 B. WING	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LAPORTE CARE CENTER	1700 I STREET LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00404690, IN00406061 and IN00408752. Complaint IN00404690 - No deficiencies related to the allegations are cited. Complaint IN00406061 - No deficiencies related to the allegations are cited. Complaint IN00408752 - Federal/State deficiencies related to the allegations are cited at F580, F600, F609, F610 and F842. Survey dates: May 24 and 25, 2023. Facility number: 000023 Provider number: 155062 AIM number: 100289400 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 6 Medicaid: 47 Other: 12 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/2/23.	F 0000	The facility requests paper compliance for these citations. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Bradford, RN, BSN	Director of Nursing Services	06/15/2023

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

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	(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)			

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	Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure residents' family and Physicians were notified following a resident to resident incident that required staff intervention for 2 of 3 residents reviewed for abuse. (Residents B and C) Finding includes: Resident B's record was reviewed on 5/24/23 at 10:28 a.m. Resident diagnosed included, but were not limited to, bipolar depression, unspecified dementia and Diabetes Mellitus. She resided in room 39-2. The Annual Minimum Data Set (MDS) assessment, dated 4/9/23, indicated the resident was cognitively intact and was able to transfer and bed mobility with supervision. A Mental Health Care Plan indicated the resident had health needs related to bipolar disorder that will adequately met by the facility. Interventions included to monitor signs of depression including verbalizing negative statements and repetitive anxious or health related complaints. Resident C's record was reviewed on 5/24/23 at 11:24 a.m. The resident was admitted to the facility on 5/4/23 to room 39-1. Diagnoses included, but were not limited to, urinary tract infection, sepsis and psychotic disorder with delusions.	F 0580	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Family and physician were notified per the Director of Nursing Services (DNS) on 5/26/2023. 2. The Director of Nursing completed a review of the medical records for all other residents with a noted change requiring family and/or legal representative and physician notification over the last 30 days to ensure appropriate notification occurred with no other deficient practices identified. 3. Licensed nursing staff will be re-educated per the DNS/Designee on the "Notification of Changes" policy by date of compliance. All Nurses' notes and physician orders will be reviewed daily per the DNS/designee to ensure that the physician and the	06/26/2023

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	The Admission MDS assessment, dated 5/10/23, indicated the resident was moderately cognitively impaired, and required extensive assist of one staff for transfers and bed mobility. General notes, dated 5/6, 5/7 and 5/8/23, indicated the resident was exhibiting behaviors of confusion, wandering, yelling out at night, throwing television off dresser and scratching staff. A confidential interview with Employee 1, on 5/24/23, indicated on 5/5/23 around 8:00 p.m., she entered the residents' room and observed Resident B standing over Resident C, there was an electric cord around her neck and Resident B was holding the ends of the cord. The residents were separated. Employee 1 notified the nurse on duty, LPN 1 of what had happened. Interview with LPN 1, on 5/25/23 at 9:47 a.m., indicated she had been notified by Employee 1 and CNA 1 of what had been witnessed. She assessed Resident C for injuries and called the Director of Nursing (DON) to report the event. The LPN indicated she did not notify family members or Physicians at that time, she thought the DON was going to take care of it. Resident B was moved into a different room that night. Interview with the Social Service Director (SSD), on 5/24/23 at 3:22 p.m., indicated she had notified Resident B's family of the room change. Resident C did not get a new roommate so family had not been notified. The SSD indicated she had not been aware of the incident on 5/5/23 until 5/24/23. The residents' records lacked documentation of the event or that family or Physicians had been		family/legal guardian have been notified of any changes that require notification and that the notification is documented in the medical record. These reviews will be on-going. All identified changes will also be discussed in the morning "Clinical Start-up" 5x/week to ensure that the family/legal guardian have been notified and that the notification is documented. 4. If any deficient practices are identified the Director of Clinical Education or designee will provide additional training for the identified licensed nurse. 5. The DNS will present the findings of the reviews every month to the Quality Assessment Process Improvement Committee (QAPI). The QAPI committee to review for any trends or patterns of deficient practices (3 deficient practices in 1 month will be considered as a trend/pattern) and make further recommendations as necessary.	

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	notified. This Federal tag relates to Complaint IN00408752. 3.1-5(a)(1)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect a resident's (Resident C) right to be free from physical abuse by another resident (Resident B) for 1 of 3 residents reviewed for abuse. Finding includes: A confidential interview with Employee 1 on 5/24/23, indicated on 5/5/23 around 8:00 p.m., Employee 1 entered the residents' room and observed Resident B standing over Resident C. There was an electric cord around her neck and Resident B was holding the ends of the cord. The residents were separated. Employee 1 notified the	F 0600	p="" xml:="" paraid="628400245" paraeid="{1e1bf4c6-3ef2-4d67-be3e-b7bb084affb9}{186}">Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. p="" xml:="" paraid="628400245" paraeid="{1e1bf4c6-3ef2-4d67-be3e-b7bb084affb9}{186}">	06/26/2023

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	nurse on duty, LPN 1 of what had happened. Interview with CNA 1, on 5/25/23 at 11:18 a.m., indicated on the evening of 5/5/23, she had been assisting a resident across the hall when she heard Resident C calling for help. On entering the room, she saw Resident B standing over Resident C and Resident C had an electrical cord around her neck. Interview with LPN 1 on 5/25/23 at 9:47 a.m., indicated she had been notified by Employee 1 and CNA 1 of what had been witnessed. She assessed Resident C for injuries and called the Director of Nursing (DON) to report the event. Resident B was moved into a different room that night. Interview with the Administrator on 5/24/23 at 3:25 p.m., indicated he had been made aware of the incident two or three days later when a staff member approached him and asked about it. He did not recall who the staff member was. He indicated the DON had been involved with the incident. He also indicated Resident C had been loud and confused since admission. Interview with the DON on 5/24/23 at 3:15 p.m., indicated when LPN 1 notified her of the event on 5/5/23, she was told Resident B was very agitated and afraid the electrical cord was going to end up around her roommate's neck. Resident B was moved to a different room. There was no documentation and no report made to IDOH. Interview with Social Services on 5/24/23 at 3:22 p.m., indicated when she came to work the following Monday, 5/8/23, she was told by the Administrator they were concerned with Resident C's behaviors agitating Resident B, and had		p="" xml:="" paraid="628400245" paraeid="{1e1bf4c6-3ef2-4d67-be3e-b7bb084affb9}{186}"> p="" xml:="" paraid="628400245" paraeid="{1e1bf4c6-3ef2-4d67-be3e-b7bb084affb9}{186}"> p="" xml:="" paraid="628400245" paraeid="{1e1bf4c6-3ef2-4d67-be3e-b7bb084affb9}{186}">1. Resident C no longer resides in the facility. Resident C's physician and husband were notified of the event that occurred on 5/5/2023. It was determined per investigation that resident B was trying to assist Resident C to untangle herself from the call-light cord and was not attempting to injure Resident C injuries occurred to either resident in the event. Resident C had no recollection of the event per interviews. 2. All residents have the potential to be affected. DNS completed a review of the last 30 days of behaviors within the facility with no deficient practices noted. 3. All staff will be re-educated on the "Abuse, Neglect and Exploitation" policy per the Director of Clinical Education (DCE) or designee prior to the date of compliance. 4. All behaviors, events, and/or change of condition will be reviewed by the Interdisciplinary Team in the clinical morning meeting 5 times/week to ensure that	

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	moved Resident B to another room as a proactive measure. a. Resident C's record was reviewed on 5/24/23 at 11:24 a.m. The resident was admitted to the facility on 5/4/23 into the same room as Resident B. Diagnoses included, but were not limited to, urinary tract infection, sepsis and psychotic disorder with delusions. The Admission MDS assessment, dated 5/10/23, indicated the resident was moderately cognitively impaired, and required extensive assist of one staff for transfers and bed mobility. General notes, dated 5/6, 5/7 and 5/8/23, indicated the resident was exhibiting behaviors of confusion, wandering, yelling out at night, throwing television off dresser and scratching staff. There was no documentation related to the observed incident involving her roommate on 5/5/23. b. Resident B's record was reviewed on 5/24/23 at 10:28 a.m. Diagnoses included, but were not limited to, bipolar depression, unspecified dementia and Diabetes Mellitus. The Annual Minimum Data Set (MDS) assessment, dated 4/9/23, indicated the resident was cognitively intact and was able to transfer and move in bed with supervision. A Mental Health Care Plan indicated the resident had health needs related to bipolar disorder that will adequately met by the facility. Interventions included to monitor signs of depression including verbalizing negative statements and repetitive		appropriate interventions are in place related to the identified behavior/events/or change of condition. DNS/designee will interview/assess 5 residents per week for 4 weeks to determine whether or not an alleged violation has occurred, then 3 residents per week for 2 months then 1 resident weekly for 3 months. The DNS/Designee will also interview 3 staff members per week for 8 weeks then 1 staff member weekly for 4 months to ensure compliance and accurate reporting of behaviors/events/or changes in condition to ensure no alleged violations have occurred. Audits/observations/interviews will be conducted randomly, across all 3 shifts, and will include weekends. Any deficient practices will be addressed immediately, and re-education will be completed immediately. 5. The results of these audits will be reviewed monthly in the Quality Assurance Process Improvement (QAPI) meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QAPI committee will review for any trends or patterns of deficient practices (3 deficient practices in 1 month will be considered as a trend/pattern) and make further recommendations as necessary.	

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	anxious or health related complaints. A Social Services General Note, dated 5/4/23, indicated the resident had not had any behaviors, delusions or hallucinations in the look back period. A General Note, dated 5/5/23, indicate the resident was being moved to a different room due to high irritation/anxiety with roommate. The current policy, "Abuse, Neglect and Exploitation", indicated, "..."Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations...." This Federal tag relates to Complaint IN00408752. 3.1-27(a)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not			

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	result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure a resident to resident incident involving abuse was reported to the Indiana Department of Health (IDOH) as required for 2 of 3 residents reviewed for abuse. (Residents B and C) Finding includes: Resident B's record was reviewed on 5/24/23 at 10:28 a.m. Resident diagnosed included, but were not limited to, bipolar depression, unspecified dementia and Diabetes Mellitus. She resided in room 39-2. The Annual Minimum Data Set (MDS) assessment, dated 4/9/23, indicated the resident was cognitively intact and was able to transfer and bed mobility with supervision. A Mental Health Care Plan indicated the resident had health needs related to bipolar disorder that will adequately met by the facility. Interventions included to monitor signs of depression including verbalizing negative statements and repetitive	F 0609	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. The 5/5/23 Event involving residents B and C was reported to the Indiana Department of Health on 5/31/2023. 2. All residents have the potential to be affected by the alleged deficient practice. Prior to the date of compliance, the Executive Director (ED) reviewed all abuse allegations in the past . No other residents were found to be affected by the deficient practice. 3. On 6/6/23 the Regional Director	06/26/2023

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	anxious or health related complaints. Resident C's record was reviewed on 5/24/23 at 11:24 a.m. The resident was admitted to the facility on 5/4/23. Diagnoses included, but were not limited to, urinary tract infection, sepsis and psychotic disorder with delusions. The Admission MDS assessment, dated 5/10/23, indicated the resident was moderately cognitively impaired, and required extensive assist of one staff for transfers and bed mobility. General notes, dated 5/6, 5/7 and 5/8/23, indicated the resident was exhibiting behaviors of confusion, wandering, yelling out at night, throwing television off dresser and scratching staff. A confidential interview with Employee 1, on 5/24/23, indicated on 5/5/23 around 8:00 p.m. She entered the residents room and observed Resident B standing over Resident C, there was an electric cord around her neck and Resident B was holding the ends of the cord. The residents were separated. Employee 1 notified the nurse on duty, LPN 1 of what had happened. Interview with CNA 1, on 5/25/23 at 11:18 a.m., indicated on the evening of 5/5/23, she had been assisting a resident across the hall when she heard Resident C calling for help. On entering the room, she saw Resident B standing over Resident C, Resident C had an electrical cord around her neck. Interview with LPN 1 on 5/25/23 at 9:47 a.m., indicated she had been notified by Employee 1 and CNA 1 of what had been witnessed. She assessed Resident C for injuries and called the		of Clinical Operations (RDCO) re-educated the ED and the Director of Nursing Services (DNS) regarding the "Abuse/Neglect/Exploitation" policy guidelines, The Long-Term Care Abuse and Incident Reporting Policy" and the "Allegation of Abuse or Neglect Checklist." All staff will also to be re-educated per the DNS/designee regarding the Abuse/Neglect/Exploitation policy guidelines. Specifically, this education will focus on the facility's responsibility to ensure alleged violations involving potential abuse are immediately reported to the Executive Director and respective State Agency as indicated. This training will be completed prior to the date of compliance. 4. The DNS/designee to randomly interview 3 staff members per week x 8 weeks, then 1 staff member weekly for 4 months regarding signs/symptoms of abuse and abuse reporting guidelines. Any education deficiencies noted will be corrected immediately. DNS/designee to randomly interview 5 residents per week for 4 weeks then 3 residents per week for 2 months then 1 resident weekly for 3 months to determine if a violation was reported or suspected and to determine if the violation was reported to the	

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	Director of Nursing (DON) to report the event. Resident B was moved into a different room that night. Interview with the Administrator on 5/24/23 at 3:25 p.m., indicated he had been made aware of the incident two or three days later when a staff member approached him and asked about it. He did not recall who the staff member was. He indicated the DON had been involved with the incident. The incident had not been reported to IDOH. Interview with the DON on 5/24/23 at 3:15 p.m., indicated when LPN 1 notified her of the event on 5/5/23, she was told Resident B was very agitated and afraid the electrical cord was going to end up around her roommate's neck. Resident B was moved to a different room. There was no report made to IDOH. The current policy, "Abuse, Neglect and Exploitation", indicated, "...VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies...within specified time frames...." This Federal tag relates to Complaint IN00408752. 3.1-28(c)		appropriate agencies within a timely manner. Any deficiencies identified will be reported to the Indiana Department of Health immediately. 5. The DNS will present the findings of the reviews every month to the Quality Assessment Process Improvement Committee (QAPI). The QAPI committee to review for any trends or patterns of deficient practices (3 deficient practices in 1 month will be considered as a trend/pattern) and make further recommendations as necessary.	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged			

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	155062	A. BUILDING 00 B. WING	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LAPORTE CARE CENTER	1700 I STREET LA PORTE, IN 46350

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	violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure a resident to resident incident involving abuse was thoroughly investigated for 2 of 3 residents reviewed for abuse. (Residents B and C) Finding includes: Resident B's record was reviewed on 5/24/23 at 10:28 a.m. Resident diagnosed included, but were not limited to, bipolar depression, unspecified dementia and Diabetes Mellitus. The Annual Minimum Data Set (MDS) assessment, dated 4/9/23, indicated the resident was cognitively intact and was able to transfer and move in bed with supervision. A Mental Health Care Plan indicated the resident had health needs related to bipolar disorder that will adequately met by the facility. Interventions included to monitor signs of depression including verbalizing negative statements and repetitive anxious or health related complaints. Resident C's record was reviewed on 5/24/23 at	F 0610	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Resident B no longer resides in the facility. Resident C was assessed at the time of the event per the licensed nurse, and no psychosocial distress or adverse effects were noted related to the occurrence. 2. All residents have the potential to be affected by the alleged deficient practice. Prior to the date of compliance, the Executive Director (ED) reviewed all abuse allegations in the past . No other residents were found to be	06/26/2023

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	11:24 a.m. The resident was admitted to the facility on 5/4/23 to room 39-1. Diagnoses included, but were not limited to, urinary tract infection, sepsis and psychotic disorder with delusions. The Admission MDS assessment, dated 5/10/23, indicated the resident was moderately cognitively impaired, and required extensive assist of one staff for transfers and bed mobility. General notes, dated 5/6, 5/7 and 5/8/23, indicated the resident was exhibiting behaviors of confusion, wandering, yelling out at night, throwing television off dresser and scratching staff. A confidential interview with Employee 1, on 5/24/23, indicated on 5/5/23 around 8:00 p.m. She entered the residents' room and observed Resident B standing over Resident C, there was an electric cord around her neck and Resident B was holding the ends of the cord. The residents were separated. Employee 1 notified the nurse on duty, LPN 1 of what had happened. She indicated she was instructed not to document anything about the incident. Interview with CNA 1 on 5/25/23 at 11:18 a.m., indicated on the evening of 5/5/23, she had been assisting a resident across the hall when she heard Resident C calling for help. On entering the room, she saw Resident B standing over Resident C, Resident C had an electrical cord around her neck. Interview with LPN 1 on 5/25/23 at 9:47 a.m., indicated she had been notified by Employee 1 and CNA 1 of what had been witnessed. She assessed Resident C for injuries, and called the Director of Nursing (DON) to report the event.		affected by the deficient practice. 3. On 6/6/23 the Regional Director of Clinical Operations (RDCO) re-educated the ED and the Director of Nursing Services (DNS) regarding the “Abuse/Neglect/Exploitation” policy guidelines, The Long-Term Care Abuse and Incident Reporting Policy" and the “Allegation of Abuse or Neglect Checklist.” Education focused on the facility’s responsibility to ensure that in response to allegations of abuse, that the alleged violations are thoroughly investigated and reviewed to prevent further potential events. 4. DNS/designee to randomly interview 5 residents per week for 4 weeks then 3 residents per week for 2 months then 1 resident weekly for 3 months to determine if a violation was reported or suspected and to determine if the reported violation was thoroughly investigated. Any deficiencies identified will be corrected immediately. The ED/designee will audit all allegations of abuse to ensure the allegations are thoroughly investigated and resident/staff interviews are conducted per the Abuse/Neglect/Exploitation” policy utilizing the "Allegation of Abuse or Neglect Checklist.” The Audits will be completed per the	

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	She indicated she was told it was not necessary to document anything about the incident. Resident B was moved into a different room that night. Interview with the Administrator, on 5/24/23 at 3:25 p.m., indicated he had been made aware of the incident two or three days later when a staff member approached him and asked about it. He did not recall who the staff member was. He indicated the DON had been involved with the incident. Interview with the DON on 5/24/23 at 3:15 p.m., indicated when LPN notified her of the event on 5/5/23, she was told Resident B was very agitated and afraid the electrical cord was going to end up around her roommate's neck. Resident B was moved to a different room. There was no documented investigation of the event. The current policy, "Abuse, Neglect and Exploitation", indicated, "...V. Investigations of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur...6. Provide complete and thorough documentation of the investigation...." This Federal tag relates to Complaint IN00408752. 3.1-28(d)		ED/designee for all events/allegations of abuse and will be reviewed per the RDCO and will be on-going. 5. The ED will provide the results of these audits to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in			

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	accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.			

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	§483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure a medical record was complete and accurate related to lack of documentation of observations of alleged abuse for 2 of 3 residents reviewed for medical records. (Residents B and C) Finding includes: A confidential interview with Employee 1, on 5/24/23, indicated on 5/5/23 around 8:00 p.m., Employee 1 entered the residents' room and observed Resident B standing over Resident C. There was an electric cord around her neck and Resident B was holding the ends of the cord. The residents were separated. Employee 1 notified the nurse on duty, LPN 1, of what had happened.	F 0842	p="" paraid="327240368" paraeid="{e1c27b52-157a-4f04-a2bd-1314583ef8b8}{149}">Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. p="" paraid="327240368" paraeid="{e1c27b52-157a-4f04-a2bd-1314583ef8b8}{149}">	06/26/2023

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	Interview with CNA 1 on 5/25/23 at 11:18 a.m., indicated on the evening of 5/5/23, she had been assisting a resident across the hall when she heard Resident C calling for help. On entering the room, she saw Resident B standing over Resident C, Resident C had an electrical cord around her neck. Cross reference F600 & F610. Resident B's record was reviewed on 5/24/23 at 10:28 a.m. Resident diagnosed included, but were not limited to, bipolar depression, unspecified dementia and Diabetes Mellitus. She resided in room 39-2. There was no documentation of the the incident observed by staff on 5/5/23. Resident C's record was reviewed on 5/24/23 at 11:24 a.m. The resident was admitted to the facility on 5/4/23. Diagnoses included, but were not limited to, urinary tract infection, sepsis and psychotic disorder with delusions. There was no documentation of the incident observed by staff on 5/5/23. During a phone interview with LPN 1 on 5/25/23 at 9:47 a.m., she indicated she reported the incident to the Director of Nursing (DON) and was told there was no need to document anything. Interview with the DON, on 5/24/23 at 3:15 p.m., indicated that was not what had been reported to her on 5/5/23. She indicated they did not document anything. This Federal tag relates to Complaint IN00408752.		p="" paraid="327240368" paraeid="{e1c27b52-157a-4f04-a2bd-1314583ef8b8}{149}">1. A late entry note was added to the medical record for resident B and C to document the event that occurred on 5/5/2023. p="" paraid="327240368" paraeid="{e1c27b52-157a-4f04-a2bd-1314583ef8b8}{149}"> 2. All other residents had the potential to be affected by the deficient practice. 3. Licensed nursing staff to be re-educated per the Director of Nursing Services (DNS)/designee on the "Documentation in Medical Records" policy prior to date of compliance. 4. All behaviors, events, and/or changes of condition will be reviewed by the Interdisciplinary Team in the clinical morning meeting 5 times a week to ensure that an appropriate representation of the actual behavior, event, and/or change in condition is documented in the medical record. The DNS/Designee will interview 3 random staff members 2 times a week for 4 weeks and then 3 staff members a week for 4 weeks and then 1 staff member a week for 4 months to ensure compliance and accurate reporting and documentation of behaviors, events, and/or changes in condition. The audits/observations will be conducted randomly,	

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	3.1-50(a)(1)		across all 3 shifts, and will include weekends. If any deficient practices are identified, re-education will be completed immediately. 5. The DNS will present the findings of the reviews every month to the Quality Assessment Process Improvement Committee (QAPI). The QAPI committee to review for any trends or patterns of deficient practices (3 deficient practices in 1 month will be considered as a trend/pattern) and make further recommendations as necessary.	