STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00409741. Complaint IN00409741 - No deficiencies related to the allegations were cited. Survey dates: September 19, 20, 21, 22, 25 & 26, 2023 Facility number: 000045 Provider number: 155109 AIM number: 1002914000 Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 0 Medicaid: 42 Other: 16 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 10/4/23.	F 0000	**Brickyard 12th St Care Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** We at 12th Street Care Center respectfully request paper compliance.	
F 0655 SS=B Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed			

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

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	to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on interview and record review, the facility	F 0655	**F655 Baseline Care Plan**	10/26/2023

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	failed to provide the base line care plan to the resident and resident representative within 48 hours of admission for 2 out of 2 residents reviewed for base line care plans. (Resident 3 & 35) Findings include: 1. A record review was completed on 9/21/2023 at 10:04 A.M. Diagnoses included, but not limited to: end stage heart failure, type 2 diabetes, and peripheral vascular disease. Resident 35 was admitted on 7/21/2023. During a resident interview, on 9/19/2023 at 11:01 A.M., Resident 35 indicated he has had no type of meeting about his plan of care with the Social Worker or nursing. During an interview, on 9/21/2023 at 11:55 A.M., the Area Vice President indicated that they prefer under the assessment tab to initiate the Baseline Care Plan. Documentation of a baseline care plan could not be located under the assessment tab, or in the progress notes. The MDS Nurse initiated on 7/21/2023 care plans under the care plan tab and she should have reviewed them with the resident and family within 72 hours 2. A record review was completed on 9/21/2023 at 10:45 A.M. Diagnoses are included, but not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and chronic obstructive pulmonary disease. Resident 3 admitted on 6/16/2023. During an interview, on 9/20/2023 at 10:22 A.M., Resident 3 indicated that he did not have a baseline care plan or any care plan conferences since he has been here.		It is the practice of the facility to complete baseline care plans for all residents admitted to the facility in order to provide effective, person-centered care of the residents that meet professional standards of quality care. 1 Comprehensive care plans are in place for residents # 3 and # 35 and have been reviewed with both residents. 2 All residents admitted to the facility within past 30 days reviewed to ensure baseline care plans were provided to the resident and resident representative. A care plan was provided to the resident and resident representative for any resident found to have been affected by the deficient practice. 3 The facilities baseline care plan guidelines and procedures were reviewed. The DNS/Designee will in-service the IDT and licensed nursing staff regarding the baseline care plan guidelines and procedures to ensure policy and procedures are followed. 4 DNS/Designee to review in clinical start-up the admission audit, which will include provisions to include the base line care plan completion. These audits will be conducted 5 times weekly x 2 months, then 3 times weekly x 2 months, then weekly x 2 months. Results of the audits will be	

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	During an interview, on 9/21/2023 at 2:38 P.M., the Area Vice President indicated that Resident 3's baseline care plan was done on 6/20/2023, 96 hours instead of 72 hours. They do have weekend managers on duty and they can do the baseline care plan on the weekend. On 9/21/2023 at 3:13 P.M., the Regional Nurse 7 provided a policy titled, "Baseline Care Plan", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. 3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. 4. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. 5. A supervising nurse or MDS nurse/designee is responsible for providing a written summary of the baseline care plan to the resident and representative. 6. The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided. b. Make a copy of the summary for the medical record...."		reviewed at QAPI for a minimum of 6 months to track for any deficient practices. If any deficient practices are identified, then audits will be continued based on QAPI recommendations. If no deficiencies are identified, then QAPI will review on a prn basis.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.			

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	(B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on observation, interview, and record review, the facility failed to review the care plan, and include a fall intervention to the care plan for 1 of 20 resident reviewed for care plans. (Resident 29) Finding includes: A record review was completed for Resident 29 on 9/20/2023 at 1:00 P.M. Diagnoses included, but were not limited to: cerebrovascular disease, anxiety disorder and major depression. A Progress Note, dated 8/15/2023 at 8:01 A.M., indicated that Resident 29 was found lying on her back in front of unlocked wheelchair in her room. Her right shoulder was asymmetrical compare to the left shoulder. An x-ray of right shoulder was completed and an intervention to remove bed chuck from the wheelchair seat.	F 0657	**F657 Care Plan Timing and Revision** It is the practice of the facility to develop and implement care plans, as well as to revise or update as necessary to guide in the provision of necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident. 1 Resident #29 no longer resides at facility. 2 All residents who have had a fall in the past 30 days were reviewed to ensure the care plan was reviewed and updated with a fall intervention post fall. Individual care plans were revised and	10/26/2023

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	A Post Fall Evaluation, dated 8/24/2023 at 5:37 P.M., indicated unwitnessed fall in the resident's room, she was getting up alone. An Interdisciplinary Team (IDT) Progress Note, dated 8/25/2023 at 1:00 P.M. indicated the intervention was for staff to increase observation and offer assist with mobility as able. A Progress Note, dated 9/8/2023 at 6:46 P.M., indicated an unwitnessed fall near the foot of bed. She received a skin tear to the right outer elbow 6 x 6 centimeters and a bruise to the nose and slit to bottom lip. A Progress Note, dated 9/9/2023 at 10:51 P.M., indicated unwitnessed fall in resident room found on the floor. During an interview, on 9/25/2023 at 2:38 P. M., the Director of Nursing (DON) indicated when a resident falls the nurse does a set of vitals, neuro checks if unwitnessed fall, head to toe assessment, put an immediate intervention in place, and each shift they follow up for 72 hours in the progress notes. A risk assessment and post fall assessment is done and (IDT) meets as a group and updates the plan of care. During an interview, on 9/25/2023 at 3:57 P. M., the DON indicated that the fall care plan was not updated for the fall on 8/15/2023, 8/24/2023, 9/8/2023 and 9/9/2023. The intervention on 8/15/2023 was to remove the chuck from the wheelchair, 8/24/2023 increase visual observation, 9/8/2023 no intervention, 9/9/2023 every hour checks were put into place. A Care Plan, initiated 3/28/2023, indicated "...At		updated as necessary. 3 The facilities care plan guidelines and procedures were reviewed. The DNS/Designee will in-service the IDT and licensed nursing staff regarding the care plan timing and revision process as it relates to a resident fall to ensure the policy and procedures are followed. 4 DNS/Designee to review in clinical start up any resident identified to have had a fall the previous day and as such will review, and revise, or update the care plans as necessary to reflect that a fall intervention was updated on the care plan. These audits will be conducted 5 times weekly x 2 months, then 3 x weekly x 2 months, then weekly x 2 months. Residents care plans will be reviewed at least quarterly following the MDS schedule during care plan meetings by the interdisciplinary, to ensure that care plans are accurate reflecting resident's current level of care and will encompass all necessary identified interventions to provide provision of necessary care and services to attain or maintain, the highest practicable physical, mental, and psychological well-being of the resident. Results of the audits will be reviewed at QAPI for a minimum of 6 months to track for observed deficient practice. If any deficient practices are identified, then audits will	

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	risk for falls related to: New environment, Use of medication, non ambulatory, hx of fall. Interventions: assist resident to sit near lobby, as she enjoys when observed in w/c attempting to take self to lobby, bed in low position, environmental review, floor mat at bedside, footwear to prevent sliding, keep environment well lit and free of clutter, observe for side effects of Medications...." A Care Plan, initiated 8/24/2023, indicated "... Risk for Falls. Interventions assist Resident with ambulation and transfers, utilizing therapy recommendations, evaluate fall risk on admission and PRN, I fall occurs, alert provider, If Resident is a fall risk, initiate fall risk precautions...." A current policy provided, on 9/25/2023 at 11:10 A.M., by the Vice President of Regulatory Compliance, titled, "Care Planning - Resident Participation" included, but was not limited to: " ...The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals and after significant changes ...." " ...The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan ...." On 9/26/2023 at 8:58 A.M., the Regional Nurse 7, provided a policy titled, "Care Plan Revisions Upon Status Change," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change...." 3.1-35(d)(2)(B)		continue based on the recommendations of the QAPI, IDT team. If no deficient practices are identified, then QAPI will review on a prn basis.	

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to ensure nail care and shaving was provided for 2 of 7 residents reviewed for Activities of Daily Living (ADL) needs. (Resident 3 & 50) Findings include: 1. A record review was completed for Resident 3 on 9/21/2023 at 10:45 A.M. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and chronic obstructive pulmonary disease. A Quarterly Minimum Data Set (MDS) assessment, dated 7/7/2023, indicated extensive assist of one staff for personnel hygiene and total dependent for bathing. During an observation, on 9/20/2023 at 10:24 A.M., Resident 3 was in bed his right hand fingernails had a brown substance under the nails. During an observation, on 9/21/2023 at 9:47 A.M., Resident 3 was in bed his right hand fingernails had a brown substance under the nails. During an observation, on 9/25/2023 at 1:19 P.M., resident was in bed his right hand fingernails had a brown substance under them. A Care Plan, dated 6/19/2023, indicated "...I have	F 0677	**F677 ADL Care Provided for Dependent Residents** It is the practice of the facility to provide ADL care for dependent residents, who are unable to carry out activities of daily living, and residents will receive the necessary services to maintain good nutrition, grooming and personal, as well as oral hygiene care. 1 Resident #3 received nail care. Resident # 50 received nail care and grooming. 2 All residents have the potential to be affected by the alleged deficient practice. All other residents were observed to ensure their nails were clean and they were shaven if so desired. A review of resident's preferences regarding ADL care was also conducted for current residents. No other residents were identified as being affected. 3 The facilities process and procedure for providing ADL care as appropriate and as preferred by the residents was reviewed. The DNS/Designee in-serviced the IDT as well as all direct care staff to include licensed nurses and	10/26/2023

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	an ADL self care deficit related to Dx of Hemiplegia affecting left non dominant side. Hx of CVA. I have at times disassembled my call light and placed it on the floor. Interventions: bathing assistance of extensive to complete dependence. Personal Hygiene: Extensive assist of one...." 2. A record review was completed for Resident 50 on 9/21/2023 at 1:34 P.M. Diagnoses included, but were not limited to: dementia, unspecified severity, with psychotic disturbance, type 2 diabetes and schizoaffective disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 8/21/2023, indicated personal hygiene extensive assist of one and bathing total dependent of one staff. A Care Plan, dated 2/22/2023 and revised on 8/21/2023, indicated, "...I have a physical functioning deficit related to: Mobility impairment, Self care impairment. Interventions: assist with self care, Personal Hygiene assistance of set up to one...." During an observation and resident interview, on 9/19/2023 at 11:40 A.M., Resident 50 indicated that he preferred to be shaved and would like his fingernails trimmed. He was unshaved and his nails were long with a brown substance under the nails. During an observation, on 9/21/2023 at 9:52 A.M., Resident 50 was unshaved and his fingernails were long with a brown substance under the nails. During an observation and interview, on 9/25/2023 at 9:06 A.M., Resident 50 indicated that he would like to be shaved but no one helps him. He was		certified nurse assistants regarding providing ADL care to include nail care and shaving. 4 The UM/Designee will observe residents to ensure their nails are clean and they are shaven as appropriate. These observations to be random to include all units and will be conducted as follows: 3 residents/day x 5 times weekly x 2 months, 3 residents/day x 3 times weekly x 2 months, then 3 residents weekly x 2 months. The results of these audits will be discussed in QAPI and if there is deficient practice noted, further recommendations will be made per the QAPI IDT. If no deficient practice noted, QAPI IDT will review on a prn basis.	

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	unshaved and his fingernails were long with brown substance under them. During an interview, on 9/22/2023 at 10:54 A.M., CNA 1 indicated that when she gave a shower she washed the resident's hair, performed peri care, shaved if needed and cleaned fingernails. For A.M. care she assisted with the washing of the face and peri care, and offerred a shave and combed hair. During an interview, on 9/22/2023 at 11:04 A.M., CNA 3 indicated she provided privacy during a shower she performs nail care, trims beard or shaves, oral care, and peri care. For A.M. care she performs a partial bath and assists with dressing. During an interview, on 9/25/2023 at 9:01 A. M., the Director of Nursing indicated during A.M. care she would expect her staff to wash residents up at the sink if that is what they prefer, brush teeth/dentures and get them dressed. For shower she would expect them to get clothing and what they needed for the shower and change the bed linen. On 9/25/2023 at 9:13 A.M., the Vice President of Regulatory Compliance provided a policy titled, "Activities of Daily Living (ADLs)", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Care and services will be provided for the following activities of daily living: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. 1. Bathing, dressing, grooming and oral care...." 3.1-38(3)(E)			

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F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview and record review, the facility failed to follow a Physician's order to obtain an evaluation and treatment for psychiatric servies for 1 of 20 residents reviewed. (Resident 19) Finding includes: 1. A record review was completed on 9/20/2023 at 2:31 P.M. Resident 19's diagnoses included, but were not limited to: toxic encephalopathy, bipolar disorder, opioid abuse, and history of traumatic brain injury. Current Physician Orders, dated 6/23/2023 to 9/20/2023, indicated Resident 19 was to have had an evaluation and treatment provided by psychiatric services. The clinical record lacked any documentation to show that the evaluation/treatment had been completed. A current care plan, dated 6/26/2023, indicated that Resident 19 had mental health needs that would be resident to express mental health needs,	F 0740	**F740 Behavioral Health Services** It is the practice of the facility for residents to receive behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, to encompass a residents emotional and mental well-being. 1 Resident #19, referral made to psych services and resident was seen on 10/5/23. 2 All residents have the potential to be affected by the alleged deficient practice. A review of residents with an order for psych services was completed to ensure that all residents with psych services orders who have agreed to the services have been seen by psych services provider. No other residents were identified as being affected. 3 The facilities process for obtaining orders with subsequent	10/26/2023

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	articulation of mental health needs and skilled staff members providing opportunities to identify mental health needs. During an interview, on 9/22/2023 at 2:55 P.M., the Area Vice President and the Social Services Director both indicated the Resident 19 was not seen by psychiatric services, and that the referral to Psychiatric Services had not been made prior to 9/22/2023. Resident 19 was not included on the list for the behavior meeting that was held on 8/24/2023. On 9/25/2023 at 1:55 P.M., the Vice President of Regulatory Compliance provided a policy titled "Provision of Physician Services", with no date or revision date found on the policy. She indicated this was the current policy used by the facility. The policy indicated ..."The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality ...Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology consultations) to the appropriate entity ...Documentation of consultations, diagnostic tests, the results, date/time of Physician notification will be maintained in the resident's clinical record ...." 3.1-37 3.1-43		referral to psych services was reviewed. The DNS/Designee will in-service the IDT as well as all licensed care staff to ensure that the facilities process, and guidelines are being followed with regards to orders and implementation of psych services. 4 The DNS/Designee will review in clinical start-up all new orders to ensure that anyone with an order for a psych eval and treat and who has agreed to be seen by psych services has been evaluated by the provider. These audits to be completed 5x weekly x 2months, then 3 x weekly x 2 months, then weekly x 2 months. The results of these audits will be discussed in QAPI and if there is deficient practice noted, further recommendations will be made per the QAPI IDT. If no deficient practice noted, QAPI IDT will review on a prn basis.	
F 0807 SS=D Bldg. 00	483.60(d)(6) Drinks Avail to Meet Needs/Prefs/Hydration §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and			

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	other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, record review and interview, the facility failed to ensure thickened liquids were at the bedside as ordered for 2 of 2 residents reviewed. (Resident 18 and 29) Findings include: 1. A record review was completed for Resident 18 on 9/20/2023 at 1:30 P.M. Diagnoses included, but not limited to: hemiplegia and hemiparesis cerebrovascular disease, dementia without behavioral disturbances, major depressive disorder, Parkinson's, and dysphagia. A Physician Order, dated 7/26/2023, indicated regular diet, mechanical soft, thickened liquid nectar, mildly thick consistency. A Care Plan, dated 6/27/2023, indicated, "...I have a Diet alteration related to: Dysphagia. I require mechanical soft/easy chew diet nectar thickened liquids...." During an observation, on 9/20/2023 at 1:34 P.M., resident 18 was in bed and had a styrofoam cup with just a little bit of thin liquids left and an orange print plastic bottle with a clear liquid on the bedside table. The resident indicated she drank the water and the plastic bottle is drinking water. During an interview, on 9/20/2023 at 1:35 P.M., LPN 5 indicated that Resident 18 did not have thickened liquids on the bedside table. She viewed the orders in the electronic medical record which was nectar thickened liquids. CNA's are informed of residents on thicken liquids on their	F 0807	**F807 Drinks Avail to Meet Needs/Prefs/Hydration** It is the practice of the facility to have drinks available to meet needs and preference for residents with altered consistency liquids, and sufficient to maintain resident hydration. 1 Resident #18, after being assessed by speech therapy, resident remains on nectar thickened liquids and staff provide nectar thick liquids for resident. Resident #18 has been observed to be non-compliant with orders and to consume thin liquids obtained per self. Staff educate resident regarding risk of consuming liquids that are not per the consistency that is ordered when observed to be non-compliant. Resident #19, resident's fluid consistency was changed to thin liquids following a speech therapy evaluation. 2 All residents with altered fluid consistencies ordered have the potential to be affected. An audit of the current residents with orders for altered fluid consistencies was conducted and no other residents were found to be affected. 3 The DNS/Designee will in-service the IDT and all direct care staff to include licensed nurses and certified nurse aides, to ensure that policy and	10/26/2023

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	CNA sheet. The paper was reviewed, and nectar thicken liquids was not on the CNA sheet for Resident 18. 2. A record review was completed for Resident 29 on 9/20/2023 at 1:00 P.M. Diagnoses included, but were not limited to: cerebrovascular disease, anxiety disorder and major depression. During a family interview, on 9/20/2023 at 8:57 A.M., the daughter indicated during her visit last night that her mother had thin liquids at her bedside and not nectar and was worried she would aspirate. She did inform the staff. During an observation, on 9/20/2023 at 9:38 A.M., Resident 29 was not in the room but there was a Styrofoam cup on the bedside table with a lid and straw with thin liquids in it. During an interview, on 9/20/2023 at 1:10 P.M., Licensed Practical Nurse indicated that she should have nectar thick liquids at the bedside and not the thin liquids. Certified Nurse Aides (CNA) are informed of residents on thicken liquids on their CNA sheet. The paper was reviewed, and nectar thicken liquids was not on the CNA sheet for Resident 29. On 9/20/2023 at 3:05 P.M., the Director of Nursing provided a policy titled, "Thickened Liquids," and indicated the policy was the one currently used by the facility. The policy indicated "...The facility provides commercially-prepared thickened liquids, as prescribed, to resident who require them...Thickened liquids are provided only when ordered by a physician/practitioner or when ordered by a dietitian or speech-language pathologist who has been delegated to write diet orders, to the extent allowed by state law...."		procedures regarding altered fluid consistencies are followed. 4 UM/Designee will observe residents on thickened liquids to ensure that residents are receiving the appropriate consistency of liquids and have liquids at bedside sufficient to maintain the resident's hydration. These observations will be random and include all units and shifts and will take place 5 x weekly x 2 months, then 3 x weekly x 2 months, then weekly x 2 months. The results of these audits will be discussed in QAPI and if there is deficient practice noted, further recommendations will be made per the QAPI IDT. If no deficient practice is noted, QAPI will review on a prn basis.	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to store and serve food in accordance with professional standards for food service safety. This deficient practice had the potential to affect 58 of 58 residents who received their meals in the dining room. Findings include: During an observation and tour of the kitchen with the Dietary Manager, on 9/19/2023 at 9:15 A.M., the following was observed: -The freezer contained bags of frozen fish that were open and not resealed or dated and cups of	F 0812	**F812 Food Procurement Store/Prepare/Serve-Sanitary** It is the practice of the facility to safely Store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility failed to store and serve food in accordance with the professional standards for food safety. The facility failed to ensure areas of the kitchen floor were free of grime and build up and failed to ensure the floor was free from chips. No ill effect noted due to	10/26/2023

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	ice cream were not dated. -The walk-in refrigerator contained soup, diced ham, and magic cups that were not dated. It also contained a bag of chicken patties, dinner rolls, and lettuce that were open, not resealed and not dated. -The dry storage area had containers of gravy. Italian dressing, cans of evaporated milk, parsley flakes, and garden seanoning that were not dated, and packages of pasta, dried cranberries, and cereal that were opened and not resealed or dated. -There was visible black grime on the floor and baseboards in various areas. -The vinyl tile floor was chipped where it meets the ceramic tile. - The double overn had brown sticky matter on the doors and the shelf under the prep table was rusty and had dark brown grime on it and clean hotel pans were stored on this shelf. During an interview with the Dietary Manager at the time of the tour, she indicated that she started a month ago and was aware of the issue with dating and sealing food and it was a problem that she and the staff are working on fixing. She indicated that the shelf under the prep table needed to be repainted. During a tour of the 200 Unit nutrition pantry, on 9/25/2023 at 1:36 P.M., the following was observed: - Staff drinks, a can of air freshener, and a bottle of hand lotion were noted on a shelf. -The microwave had a wet paper towel and green particles on the inside. During an interview, on 9/25/2023 at 1:36 P.M., the Director of Nursing indicated that staff drinks, air freshener, and hand lotion should not be in the nutrition pantry. The microwave should be clean		the alleged deficient practice. All current residents have the potential to be affected by this alleged deficient practice. All storage items audited and dated to reflect appropriate date of use, Floor to be cleaned to remove any grime as well as repair of chipped areas in the kitchen floor. Facility staff were educated on practice of the facility to safely store, prepare, distribute and serve food in accordance with professional standards for food service safety, Kitchen manager / designee will audit all storage of items as well as sanitation of kitchen 5 times each week x 6 months to ensure proper storage of items as well as sanitation is maintained. Audits will include weekends. The dietary manager / designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	and that the dietary department was responsible. A current policy provided, on 9/25/2023 at 11:10 A.M., by the Regional Vice President for Regulatory Compliance titled, "Food Safety Requirements" included, but was not limited to: " ...Food safety practices shall be followed throughout the facility's entire food handling process. Elements of the process include the following: Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. Preparation of food, including thawing, cooking, cooling, holding, and reheating. Equipment used in handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food ...." 3.1-21(i)(1)(3)			
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:			

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	(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.			

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	(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide			

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	bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient.			

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	(B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.			
	Based on observation, interview, and record review, the facility failed to review the care plan, and include the resident, or resident representative, after each assessment for 2 out of 20 residents reviewed. (Residents 32 and 29) Findings include: 1. During an interview, on 9/19/2023 at 2:56 P.M., Resident 32 indicated she had not attended a care conference to discuss her plan of care.	F 0849	**F849 Hospice Services** It is the practice of the facility to coordinate a resident plan of care with the hospice provider and to include the resident and their responsible party, the hospice provider in the planning of their care. 1 Resident #29 was discharged from the facility.	10/26/2023

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	A record review, conducted 9/21/2023 at 10:15 A.M., indicated Resident 32's diagnoses included, but were not limited to: COPD, heart failure, migraine, fibromyalgia, and type 2 diabetes mellitus. A Significant Change Minimum Data Set (MDS) assessment, dated 7/23/2023, indicated Resident 32's cognition was intact. Care Plan Meeting minutes, for 5/4/2023 and 5/18/2023, indicated Resident 32 attended the meeting. The record lacked any documentation of meetings before or since those dates. Resident 32 was admitted to Hospice on 7/17/2023, which required a Significant Change MDS (Minimum Data Set) assessment, but the record lacked documentation of a care plan meeting with the resident and hospice to discuss the resident's care. During an interview, on 9/21/2023 at 3:36 P.M., the Director of Nursing (DON) provided copies of the care plan meetings conducted on 5/4/2023 and 5/18/2023 and indicated they were the only care plan meetings that could be found in the record. Care plan meetings should be held after each assessment and were not. During an interview, on 9/22/2023 at 11:55 A.M., RN 4, from hospice, indicated that she has not attended or been invited to a care plan meeting. During an interview, on 9/22/2023 12:05 P.M., the Area Vice President indicated care plan meetings were documented as completed in the hospice binder, and that the resident, or representative, facility staff, and hospice staff, were aware of and		Therefore, no further review or revision was made for the resident regarding hospice care and coordination of care plan meetings. A care plan meeting has been scheduled for Resident #32. The hospice provider, the resident, and their responsible party have been invited to attend the meeting. 2 All residents who receive hospice services have been reviewed to ensure the hospice provider, the resident, and the responsible party have all been invited to care plan meetings. A care plan meeting has been scheduled for anyone identified to have been affected by the deficient practice. 3 The facilities guidelines and policy regarding hospice services and care plan meetings were reviewed. The DNS/Designee will in-service the IDT and licensed nursing staff regarding the provision of hospice services and the inclusion of the resident, their responsible party, the hospice provider, as well as facility staff as part of the Interdisciplinary team to hold meetings regarding the resident plan of care, to ensure that policy and procedure are followed. 4 The DNS/Designee will audit documentation of care plan meetings for all residents who receive hospice services to ensure that the hospice provider, resident	

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	agree on the plan of care. She did not have any documentation of facility care plan meetings or of inviting the resident to a meeting. A current policy provided by the Regional Nurse, on 9/21/2023 at 3:13 P.M., titled, "Comprehensive Care Plan" included but was not limited to: " ...The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ...." " ...Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated ...." During an interview, on 9/25/2023 at 11:14 A.M., the Vice President of Regulatory Compliance indicated that they incorporate the hospice plan of care into their facility care plan meeting. The meeting is documented in an IDT note, a paper note, or a progress note. 2. A record review for Resident 29 was completed on 9/20/2023 at 2:38 P.M. Diagnoses included, but were not limited to: cerebrovascular disease, anxiety disorder and major depression. During a family interview, on 9/20/2023 at 8:48 A.M., the daughter indicated she has never been invited to a care conference with the team nor one coordinated with Hospice present. On 9/21/2023 at 9:30 A.M., the Social Worker indicated that there was a care conference on 3/23/2023 with the resident present and the next care conference should have been in June. On 9/21/2023 at 9:32 A.M., the Area Vice President indicated they follow the 90 day plan and there		and resident representative are all being invited to the care plan. Audits will be conducted as care plans are conducted, auditing weekly x 6 months. Results will be reviewed at QAPI for a minimum of 6 months to track for any deficient practices. If any deficient practices are identified, then audits will be continued based on QAPI recommendations. If no deficiencies are identified, then QAPI will review on a prn basis.	

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	155109	A. BUILDING 00 B. WING	09/26/2023

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	may be a progress note or a paper sign in sheet for the care conferences. During an interview, on 9/21/2023 at 2:21/2023, the Area Vice President indicated that in the Hospice binder there is a Hospice IDG Comprehensive Assessment and Plan of Care Update Report on 6/16/2023 electronically signed by the Hospice team indicating that they had collaborated with Hospice and the family. During an interview, on 9/21/2023 at 2:31 P.M., Hospice Social Worker indicated she has not been invited to attend a care conference in the facility. During an interview, on 9/21/2023 at 2:51 P.M., the Hospice primary nurse indicated she has not attended a care conference or been invited to one at the facility. During an interview, on 9/25 2023 at 11:09 A.M., the Vice President of Regulatory Compliance indicated that the process for care conferences is to invite family and the resident schedule to accommodate them, if unable to attend a phone conference could be scheduled. Hospice should be invited but if they do not attend, they can call and communicate with them to correlate the care. They have a new process that has not been initiated in this facility yet. So, the current process is document in the progress note about the care plan and/or paper. A current policy provided, on 9/25/2023 at 11:10 A.M., by the Vice President of Regulatory Compliance, titled, "Care Planning - Resident Participation" included, but was not limited to: " ...The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them			

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	to see the care plan, initially, at routine intervals and after significant changes ...." " ...The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan ...." On 9/26/2023 at 8:58 A.M., the Regional Nurse 7, provided a policy titled, "Care Plan Revisions Upon Status Change," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change...."			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education			

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	regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview and record review, the facility failed to ensure that vaccination consent forms were provided to the resident upon admission to the facility for 1 of the 5 reviewed for infection control. (Resident 18) Finding includes:	F 0883	**F883 Influenza and Pneumococcal Immunizations** It is the practice of the facility to educate and inform all residents and/or their responsible parties upon admission regarding the Influenza, Pneumococcal, and	10/26/2023

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	A record review was completed for Resident 18 on 9/20/2023 at 1:30 P.M. Diagnoses included, but not limited to: hemiplegia and hemiparesis cerebrovascular disease, dementia without behavioral disturbances, major depressive disorder, Parkinson's, and dysphagia. Resident 18 was admitted to the facility on 7/7/2023. A copy of CHIRP-Patient Vaccination was scanned in under miscellaneous, it indicated that she had one COVID vaccine on 11/23/2021, last influenza vaccine on 10/17/2017 and no history of pneumococcal in the community. During an interview, on 9/26/2023 at 11:29 A.M., the Infection Preventionist indicated she did not have any signed vaccination consents in her Admission Agreement indicating she would like to have a COVID booster, pneumococcal or influenza vaccine. On 9/19/2023, at 2:00 P.M., the Administrator provided a policy titled, "Infection Preventionand Control Program," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...7. Influenza and Pneumococcal Immunizations: b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere. c. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunization prior to offering the vaccines. d. Residents will have the opportunity to refuse the immunization. e. Documentation will reflect the education provided and details regarding whether or not the resident received immunization. 8. COVID-19 Immunization: c. Education about the		COVID Immunizations, with completion of consent or refusal of vaccinations upon admission. 1 Resident #18 was educated and informed of Influenza, Pneumococcal and COVID immunizations and resident declined vaccinations. 2 All residents have the potential to be affected by the alleged deficient practice. A review of all residents currently living at the facility was conducted regarding Influenza, Pneumococcal and COVID immunizations with subsequent consent or refusal documented as appropriate. 3 The facilities guidelines and procedures were reviewed. DNS/Designee will in-service the IDT and licensed nursing staff regarding obtaining consent/refusal and documentation of such upon admission for influenza, pneumococcal and COVID vaccines. 4 DNS/Designee will review in clinical start-up the admission audit, which will include reviewing that the resident received the consents for the influenza, pneumococcal and COVID vaccination. These audits will be conducted 5 x weekly x 2 months, 3 x weekly x 2 months, then weekly x 2 months. Results of the audits will be reviewed at QAPI for a minimum of 6 months to track	

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	vaccine, risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine. d. Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance...."		for any deficient practices. If any deficient practices are noted, then audits will be continued based on the QAPI recommendations. If no deficiencies are noted, then QAPI will review on a prn basis.	
F 0908 SS=F Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure the lint trap of two dryer vents were removed every two hours to prevent a fire. This deficient practice had the potential to affect 58 of 58 residents who reside in the facility. Finding includes: During a tour of the laundry room on 9/26/2023, from 9:06 A.M. to 9:15 A.M. two of the dryers' lint traps were inspected and both had a thick layer of white lint covering the filter and pieces of lint on the floor of the machine. Both dryers were full of a completed load inside. A log titled, "Dryer Clean Out Schedule," was taped to the first dryer without an initial from the laundry aide indicating that it was cleaned at 6:00 A.M. and 8:00 A.M. for 9/26/2023. During an interview, on 9/26/2023 at 9:06 A.M., The Maintenance Director indicated that the lint trap is emptied every 2 hours. During an interview, on 9/26/2023 at 9:11 A.M., the Laundry Aide indicated that she did not clean	F 0908	Requesting an IDR for this tag due to fact that the staff member assigned to laundry that day did not arrive until approximately 9am, therefore, the dryer had not been in operation for 2 hours at the time the surveyor observed the lint trap to have collected lint. thus, not requiring to be cleaned/emptied. **F908 Essential Equipment, Safe Operating Condition (Dryer Vents)** It is the practice of the facility to maintain all mechanical, electrical, and patient care equipment in safe operating condition. Lint trap of both dryers immediately cleaned and audited every 2 hours to prevent a fire. No ill affect noted from this alleged deficient practice. Housekeeping staff educated on	10/26/2023

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	out the lint traps since she has been here this morning and it should have been cleaned out every two hours at 6 and 8 A.M. On 9/26/2023 at 10:55 A.M., the Transitional Executive Director provided a policy from the Environmental Services Operational Manual titled, "C. Lint Screens", revised 9/5/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...These lint screens must be brushed and cleaned after every two hours. If not, the screen will become packed with lint. When this occurs, the warm air moving through the system is blocked, raising the temperature in the basket and causing a potentially dangerous situation: i.e, where one spark on lint can cause a fire....: 3.1-19		the appropriate cleaning and timeliness of cleaning dryer vents. Housekeeping supervisor or designee to audit lint trap cleaning x 5 days a week for 6months to ensure they are free of hazardous debris. The Housekeeping supervisor will present the summaries of the audits to the Quality Assurance Committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	