STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. BUILDING 00 B. WING	10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	745 N SWOPE ST GREENFIELD, IN 46140

(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 IN00385199. Complaint IN00385199 - Substantiated. Federal/State deficiencies related to the allegations are cited at F558 and F684. Survey dates: October 18, 19, 20, 21, 24 and 25, 2022 Facility number: 000050 Provider number: 155120 AIM number: 100266170 Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 6 Medicaid: 67 Other: 23 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 31, 2022	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to this survey.	
F 0552 SS=D Bldg. 00	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Oliver	RN	11/11/2022

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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	including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Based on observation, interview, and record review, the facility failed to ensure there was communication between staff and a resident in a language that both could understand, with a resident who spoke a different language than the facility. This affected 1 of 1 resident reviewed for communication. (Resident E) Findings include: Resident E's record was reviewed on 10/20/22, at 11:38 a.m., and indicated diagnoses that included, but were not limited to, traumatic brain bleeding, respiratory failure, generalized muscle weakness, atrial fibrillation, high blood pressure, gastro-esophageal reflux disease, has a gastrostomy tube and a tracheostomy, cognitive communication deficit, anemia, seizures, and joint stiffness.	F 0552	F552 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Res E was assessed and referred to Speech Therapy for communication interventions. Care Plan has been updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents have been assessed for language barriers; any resident identified as having a language barrier has had their care plan reviewed and interventions put in place for effective communication. What measures will be put into	11/15/2022

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	An Annual Minimum Data Set assessment (MDS), dated 3/18/22, indicated Resident E was severely impaired in cognitive skills for daily decision making, was totally dependent on two staff for bed mobility, dressing, personal hygiene, did not walk, was impaired on both sides of upper and lower extremities in range of motion, had a gastrostomy tube, received oxygen and had a tracheostomy. A Quarterly MDS, dated 9/16/22, indicated he was severely impaired in cognitive skills for daily decision making, had total dependence on two for bed mobility, bathing, and transfers, did not walk, total dependence of one for dressing, personal hygiene, and eating, was impaired on both sides of upper and lower extremities in range of motion, had a gastrostomy tube, received oxygen and had a tracheostomy. A care plan, dated 3/25/21, indicated a focus for: "Impaired Communication due to not always being understood as resident only speaks French Creole. Goal: Will use alternative communication systems effectively. Interventions: Allow calm unhurried environment to encourage communication. Anticipate patient needs. Listen carefully, validate verbal and non verbal expressions. Use simple and direct communication to promote understanding. Utilize family or interpreter PRN [as needed]." A care plan, dated 3/26/21, indicated a focus for: "I cannot speak or understand English. My primary language is French. Goal: I will be able to participate in activities I enjoy in my native language, as well as programs that are not dependent on my being able to understand or speak English. Interventions: As answering questions in English is difficult for me, please		place and what systemic changes will be made to ensure that the deficient practice does not recur Staff were educated on effective communication and how to communicate with residents with a language barrier Audits will be completed on 4 residents weekly that have a language barrier to assure effective communication x 4weeks than 3 resident weekly x 4 weeks than 2 residents weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	provide me with questions requiring short, non-complex verbal responses, i.e. "yes/no" or simple word answers. Ask my family to face time with me in my native language. Introduce me to other patients, staff, and visitors who also speak my native language. Please use a communication board, pictures or gestures to help you understand my needs and to help me understand you as needed. Use google app to translate English to French." A care plan, dated 3/25/21, indicated a focus for "I am at risk for psychosocial well-being concern r/t (related to) impaired communication skills. Goal: I will not show a decline in psychosocial well-being or experience adverse effects through next care review. Interventions: Provide support and allow me to express feelings, fears and concerns as able. Observe me for psychosocial and mental status changes - document and report as indicated. Provide me with in room activities of choice as I'm able. Provide alternative methods of communication to my family/visitors." A Social Service progress notes, dated 9/12/2022 at 2:10 p.m., indicated: "Mood interview can not be conducted. Resident is rarely/never understood...." Social Service progress notes on 9/12/2022 at 2:07 p.m.: "BIMS [brief interview for mental status] Evaluation Interview: BIMS Score: 99.0 Staff assessed. Brief Interview for Mental Status should not be conducted. (Resident is rarely/never understood). Complete staff assessment for mental status. Yes. Resident was unable to complete Brief Interview for Mental Status. Seems or appears to recall after 5 minutes: Memory problem. Seems or appears to recall long past: Memory OK. Resident is normally able to			

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	recall staff names and faces. Resident is able to recall he or she is in a nursing home/hospital swing bed. Resident made decisions regarding tasks of daily life: Severely impaired. Presence: No. Frequency: Never or 1 day." On 10/19/22 at 2:22 p.m., Resident E was observed in bed, his TV was on, the head of his bed was up 30 degrees, he was non verbal when spoken to, and did not make eye contact. On 10/24/22 at 9:55 a.m., Resident E was observed in bed, his eyes open, he was non verbal. LPN 2 indicated he will be assisted out of bed after lunch. On 10/24/22, at 11:05 a.m., Resident E was observed as he received tracheostomy care, and was transferred from his bed to a specialty reclining chair with assistance from CNA 7, LPN 2, and QMA 6. LPN 2 explained to the resident what they were going to do and there was no response from Resident E. He had no facial expressions nor attempted to speak. On 10/25/22, at 1:55 p.m., CNA 7 said he has facial expressions and eye movements, he makes faces, said no one here speaks French but he has a family friend who comes in who speaks French. She indicated he possibly doesn't understand what they are saying, or his level of competency is low. On 10/25/22, at 2:30 p.m., the Director of Nurses indicated Resident E has family that face times on his tablet, his primary language is French but he can understand some English as well, they explain what they are going to do with him, they go by step by step instructions with him, they go by facial expressions from him, he will make eye			

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	contact, they watch for squinting to show he is uncomfortable. His friend [name of friend] calls and checks on him, and he has a guardian. The Resource Nurse said, at this time, that he doesn't communicate anymore because his baseline is nonverbal. A policy for "Comprehensive Care Plans" was provided by the Nurse Consultant, on 10/25/22 at 3:36 p.m. The policy included, but was not limited to, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment...3. The comprehensive care plan will describe, at a minimum, the following...f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate...." 3.1-4(c)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record	F 0558	**F558** **What corrective actions will be**	11/15/2022

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	review the facility failed to ensure fluids were available and within reach for Resident C and failed to ensure call lights were within reach for 2 of 2 residents reviewed for accommodation of needs (Resident C and Resident 59). Findings include: 1.) During an interview with Resident C's family member, on 10/19/22 at 2:27 p.m., indicated Resident C had a history of being dehydrated and the family member had concerns the resident was not receiving enough fluids at the facility. During an observation on 10/20/22 at 3:54 p.m., Resident C was laying in bed awake, the resident's lidded cup and call light was on the bedside table out of the resident's reach and the resident's styrofoam cup was on the nightstand out of the resident's reach. The resident's call light was activated for staff assistance. During an observation and interview on 10/20/22 at 4:00 p.m., the Nurse Consultant came into Resident C's room and provided him with his call light and fluids. The Nurse Consultant indicated it was the responsibility of all nursing staff to ensure the resident's call light and fluids were within reach. Review of the record of Resident C, on 10/21/22 at 2:25 p.m., indicated the resident's diagnoses included, but were not limited to, bipolar disorder, manic severe with psychotic disorder, diabetes, kidney complication, major depression disorder, muscle weakness, Alzheimer's disease and general anxiety. The October 2022 physician for Resident C, indicated the resident was ordered thickened		**accomplished for those residents found to have been affected by the deficient practice?** Resident C and Resident 59 had no ill effects noted related to the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents have the potential to be affected by the same alleged deficient practice **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Staff were educated on assuring residents always have fluids within reach (unless on a fluid restriction) and call lights within reach. Audits will be completed on 10 randomly selected residents on various shifts weekly x 4 weeks to assure that residents have fluids and call light within reach than 8 residents on various shifts x 4 weeks than 5 residents on various shifts x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6	

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	liquids, lidded cups with fluids. The alteration in elimination of bladder urinary retention and incontinent of urine for Resident C, dated 9/19/22. The interventions included, but were not limited to, call bell within reach and reminders to use call bell as needed and encourage fluids. The at risk fall risk care plan for Resident C, dated 9/19/22, indicated the resident was at risk for falls due to medication, the interventions included, but were not limited to, call light in easy reach. The potential for alteration in hydration related to does not always drink well. The interventions included, but were not limited to, encourage fluids and assist as needed. The alteration in elimination of bowel for Resident C, dated 9/19/22, indicated the resident was encouraged to drink fluids. The Quarterly Minimum Data (MDS) assessment for Resident C, dated 9/22/22, indicated the resident was severely impaired for daily decision making. The resident required extensive assistance with drinking of one person. During an observation on 10/24/22 at 11:05 a.m., Resident C laying in bed, no water or fluids available in his room. During an observation on 10/24/22 at 12:30 p.m., Resident C continued not to have fluids available in his room. During an observation on 10/24/22 at 3:00 p.m., Resident C continued not to have fluids available in his room.		months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	The hydration policy provided by the Director Of Nursing (DON) on 10/24/22 at 2:35 p.m., indicated the facility would ensure beverages are available and within reach. 2. Resident 71's record was reviewed on 10/20/22 at 3:50 p.m. and indicated diagnoses that included, but were not limited to, traumatic brain injury, chronic obstructive pulmonary disease with acute exacerbation, tremor, depression, stroke, anxiety, adult failure to thrive, insomnia, and history of Covid-19. An Admission Minimum Data Set (MDS) assessment, dated 6/17/22, indicated Resident 71 was cognitively intact, required extensive assist of two for bed mobility, toilet use, dressing, and transfers, limited assist of one for walking, balance is not steady, had impairment on one side of upper extremity in range of motion, and used a walker and a wheelchair. A Quarterly MDS, dated 10/14/22, indicated Resident 71 was moderately cognitively impaired, required limited assistance of one for bed mobility, walked with supervision of one, balance was unsteady but he was able to stabilize without staff assistance, except for moving on and off toilet and surface-to-surface transfer (between bed and chair or wheelchair), and had no impairment in range of motion. Resident 71 had care plans for a physical functioning deficit related to mobility impairment, range of motion limitations, alteration in elimination of bowel and bladder, at risk for falls, and mobility impairment that included an intervention to keep his call bell within reach. On 10/21/22 at 2:36 p.m., Resident 71 was			

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	observed sitting on the edge of his low bed and his light-touch call light pad was lying on his overbed table, out of reach. He had his TV remote in his hand pointed at the TV and it wasn't working. He couldn't reach his call light. RN 8, his nurse, was informed, and she helped him with the remote and placed his call light pad where he could reach it. On 10/25/22, at 12:40 p.m., Resident 71 was lying on his bed, he was alert and mumbled when spoken to. When asked if he could reach his call light if he wanted to get help, he put his arm towards the call light and could not reach it. Lunch trays were being delivered to the rooms on his hall, and the CNA who brought his lunch tray assisted him. A policy for "Call Lights: Accessibility and Timely Response" was provided by the Resource Nurse on 10/25/22 at 2:25 p.m. and included, but was not limited to, "Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response...5. Staff will ensure the call light is within reach of resident and secured, as needed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room...." This Federal tag relates to Complaint IN00385199. 3.1-3(v)(1)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans			

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	§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with			

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	the requirements set forth in paragraph (c) of this section. Based on interview and record review, the facility failed to develop and implement care plans for blood pressure medications, a gastro-esophageal medication, a hyperlipidemia (high blood fats) medication, and Parkinson's disease medication. This affected 1 of 27 residents reviewed for care plans. (Resident 71) Findings include: Resident 71's record was reviewed, on 10/20/22 at 3:50 p.m. and indicated diagnoses that included, but were not limited to, traumatic brain injury, chronic obstructive pulmonary disease with acute exacerbation, tremor, high blood fats, high blood fats, Parkinson's disease, depression, stroke, and anxiety. An Admission Minimum Data Set assessment (MDS), dated 6/17/22, indicated Resident 71 was cognitively intact and received antianxiety, antidepressant, anticoagulant, and opioid medications. A Quarterly MDS, dated 10/14/22, indicated Resident 71 was moderately cognitively impaired, and received antianxiety, antidepressant, anticoagulant, and opioid medications. Current physician's ordered medications included, but were not limited to: - Lisinopril 5 mg, one by mouth every day for high blood pressure, started 6/10/22 - Propanolol 40 mg, one by mouth twice a day for high blood pressure, started 6/10/22 - Omeprazole suspension two mg per milliliter, give 20 mg by mouth twice a day for	F 0656	**F656** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 71's Care plan has been updated to include Cardiovascular disease, Parkinson's disease, or GERD diagnosis with related medication management. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that have Cardiovascular disease, Parkinson's disease, or GERD diagnosis with related medication management have the potential to be affected by the alleged deficient practice All residents with these diagnoses have had their care plans updated to include medication management. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** MDS Coordinator has been educated on implementation of care plan when residents have Cardiovascular disease, Parkinson's disease, or GERD diagnosis with related medication management. An audit will be	11/15/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	gastro-esophageal reflux disease, started 6/10/22 - Atorvastatin calcium 40 mg (milligrams), one by mouth in the evening for high blood fats, started 6/10/22 - Sinemet 25/250, one by mouth four times a day for Parkinson's, started 6/10/22 - Entacapone 200 mg, one by mouth four times a day for Parkinson's, started 6/10/22 There were no care plans in the clinical record that addressed high blood pressure, gastro-esophageal reflux disease, high blood fats, or Parkinson's disease. On 10/25/22, at 2:30 p.m., the Corporate Consultant provided newly written care plans for high blood pressure, gastro-esophageal reflux disease, high blood fats, and Parkinson's disease that included the medications and the care plans were dated 10/25/22. A policy, for Comprehensive Care Plans, was provided by the Corporate Consultant on 10/25/22, and indicated, but was not limited to: "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment...." 3.1-35(a)		completed on 4 new admissions and/or current residents that receive a new diagnosis to assure care plans are implemented for residents that have Cardiovascular disease, Parkinson's disease, or GERD diagnosis with related medication management weekly x 4 weeks than 3 weekly x 4 weeks than 2 weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis	
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			

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	155120	A. BUILDING 00 B. WING	10/25/2022

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	nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to ensure a dependent resident was assisted with getting dressed and transferred out of bed for 1 of 5 residents reviewed for Activities of Daily Living (ADL) (Resident 54). Finding include: During an observation on 10/18/22 at 2:32 p.m., Resident 54 was laying in bed awake in a hospital gown. During an observation on 10/19/22 at 2:47 p.m., Resident 54 was laying in bed awake in a hospital gown. During an observation on 10/20/22 at 3:40 p.m., Resident 54 was asleep in bed in a hospital gown. During an observation on 10/21/22 at 1:35 p.m., Resident 54 was sitting in bed in a hospital gown eating lunch independently. Review of the record of Resident 54 on 10/21/22 at 1:55 p.m., indicated the resident's diagnoses included, but were not limited to, displaced interchanteric fracture of left femur, congestive heart failure, osteoarthritis, dementia, anxiety, depression, adult failure to thrive and muscle weakness. The plan of care for Resident 54, dated 6/2/22, indicated the resident had physical functioning deficit related to: mobility impairment, range of motion limitations, bilateral fractured femurs and self care impairment. The interventions included, but were not limited to, extensive assist with	F 0677	**F677** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Res 54 had no ill effects noted related to the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All dependent residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education was given to nursing staff on ADL care for dependent residents to include assisting with dressing and transferring out of bed. Audits will be completed on 4 residents weekly to ensure dependent residents are assisted with dressing and transferring x 4weeks than 3 residents weekly x 4 weeks than 2 residents weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality**	11/15/2022

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	dressing of one person and transfer with two staff and a mechanical lift. The Quarterly Minimum Data Set (MDS) assessment for Resident 54, dated 8/31/22, indicated the resident was severely cognitively impaired for daily decision making. The resident had no behaviors of rejecting care. The resident required extensive assistance of one person for transfers and getting dressed. The resident did not ambulate. During an observation on 10/24/22 at 11:10 a.m., Resident 59 ways laying in bed awake in a hospital gown. During an observation and interview on 10/24/22 at 2:30 p.m., Resident 59 was laying in bed awake in a hospital gown. CNA 9 indicated she did not know why the resident was not up out of bed and dressed. CNA 9 indicated normally the resident got out of bed every day. 3.1-38(a)(3)		**assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record	F 0679	**F679**	11/15/2022

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	review the facility failed to provide an ongoing activity program for 1 of 1 resident's reviewed for activities (Resident 59). Finding include: During an observation on 10/18/22 at 2:43 p.m., Resident 59 was laying in bed, there was no TV no radio on. The resident was in bed talking to herself. During an observation on 10/20/22 at 3:48 p.m., Resident 59 was laying in bed awake, the resident's fingernails were dirty and jagged. There were no activities, TV or radio.\ During an observation on 10/21/22 at 11:59 a.m., Resident 59 was in bed in a gown awake no TV or radio on, the resident says hi and smiles. Review of the record of Resident 59 on 10/21/22 at 12:20 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, diabetes, cognitive communication disorder, and delusional disorder. The Annual Minimum Data Set (MDS) assessment for Resident 59, dated 9/5/22, indicated the resident was severely impaired for daily decision making. The resident required extensive assistance of two people to transfer, the resident did not ambulate. The enjoyed listening to music, being around animals such as pets, spending time outdoors, participating in religious activities and participating in her favorite activity. The resident had no natural teeth or tooth fragment(s) (edentulous). The activity care plan for Resident 59, dated 9/14/22, indicated the resident would participate in		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Res 59 Activity Care Plan updated to include 1:1 activities **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education was provided to staff to assure residents are receiving activities of their preference. Audits will be completed on 10 randomly selected residents on various shifts weekly x 4 weeks to assure they are receiving activities of their preference than 8 residents on various shifts x 4 weeks than 5 residents on various shifts x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to	

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	the recreational activities. The resident enjoyed watching TV in her room and sitting in the dining room. The interventions were invite me to my favorite activity and to try new things that might be interesting such as crafts and music programs, give cues and instructions if needed and sit the resident near the activity leader or volunteer for assistance. Review of Resident 59's activity participation for August 2022, September 2022 and October 2022, indicated the resident had no documented participation in activities. During observation on 10/21/22 at 1:10 p.m., Resident 59 was laying in bed, staff brought her tray in and raised the head of the bed, there was no TV or radio on. During an observation on 10/21/22 at 1:45 p.m., Resident 59 was laying in bed eating ice cream, no TV or radio on. During an observation on 10/24/22 at 11:15 a.m., Resident 59 sitting in the dining room no activities sitting by herself. During an observation on 10/24/22 at 3:10 p.m.., Resident 59 sitting in the dining room no activities sitting by herself. During an interview with the Activity Director on 10/25/22 at 1:40 p.m., indicated Resident 59 was not currently on one on one activity schedule. The resident usually sat during group activities and actively listened. Today she did a craft and responded very well. The facility realized and noticed recently she should be one on one activities and not just sitting there listening and do more focused personal activities. The CNA's		make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis	

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	are responsible to get her up and then activities and nursing staff are suppose to bring her to the activities. No one specifically responsible to ensure TV or radio on in her room, anyone could turn on a TV and radio for her, the resident was unable to do that herself. The activity policy provided by the Regional Resource Nurse on 10/25/22 at 11:20 a.m., indicated the facility would provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan and preferences. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. 3.1-33(a)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to follow up with a resident's change in condition (Resident B) in regard to loose stools for excessive duration that resulted in hospitalization, sepsis, and shock for 1 of 3 residents reviewed for change in condition. Findings include:	F 0684	**F684** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B no longer resides at the facility **How other residents having the**	11/15/2022

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	The clinical record for Resident B was reviewed on 10/21/22 at 12:46 p.m. The diagnoses included, but were not limited to, meningitis, respiratory failure, end stage renal disease, congestive heart failure, atrial fibrillation, systemic lupus erythematosus, viral hepatitis C, dependence on renal dialysis, muscle weakness, and nausea with vomiting. A Significant Change Minimum Data Set (MDS) assessment, dated 5/16/22, indicated Resident B was cognitively impaired, required extensive assistance with 2 staff for bed mobility and transfers, extensive assistance with 1 staff for eating, and was always incontinent of bowel. An activities of daily living care plan, revised 5/17/22, listed an intervention for Resident B of "Eating self care assist of extensive one". A care plan related to bowel elimination, dated 3/4/22, indicated Resident B was at risk in alteration in elimination of bowel related to constipation and functional incontinence. The interventions included, but were not limited to, encourage fluids and monitor bowel status frequency. A care plan related to end stage renal disease, dated 3/15/22, indicated the risk for sodium and potassium excess with interventions to obtain labs per physician order and as needed for change in condition/manifestation of clinical signs or symptoms. Resident B was scheduled for dialysis on Monday, Wednesday and Fridays. Hospital records, dated 5/6/22, indicated the discharge diagnoses of meningitis, urinary tract infection, and nausea & vomiting. There was no		**potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Residents with a change in condition have the potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Nurses educated on change in condition of a resident to include follow up with lab orders. Random audits of 4 residents weekly for 4 weeks than 3 residents weekly x 4 weeks than 2 residents weekly x 4 months. These residents will be newly assessed to ensure that any declines in condition have been identified, properly evaluated and communicated to the appropriate people. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits	

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	mentioning of Resident B having diarrhea during that hospitalization. A progress note, dated 5/10/22 at 2:36 p.m., indicated Resident B had loose stools and vomited after consuming lunch. The Nurse Practitioner was made aware of Resident B's condition change. A provider note, dated 5/10/22, indicated the nurse practitioner had seen Resident B. Resident B's diarrhea was documented as "controlled" and to continue with as needed medications for such. A lab result, dated 5/12/22, noted Resident B's creatinine level of 2.6 mg/dL (milligrams per deciliter- normal range of 0.6 to 1.0 mg/dL) (a measure of how well your kidneys are performing their job of filtering waste from your blood) and potassium level of 2.9 (normal range of 3.6 to 5.1 mEq/L [Milliequivalents Per Liter]). A lab result, dated 5/12/22, noted Resident B's white blood cell count of 10.5 (within normal range). These lab results were obtained the day after Resident B was scheduled for dialysis. A progress note, dated 5/13/22 at 1:03 a.m., indicated the on-call physician was notified of Resident B's potassium level of 2.9. A one-time order for potassium was obtained. A progress note, dated 5/15/22 at 12:21 p.m., indicated Resident B had vomited in the morning and appeared drowsy. Medication for nausea was administered and Tylenol due to Resident B having an elevated temperature of 101.8. The note indicated the on-call staff was notified of Resident B's change in condition.		based on a prn basis	

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	A progress note, dated 5/15/22 at 2:02 p.m., indicated Resident B vomited again and was given another dose of medication for nausea. A progress note, dated 5/15/22 at 2:09 p.m., indicated Resident B was noted with a distended abdomen. A progress note, dated 5/16/22 at 5:37 p.m., indicated Resident B only received a partial dialysis treatment due to becoming ill. They were given medications for vomiting. A progress note, dated 5/16/22 at 9:47 p.m., indicated Resident B had vomited twice and was given medication for nausea. There was no indication the on-call staff was notified. A physician order, dated 5/16/22, was noted for ondansetron (anti-nausea medication) 4 milligrams every 6 hours as needed for nausea and vomiting. A physician order, dated 5/16/22, was noted for loperamide (anti-diarrhea medication) 2 milligrams after each loose stool. A care plan for infection, dated 5/17/22, indicated the following, "actual or at risk related to: possible C-diff [(also known as Clostridium difficile or C. difficile) is a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon)] loose stools...Interventions...Labs as ordered...." A physician order, dated 5/17/22, indicated to place Resident B on contact precautions until C Diff results were obtained and negative. There were no labs obtained to check for c-diff for Resident B on, or around, 5/17/22.			

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	A weight note, dated 5/20/22, indicated Resident B exhibited an 8.3 pound (4.3%) weight loss over the previous week and was not taking in much nutrition since their return from the hospital. A progress note, dated 5/20/22, indicated Resident B was only able to complete a partial dialysis treatment due to becoming nauseous and vomiting. A provider note, dated 5/26/22, indicated Resident B's diarrhea was "controlled" and to continue giving as needed medication for such. The electronic medication administration record (EMAR) for May of 2022, noted loperamide administered on 5/27/22 with effective results noted. The EMAR for May of 2022, noted ondansetron administered on the following date(s)/time(s): 5/15/22 at 8:01 a.m.- ineffective results, 5/15/22 at 1:51 p.m.- effective results, 5/16/22 at 10:07 p.m.- effective results, & 5/22/22 at 3:26 p.m.- effective results. Documentation for May of 2022 in regard to Resident B's bowel continence was reviewed. The following date(s) were documented as Resident B having "loose/diarrhea" bowel movements: 5/6/22- evening shift, 5/7/22- evening and night shift, 5/8/22- evening shift, 5/10/22- day and evening shift, 5/12/22- day and evening shift, 5/14/22- day and evening shift, 5/15/22- day and evening shift, 5/16/22- twice on evening shift and night shift,			

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	5/18/22- day shift, 5/20/22- evening and night shift, 5/23/22- day shift, 5/24/22- night shift, 5/25/22- day and evening shift, 5/26/22- day shift, 5/27/22- day and evening shift, 5/28/22- day and twice on night shift, 5/29/22- day shift, & 5/30/22- evening shift. A progress note, dated 6/2/22 at 1:58 p.m., indicated Resident B vomited at lunch and had diarrhea. Resident was given a medication for the diarrhea and nausea. There was no indication the on-call staff was notified of this change in condition. A progress note, dated 6/3/22 at 5:50 p.m., indicated Resident B vomited and had runny stools. Resident B was administered medication for nausea and diarrhea. The Nurse Practitioner was notified. There were no indication any new orders were obtained at that time. A progress note, dated 6/6/22 at 3:25 a.m., indicated Resident B had many loose stools and has a c-diff odor. A lab result, dated 6/6/22, indicated Resident B had c-diff detected in her stool. A lab result, collected on 6/6/22 and reported on 6/8/22 by the dialysis center, indicated Resident B had a low potassium level of 2.2 and an extremely high white blood cell count of 26.54 (normal range of 4.80 to 10.80). The document was initialed and dated for 6/9/22 by the nurse practitioner but no new orders were noted.			

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	An interview conducted with Nurse Consultant, on 10/25/22 at 2:00 p.m., indicated the staff discussed Resident B having loose stools back in May of 2022. At that time, we were told she was only having one stool a day and it was mushy in consistency. So, at that time we didn't move forward with testing her for c-diff. A number of lab reports from Resident B's dialysis center was given by Nurse Consultant on 10/25/22 at 4:00 p.m. These lab results were faxed from the laboratory to the facility on 10/25/22 at 3:42 p.m. and were not all accessible in Resident B's clinical record. The EMAR for June of 2022 noted loperamide administered on the following date(s)/time(s): 6/2/22 at 1:37 p.m.- effective results, 6/3/22 at 3:18 p.m.- effective results, 6/7/22 at 10:48 a.m.- effective results, & 6/11/22 at 1:32 p.m.- unknown results. The EMAR for June of 2022 noted ondansetron administered on the following date(s)/time(s): 6/2/22 at 1:37 p.m.- effective results, 6/3/22 at 3:18 p.m.- effective results, 6/10/22 at 12:51 p.m.- effective results, & 6/11/22 at 1:32 p.m.- unknown results. Documentation for June of 2022 in regard to Resident B's bowel continence was reviewed. The following date(s) were documented as Resident B having "loose/diarrhea" bowel movements: 6/1/22- day shift, 6/2/22- day and evening shift, 6/3/22- evening and twice on night shift, 6/4/22- day shift,			

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BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	745 N SWOPE ST GREENFIELD, IN 46140

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	6/5/22- day shift, 6/6/22- day shift and twice on night shift, 6/7/22- day and evening shift, 6/8/22- day, evening, and night shift, 6/9/22- day, evening, and night shift, 6/10/22- day and evening shift, & 6/11/22- day shift. A provider note, dated 6/9/22, indicated Resident B complained of abdominal pain, nausea, and diarrhea. She refused dialysis on 6/8/22 with indication to monitor labs and fluid status. There were no orders listed for follow up. A progress note, dated 6/11/22 at 1:32 p.m., indicated Resident B vomited at 1:00 p.m. along with loose stools. Medication for nausea and diarrhea were administered along with a suggestion for the Nurse Practitioner to schedule Resident B on the nausea medication. A progress note, dated 6/11/22 at 5:06 p.m., indicated Resident B was sent out to the local hospital emergency room due to "vomiting up feces" and causing suspicion of perforated bowel. A hospital admission note, dated 6/12/22, indicated the following, "...Per pt [patient] reported she had been vomiting for a week...Lab work showed a WBC [white blood cell] ct [count] of 17.7, k+ [potassium] of 2.2, and creatinine of 6.9...Physical Exam...Mouth: Mucous membranes are dry...Principal Problem: Shock...Active Problems: Hypokalemia [low levels of potassium]...ESRD on hemodialysis...Atrial fibrillation...Bilious vomiting with nausea...4. ESRD on HD [hemodialysis]...the patient dialyzed Monday [6/6/22] for partial run and then did not go Wednesday because she was feeling ill...Weight...163 lbs [pounds]...Weight hx			

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	[history]...It appears she lost 37 lb or 19% body weight in one year...Recent labs...K [potassium]...2.0 [Critical result noted]...Hospital Course...Of note, her son at bedside reports being told that she had tested positive for C diff [sic] last week, he also notes that she was unable to tolerate her last HD [hemodialysis] run due to hypotension...Prior to transfer she was found to have hypokalemia with a potassium of 2.2, along with Cr [creatinine] of 8.0 (unclear when he last had HD, per records it appears he dialized [sic] 6/10, however son states it was Mon [Monday] 6/6) [sic]...She was given 2.5 AL [liters] boluses of fluid as well w/ [with] concern for hypovolemic shock in setting of Cdiff and N/V/D [nausea, vomiting, diarrhea]...Attending Attestation...Appears extremely dry and dehydrated...Nephrology Initial Consultation Note...She has missed most of her dialysis sessions over the past 2 weeks due to severe diarrhea. She was found to be hypotension and hypokalemic...On arrival here she was hypotensive in shock with confusion and transferred to the ICU [intensive care unit]. She was intubated and multiple pressors have been started...Fluid resuscitation started...." A hospital discharge summary, dated 6/12/22, indicated the following, "...Hospital Course...In summary, this unfortunate female was admitted to the intensive care unit in a state of extremist with shock. She had previously been treated for C diff colitis at the outlying facility. She presented to us in shock and required immediate intubation and mechanical ventilation, placement of arterial and central venous access and administration of vigorous vasopressor support. She was treatment with vancomycin and Flagyl. The patient continued to be markedly hypotensive despite volume resuscitation and 3 vasopressors			

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	administrations [sic]...Despite intensive fluid management, vasopressor support, and ventilatory management, heart condition continued to deteriorate and she remained profoundly hypotensive and bradycardic...The patient was terminally extubated and passed away peacefully thereafter...DISCHARGE DIAGNOSIS/CAUSE OF DEATH: Shock, likely septic versus possibly cardiogenic...." A Discharge/Death Diagnoses noted the following, "...1. Medical care withdrawn by the family...2. End-stage renal disease, on hemodialysis...3. Congestive heart failure...4. Chronic obstructive pulmonary disease...5. Recent history of Clostridium difficile colitis...6. Shock, cardiogenic versus hemodynamic...7. Acute respiratory failure...." A policy titled Notification of Changes, undated, was provided by the Executive Director on 10/24/22 at 9:25 a.m. The policy indicated the following, "...The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification...Compliance Guidelines...2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include...a. Life-threatening conditions...b. Clinical complications...3. Circumstances that require a need to alter treatment...This may include: a. New treatment...b. Discontinuation of current treatment due to...i. Adverse consequences...ii. Acute condition...iii. Exacerbation of a chronic condition...." This Federal tag relates to Complaint IN00385199.			

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	3.1-37(a)			
F 0686 SS=E Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to provide pressure ulcer interventions, turn/reposition residents and failed to provided pressure ulcer treatments as ordered for 4 of 5 residents reviewed for pressure ulcers (Resident 4, Resident 8, Resident 14 and Resident 33). Findings include: 1.) During an observation on 10/19/22 at 11:45 a.m., Resident 4 was laying in bed with her heels flat on the mattress. Review of the record of Resident 4 on 10/20/22 at 12:00 p.m., indicated the resident's diagnosis included, but were not limited, stage four pressure ulcer.	F 0686	**F686** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 4 Care Plans updated to include offloading heels and turning and repositioning, Resident 8 Cre Plan updated to include offloading heels and turning and repositioning and low air loss mattress was obtained Resident 14 Care Plan updated to include turning and repositioning, nurses educated on completing and signing out dressing change as ordered. Resident 33 nurses educated on	11/15/2022

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	The October 2022 physician recapitulation for Resident 4, indicated the resident was ordered cleanse with normal saline pat dry and paint with betadine daily. The Minimum Data Set (MDS) assessment for Resident 4, dated 10/14/22, indicated the resident was cognitively intact for daily decision making. The resident had no behaviors of refusing care. The required extensive assistance of one person for bed mobility and did not ambulate. The resident was at risk for pressure ulcers and had one stage four pressure ulcer. The October Treatment Administration Record (TAR) for Resident 4, indicated the resident did not receive a dressing change on 10/7/22, 10/15/22 and 10/16/22. The pressure ulcer risk assessment for Resident 4, dated 10/3/22, indicated the resident was at high risk of developing pressure ulcers. The wound center note for Resident 4, dated 10/6/22 and 10/20/22, indicated the resident was to ensure compliance with turning protocol and soft offloading heel boots. The care plan for Resident 4, dated 4/22/22, indicated the resident had altered skin integrity pressure ulcer related to acquired pressure ulcer to the left second toe. The pressure ulcer assessment for Resident 4, dated 10/20/22, indicated the resident had a stage four pressure ulcer (full thickness tissue loss) of the left second toe. During observation and interview on 10/20/22 at		completing and signing out dressing change as ordered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Residents with pressure ulcers have the potential to be affected by the alleged deficient practice An audit was completed on residents with pressure ulcers to assure appropriate interventions are in place, care plans updated, and treatments are signed when completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Nursing staff were educated on wound treatment management to include appropriate interventions and signing off on treatments when administered or completion of late entry. Audits will be completed on 4 residents weekly to ensure residents with pressure ulcers have interventions in place, care plan is updated, and treatments are documented timely x 4weeks than 3 residents weekly x 4 weeks than 2 residents weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	3:44 p.m., Resident 4 heels not floated, there was a blue pad under her calves, but the resident's heels continued to lay flat on the bed. The resident indicated sometimes the staff did float her heels with a pillow and/or heel protector boots but not always. During an observation on 10/21/22 at 12:01 p.m., Resident 4 was asleep in bed, the resident's heels were flat on the bed. During an observation on 10/24/22 at 11:20 a.m., Resident 4 laying in bed heels floated. 2.) During an observation on 10/19/22 at 1:58 p.m., Resident 8 was laying in bed with heels flat on the mattress. The resident did not have a low air loss mattress. During observation and interview on 10/20/22 at 3:51 p.m., Resident 8 heels were not floated. The resident indicated staff never floated her heels on pillow or apply heel protector boots. The resident indicated her pressure ulcer was almost healed. The resident indicated she had always had a regular mattress. The resident indicated it would not bother her to float her heels in bed, staff just did not do it. During an observation on 10/21/22 at 11:50 a.m., Resident 8 was laying in bed talking on the phone. The resident's heels were flat on the bed. Review of the record of Resident 8 on 10/21/22 at 11:00 a.m., indicated the resident's diagnoses included, but were not limited to, muscle wasting and atrophy, chronic kidney disease and muscle weakness.		**assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis	

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	The pressure ulcer risk assessment for Resident 8, dated 10/2/22, indicated the resident was at moderate risk to develop pressure ulcers. The physician recapitulation for Resident 8, dated October 2022, indicated the resident was ordered to float Heels as tolerated while in bed. The MDS assessment for Resident 8, dated 10/14/22, indicated the resident was cognitively intact for daily decision making and did not have any behaviors of rejection of care. The resident was at risk for developing a pressure ulcer and had one stage three pressure ulcer. The wound center evaluation for Resident 8, dated 10/20/22, indicated the resident had a stage three pressure ulcer on the coccyx. The resident was to have a turning protocol and speciality mattress. The pressure ulcer assessment for Resident 8, dated 10/20/22, indicated the resident had a stage three (full thickness loss) on her coccyx. During an observation and interview with Resident 8 on 10/24/22 at 11:00 a.m., Resident in bed heels not floated flat on bed. Resident indicated she did not want to get up today. Resident was on a regular mattress. During an interview with the Wound care Nurse Practitioner on 10/24/22 at 12:08 p.m., indicated Resident 8 should have a low air loss mattress due to having a stage three on her coxxyx. During an observation on 10/24/22 at 3:00 p.m., LPN 2 Unit manager provided pressure ulcer treatment for Resident 8. The resident was on a regular mattress, heels not floated. LPN 2			

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	indicated it was the responsibility of the CNA's to ensure resident's heels were floated when they turned and repositioned the resident. 3). The clinical record for Resident 14 was reviewed on 10/20/22 at 3:13 p.m. The diagnoses included, but was not limited to, cerebral palsy, muscle weakness, dysphagia, and difficulty in walking. A Quarterly Minimum Data Set (MDS) assessment, dated 10/20/22, noted Resident 14 needing extensive assistance with 2 staff for bed mobility and transfers along with extensive assistance with 1 staff for locomotion on and off of unit. A physician order, dated 9/8/22, was noted to apply calcium alginate to the left buttock, cover with bordered gauze, and change daily. A physician order, dated 10/3/22, was noted to apply calcium alginate to the right buttock, cover with bordered gauze, and change daily. A care plan, revised 6/1/22, indicated Resident 14 was at risk for pressure ulcer development due to assistance required with bed mobility. Interventions were to have bilateral bed canes to assist with bed mobility. A care plan, revised 6/1/22, indicated Resident 14 was at risk for skin breakdown and intervention listed to turn and reposition on a schedule. A care plan for pressure ulcers, dated 8/22/22, indicated Resident 14 had acquired pressure ulcers to left buttocks. Intervention was to apply treatments as ordered. An observation conducted on 10/20/22 at 11:47			

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	a.m., of Resident 14 up in his recliner sitting upright. An observation conducted on 10/20/22 at 2:01 p.m., of Resident 14 up in his recliner sitting upright. An observation conducted on 10/20/22 at 3:45 p.m., of Resident 14 up in his recliner sitting upright. Resident B did not have his position changed throughout these observations. The electronic treatment administration records (ETARs) for October of 2022 was reviewed and noted the following holes for the order to the right buttock: 10/4/22, 10/6/22, 10/9/22, 10/10/22, 10/11/22, 10/13/22, 10/14/22, 10/16/22, & 10/17/22. The ETAR for October of 2022 was reviewed and noted the following holes for the order to the left buttock: 10/4/22, 10/8/22, & 10/11/22. 4). The clinical record for Resident 33 was reviewed on 10/19/22 at 1:48 p.m. The diagnoses included, but was not limited to, muscle weakness,			

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	diabetes mellitus, malnutrition, and pressure ulcer of sacral region. A care plan for pressure ulcers, revised 8/17/22, noted the intervention to apply treatments as ordered. A physician order, dated 10/7/22, was noted to pack Resident 33's coccyx with Dakins gauze, cover with a foam dressing, and change daily. A physician order, dated 6/29/22, was noted to apply a hydrocolloid dressing to Resident 33's right ischium every Monday, Wednesday, and Friday. The ETAR for October of 2022 was reviewed and noted the following holes for the order to the coccyx: 10/4/22, 10/7/22, 10/8/22, & 10/11/22. The ETAR for October of 2022 was reviewed and noted the following holes for the order to the right ischium: 10/3/22, 10/7/22, 10/10/22, 10/12/22, 10/14/22, & 10/17/22. An interview conducted with Nurse Consultant on 10/25/22 at 2:40 p.m., indicated we have noticed a concern with agency staff, in particular, about not signing off treatments on the ETAR.			

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	A policy titled "Wound Treatment Management", undated, was provided by Nurse Consultant on 10/24/22 at 3:45 p.m. The policy indicated the following, "...1. Wound treatments will be provided in accordance with physician orders...7. Treatments will be documented on the Treatment Administration Record...." 3.1-40(a)(2)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident was safely assisted with locomotion while up in wheelchair for a resident observed leaning forward numerous times resulting in resident (Resident 30) falling forward and requiring sutures and failed to ensure fall interventions were implemented for Resident 54 for 2 of 3 residents reviewed for accidents. Findings include: 1. The clinical record for Resident 30 was reviewed on 10/20/22 at 3:04 p.m. The diagnoses included, but were not limited to, anxiety disorder, muscle weakness, pain, osteoarthritis, and history of	F 0689	**F689** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 30 had foot pedals put on wheelchair Resident 54 bed was lowered closer to floor **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents with history of falls have the potential to be affected	11/15/2022

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	transient ischemic attack. An Admission Minimum Data Set (MDS) assessment, dated 8/9/22, noted Resident 30 with needing extensive assistance with one staff for transfers, locomotion on and off of unit, and marked "no" for the use of a wheelchair but "yes" for a walker. An at risk for falls care plan, revised 10/21/22, indicated the following interventions: - Assess the wheelchair is of appropriate size; assess need for footrests, initiated on 8/3/22. - Education to staff and therapy staff wheelchair pedals (sic), initiated on 9/30/22. - Foot pedals to wheelchair when staff propelling wheelchair. Foot pedals not necessary when resident is propelling herself with supervision, initiated on 9/30/22 and revised on 10/21/22. A Physical Therapy Evaluation, dated 8/3/22, indicated the following, "...Musculoskeletal System Assessment...RLE [right lower extremity] Strength...Impaired...LLE [left lower extremity] Strength...Impaired...Test/Sit Balance...Functional Reach - Forward Direction = 4 inches (predictive of falls)...." A Physical Therapy Progress Report, dated 8/30/22 to 9/12/22, indicated under the Functional Skills Assessment that Resident 30 was supervision with or touching assistance when using the wheelchair with 50 feet and partial/moderate assistance when using the wheelchair with 150 feet or greater. A post fall evaluation, dated 9/29/22, indicated the following, "...9/29/2022 11:02..propel in w/c [wheel chair] by therapy...Reason for fall...res [resident]		by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** ="" p="">
Nursing staff will be educated on implementing care planned fall interventions Audits will be completed on 4 randomly selected residents on various shifts weekly x 4 weeks to assure fall interventions are in place than 3 residents on various shifts x 4 weeks than 2 residents on various shifts x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis	

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	put feet down on floor and fell out of w/c...Injury Details...laceration to nose and head...ER Visit/Hospitalization /Details...res [resident] received sutures...Fall Details Note...Resident was propelling self with therapy assistance, resident started to lean forward when therapy was trying to help resident with positioning she leaned forward and put feet on the floor causing her to fall forward hitting her head on the floor...Conclusion Note...Resident needs to ensure that foot pedals are on wheelchair when locomotion occurs in hallways...." An IDT (Interdisciplinary Team) Fall document, dated 10/2/22, indicated the following, "...Resident was propelling to therapy with therapist as they were assisting resident then fell forward out of wheelchair hitting her head on the floor and causing laceration...What is the Root Cause of the fall...Resident was leaning forward while propelling herself per norm [normal] along with being assisted by therapist then resident fell forward to hit head. Therapist was attempting to intervene and help resident with positioning when she fell forward...What immediate interventions were put into place in response to the fall...New intervention of w/c [wheelchair] foot pedals put in place when resident is locomoting with assistance...." An interview conducted with Licensed Practical Nurse (LPN) 4, on 10/21/22 at 2:40 p.m., indicated she was working the day that Resident 30 fell forward from her wheelchair. She recalled Therapy Staff 3 assisting Resident 30 in her wheelchair. Resident 30 has these tendencies to where if she doesn't want to do something she will either tell you she doesn't want to do it or she will, in this case, lean forward in her wheelchair. LPN 4 recalled Therapy Staff 3 having to stop at least			

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	155120	A. BUILDING 00 B. WING	10/25/2022

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	twice in the hallway to assist Resident 30 to sit upright in her wheelchair and move her back due to her leaning forward. LPN 4 was at the nurses' station charting and then heard a "thud" and had seen Resident 30 lying face down on the floor with her legs underneath her wheelchair. Resident 30 ended up going out to the hospital to have sutures placed. Resident 30 was able to propel herself in the wheelchair, but she didn't really utilize her feet. She would utilize her hands to propel the wheel chair and she was capable of going long distances. An interview conducted with Therapy Staff 3, on 10/24/22 at 2:27 p.m., indicated he was assisting Resident 30 with locomotion down the hallway. They were headed for group therapy at that time. Resident 30 was leaning forward a little bit. He would verbally redirect or touch her shoulder to instruct her to move her wheelchair if needed. He would ask Resident 30 to sit back up when she leaned forward, and she was able to sit back up but not completely straight. Therapy Staff 3 was not used to working with Resident 30 and was not familiar with her baseline. Resident 30 would bend her knees and brought her feet under her wheelchair to pull herself forward. Therapy Staff 3 was assisting Resident 30 a little and letting her guide the motion. When Resident 30 was propelling herself forward she would plant her feet on the floor to move herself forward. Resident 30 was leaning forward throughout the transport. It didn't appear that Resident 30 had foot pedals in place so she could propel the wheelchair. An interview conducted with Physical Therapist on 10/21/22 at 12:56 p.m., indicated Resident 30 was being propelled by therapy staff to go to group therapy from what he understood. Resident 30 had poor eyesight and that was part of the			

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	reason to make her supervision within 50 feet and partial/moderate assistance when 150 feet or greater with her wheelchair mobility. She got COVID-19 and had the incident of falling out of her wheelchair and that's why we have foot pedals on her wheelchair now. If a resident can propel themselves, we try not to place foot pedals on their chairs due to safety. An in-service attendance sheet, dated 9/30/22, indicated the following, "...ALL RESIDENTS MUST BE TRANSPORTED WITH FOOTPEDALS REGARDLESS OF ABILITY TO SELF PROPEL WHEN STAFF IS TRANSPORTING FOR SAFETY AND TO PREVENT INJURIES...." An interview conducted with Nurse Consultant on 10/25/22 at 2:40 p.m. indicated when the staff physically transport resident, they are to have foot pedals in place as part of the in-service. 2.) During an observation on 10/18/22 at 2:32 p.m., Resident 54 was laying in bed, the resident's bed in was in a high position. During an observation on 10/20/22 at 3:40 p.m., Resident 54 was laying in bed, the resident's bed was in the high position. During an observation on 10/21/22 at 1:35 p.m., Resident 54 was sitting in bed, the resident's bed was in the high position. Review of the record of Resident 54 on 10/21/22 at 1:55 p.m., indicated the resident's diagnoses included, but were not limited to, displaced interchanteric fracture of left femur, congestive heart failure, osteoarthritis, dementia, anxiety, depression, adult failure to thrive and muscle weakness.			

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	The plan of care for Resident 54, dated 6/2/22, indicated the resident was at risk for falls due to new environment, medication and poor safety awareness. The intervention included, but were not limited to, low bed when in bed (10/10/22). The fall evaluation for Resident 54, dated 10/9/22 at 4:00 a.m., the resident had a history of falls. The resident was heard yelling for help. The resident found on the floor next to bed on her bottom. The resident was confused and unable to recall the reason for trying to get out of bed. The immediate intervention was to lower the bed to the floor. The fall evaluation for Resident 54, dated 10/15/22 at 5:00 p.m., indicated the resident fell attempting to get out of bed. The resident acquired bruising on the lower back and buttocks. The environmental cause was the bed was too high, leading to a worse fall. The fall risk assessment for Resident 54, dated 10/15/22, indicated the resident was at risk for falls. During an observation on 10/24/22 at 11:10 a.m., Resident 59 was laying in bed, the resident' bed was in high position. During an observation on 10/24/22 at 11:35 a.m., Resident 59 was laying in bed, the resident' bed was in high position. During an observation and interview on 10/24/22 at 2:25 p.m., Resident 59 was in bed with a hospital gown, her bed was in high position. LPN 1 indicated she was unsure why the resident;s bed was in the high position and put the resident's bed significantly lower position.			

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	A policy titled "Accidents and Supervision", undated, was provided by the Executive Director on 10/24/22 at 9:25 a.m. The policy indicated the following, "...Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes...1. Identifying hazard(s) and risk(s)...2. Evaluating and analyzing hazard(s) and risk(s)...3. Implementing interventions to reduce hazard(s) and risk(s)...5. Supervision-Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision...b. Based on the individual resident's assessed needs and identified hazards in the resident environment...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment			

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	and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to ensure a gastrostomy tube (g-tube) flush rate was consistent with physician orders for 1 of 1 resident reviewed for g-tubes. (Resident 11) Findings include: The clinical record for Resident 11 was reviewed 10/20/22 at 2:50 p.m. The diagnoses included, but were not limited to, hemiplegia, dysphagia, gastrostomy status, and nutritional deficiency. A physician order, dated 8/15/22, indicated Osomolite 1.2 at 80 milliliters (mLs) an hour along with water flushes at 25 mLs an hour to be administered through Resident 11's g-tube. A physician order, dated 7/8/22, indicated to provide water flushes at 25 mLs an hour while the g-tube feeding is infusing. The following observations were conducted to where Resident 11 was connected to his g-tube feeding pump. The settings to the pump read 80 mL per hour g-tube feeding and 75 mL per hour water flush instead of the 25 mL an hour per physician orders: 10/19/22 at 2:14 p.m., 10/20/22 at 2:05 p.m., 10/20/22 at 3:44 p.m., & 10/21/22 at 9:05 a.m.	F 0693	**F693** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 11 G-tube flush orders were clarified, and G tube flush was changed to 35ml hour while feeding infusing as ordered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All resident with orders for G tube flushes have the potential to be affected by the alleged deficient practice. An audit was completed on all residents with orders for G tube flushes to assure the orders matched what the resident was receiving. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Nurses were educated on flushing a G tube to include verifying the orders match the flush infusion rate. Audits will be completed on 4 residents weekly to ensure flush	11/15/2022

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	A care plan for Resident 11's feeding tube, revised 8/2/22, indicated to provide water flushes as ordered. An interview conducted with Nurse Consultant, on 10/25/22 at 2:40 p.m., indicated the milliliters set to the feeding pump should match the physician orders. A policy titled "Flushing a Feeding Tube", undated, was provided by the Executive Director on 10/24/22 at 9:25 a.m. The policy indicated to verify physician orders for tube feeding flush amount. 3.1-44(a)(2)		orders match infusion rate of flush x 4weeks than 3 residents weekly x 4 weeks than 2 residents weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure the utilization of normal saline or sterile water during suctioning of a tracheostomy (Resident 78) for 1 of 1 resident reviewed for tracheostomy status, failed to have oxygen tubing dated, and orders in place for	F 0695	**F695** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Res 78 orders updated to include	11/15/2022

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	oxygen for 2 of 3 residents (Residents 30 and 52) reviewed for oxygen therapy. Findings include: 1. The clinical record for Resident 30 was reviewed on 10/20/22 at 2:52 p.m. The diagnoses included, but was not limited to, anxiety disorder, muscle weakness, and history of COVID-19. An Admission Minimum Data Set (MDS) assessment, dated 8/9/22, indicated Resident 30 was not on oxygen therapy. An observation conducted, on 10/18/22 at 2:37 p.m., of Resident 30 up in wheelchair with oxygen in place and on 1 liter. The oxygen tubing was not labeled or dated. There was no bag observed. An observation conducted on 10/19/22 at 11:06 a.m., of Resident 30 lying in bed with oxygen in place. No date or label was noted on the oxygen tubing. There was no bag observed. An observation conducted on 10/19/22 at 2:19 p.m., of Resident 30 lying in bed with oxygen in place. No date or label was noted on the oxygen tubing. There was no bag observed. An observation conducted on 10/20/22 at 11:46 a.m., of Resident 30 lying in bed with oxygen in place. No date or label was noted on the oxygen tubing. There was no bag observed. An observation conducted on 10/20/22 at 3:47 p.m., of Resident 30's oxygen tubing with the date of "10/20". The date "10/20" was noted on the humidification bottle as well. A physician order, dated 10/20/22, was noted for 3		use of normal saline or sterile water during tracheostomy suctioning. Res 30 and 52 oxygen tubing was changed and dated, and orders were added for oxygen use. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents with tracheostomies and oxygen therapy have the potential to be affected by the alleged deficient practice. An audit was completed of all residents with tracheostomies and orders were updated to include the use of normal saline or sterile water for suctioning. All residents receiving oxygen therapy were audited and any found with oxygen tubing not changed and dated were corrected and any found without orders had orders added. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Nurses were educated on tracheostomy care to include the use of normal saline or sterile water when suctioning as well as assuring residents with oxygen had orders in place. Nursing staff were educated on oxygen therapy to include changing the tubing weekly and	

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	liters of oxygen via nasal cannula continuous. There were no previous orders for oxygen in Resident 30's clinical record. A respiratory care plan, initiated 10/20/22, indicated Resident 30 having an alteration in respiratory status due to impaired gas exchange. The intervention listed was to administer oxygen as ordered. 2. The clinical record for Resident 52 was reviewed on 10/20/22 at 2:25 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, congestive heart failure, and muscle weakness. A physician order, dated 12/27/20, noted the use of oxygen at 3 liters via nasal cannula. A care plan for respiratory status, revised 10/17/22, indicated to administer oxygen as needed per physician orders, An observation conducted, on 10/18/22 at 2:30 p.m., of Resident 52's room. Her oxygen tubing was observed hanging from the concentrator with the nose prongs making contact with the floor. There was no bag with a date nor a date on the oxygen tubing. An observation conducted, on 10/19/22 at 9:18 a.m., of Resident 52's oxygen tubing hanging from the concentrator with the nose prongs making contact with the floor. There was no bag with a date nor a date of the oxygen tubing. The same was observed on 10/19/22 at 11:05 a.m. An observation conducted, on 10/20/22 at 11:47 a.m., of Resident 52's oxygen tubing. There was a		dating the tubing. Audits will be completed on 4 residents weekly to ensure tracheostomies are suctioned correctly to include the use of sterile water or normal saline x 4weeks than 3 residents weekly x 4 weeks than 2 residents weekly x 4 months. Audits will be completed on 4 residents weekly to ensure residents with oxygen therapy have orders in place and tubing is changed and dated weekly x 4weeks than 3 residents weekly x 4 weeks than 2 residents weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis	

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	date of "10/20" noted on the oxygen tubing. A policy titled "Oxygen Administration", undated, was provided by the Executive Director on 10/24/22 at 9:25 a.m. The policy indicated the following, "...1. Oxygen is administered under orders of a physician, except in the case of an emergency...4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders...5.b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated...." 3. Resident E's record was reviewed on 10/20/22 at 11:38 a.m. and indicated diagnoses that included, but were not limited to, traumatic brain bleeding, respiratory failure, tracheostomy, and cognitive communication deficit.. An Annual Minimum Data Set (MDS) assessment, dated 3/18/22, indicated Resident E was severely impaired in cognitive skills for daily decision making, received oxygen and had a tracheostomy. A Quarterly MDS, dated 9/16/22, indicated he was severely impaired in cognitive skills for daily decision making, had a gastrostomy tube, received oxygen and had a tracheostomy. On 10/24/22 at 11:05 a.m., Resident E was observed as he received tracheostomy care. LPN 2 suctioned the resident and cleansed around his tracheostomy and under his oxygen mask. LPN 2 used sterile technique to open the sterile tracheostomy suctioning supplies, then picked up a half cup of water that sat on the bedside stand and suctioned the water through the suction catheter before and after she placed the suction catheter into the tracheostomy tube. She suctioned the resident twice. Then he was			

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	transferred from bed to a specialty reclining chair with assistance of LPN 2, CNA 7, and QMA 6 and a mechanical lift. On 10/24/22, at 12:22 p.m., LPN 2 said she used warm water that she had brought in the room before, to flush his gastrostomy and she didn't know she was going to need to do trach care and suction him. Physician's orders for tracheostomy included, but were not limited to: Trach suctioning as needed & monitor skin for signs of irritation or infection. Notify MD for complications as needed and dated 5/26/2021. A Policy for "Tracheostomy Care-Suctioning" was provided by the Resource Nurse on 10/24/22 at 4:20 p.m. The policy included, but was not limited to, "Policy: The facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Tracheal suctioning is performed by a licensed nurse to clear the throat and upper respiratory tract of secretions that may block the airway. Procedure: 1. Gather equipment and set up, attach suction tubing to canister...6. Open the bottle of normal saline solution or sterile water. 7. Using sterile technique, open the suction catheter kit and put on the sterile gloves. Consider the glove on your dominant hand sterile, and the non-dominant hand clean. 8. Using non-dominant (clean) hand, pour the normal saline solution into the disposable sterile solution container...." 3.1-47(a)(4)			

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	3.1-47(a)(5) 3.1-47(a)(6)			
F 0842 SS=E 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 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			

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	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. §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 interview and record review, the facility failed to document vital signs with the accurate time obtained (Resident 94) and failed to ensure completion of the electronic medication administration record (EMAR) and electronic treatment administration record (ETAR) for 4	F 0842	**F842** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Res 94 no longer resides in the	11/15/2022

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	155120	A. BUILDING 00 B. WING	10/25/2022

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	residents (Resident 11, 14, 33, and 293). This affected 5 of 30 residents reviewed for complete and accurate records. Findings include: 1. The clinical record for Resident 94 was reviewed on 10/24/2022 at 3:25 p.m. The medical diagnoses included, but were not limited to, heart failure and atrial fibrillation. A nursing progress note, dated 9/27/2022 at 4:23 p.m., indicated that Resident 94's respiration had ceased, and the physician was notified to call the death. A burial transit permit for Resident 94 indicated the date of death on 9/27/2022 and the time of death as 4:23 p.m. Vital signs for Resident 94 were recorded at 5:55 p.m. indicated he had a blood pressure of 68/45, temperature of 89 degrees Fahrenheit, heart rate of 79 beats per minute, and respirations of 22 breaths per minutes. An interview with Resource Nurse on 10/25/2022 at 11:43 a.m. indicated that the nurse had forgotten to late entry the vital signs resulting in a documentation error. 2. The clinical record for Resident 293 was reviewed on 10/19/22 at 3:30 p.m. The diagnoses included, but were not limited to, rectal abscess, malignant neoplasm of rectum, and muscle weakness. A physician order, dated 10/6/22, was noted to pack wound to left buttock with Dakins soaked gauze, cover with an abdominal pad, and secure with tape daily.		facility Residents 11,14,33 had no ill effects from the alleged deficient practice and resident 293 no longer resides at the center. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents have the potential to be affected by from the alleged deficient practice. Nurse and QMAS were educated on Documentation in the medical record to include documentation at the time of assessment of vital signs, administration of medication and treatments and entering a late entry. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Audits will be completed on 4 residents weekly to ensure vital signs, medication and treatments are documented timely x 4weeks than 3 residents weekly x 4 weeks than 2 residents weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6	

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	The ETAR for October of 2022 was reviewed and noted the following holes: 10/7/22, 10/9/22, 10/10/22, 10/12/22, & 10/15/22. 3. The clinical record for Resident 33 was reviewed on 10/19/22 at 1:48 p.m. The diagnoses included, but was not limited to, muscle weakness, diabetes mellitus, malnutrition, and pressure ulcer of sacral region. The EMAR for October of 2022 was reviewed. The document consisted of 23 pages with 19 physician orders. There were 15 holes in total in the EMAR. The ETAR for October of 2022 was reviewed. A physician order, dated 9/22/22, was noted for a treatment to Resident 33's left medial foot. From 10/1/22 to 10/20/22 there were 12 holes in the ETAR. A physician order, dated 6/29/22, was noted to float Resident 33's heels twice daily. From 10/1/22 to 10/20/22 there were 14 holes in the ETAR. A physician order, dated 6/30/22, was noted for Foley catheter care every shift for Resident 33. From 10/1/22 to 10/20/22 there were 16 holes in the ETAR. 4. The clinical record for Resident 11 was reviewed 10/20/22 at 2:50 p.m. The diagnoses included, but were not limited to, hemiplegia, dysphagia, gastrostomy status, and nutritional deficiency.		months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis	

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	The EMAR for October of 2022 was reviewed for Resident 11. A physician order, dated 8/10/22, noted to apply a drainage sponge to their gastrostomy (g-tube) tube site twice daily. There were 5 holes in the EMAR from 10/1/22 to 10/20/22. A physician order, dated 7/11/22, noted to check placement of the g-tube prior to medication administration every shift. From 10/1/22 to 10/20/22 there were 7 holes in the EMAR. A physician order, dated 7/11/22, noted to check residual to Resident 11's g-tube every shift. From 10/1/22 to 10/20/22 there were 7 holes in the EMAR. A physician order, dated 7/8/22, noted for 100 milliliters water flush via g-tube every 8 hours for gentle hydration. From 10/1/22 to 10/20/22 there were 7 holes in the EMAR. 5. The clinical record for Resident 14 was reviewed on 10/20/22 at 3:13 p.m. The diagnoses included, but was not limited to, cerebral palsy, muscle weakness, dysphagia, and difficulty in walking. The EMAR for October of 2022 was reviewed. A physician order, dated 3/17/22, was noted for buspirone 7.5 milligrams daily. There were 4 holes in the EMAR from 10/1/22 to 10/21/22. A physician order, dated 2/20/22, was noted for Zyrtec 10 milligrams daily. There were 4 holes in the EMAR from 10/1/22 to 10/21/22. A physician order, dated 2/15/22, was noted to			

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	apply Fluocinonide Solution 0.05% to scalp twice daily. There were 5 holes in the EMAR from 10/1/22 to 10/20/22. A physician order, dated 9/20/22, was noted for Norco tablet 5-325 milligrams every 8 hours. There were 7 holes in the EMAR from 10/1/22 to 10/20/22. An interview conducted with Nurse Consultant on 10/25/22 at 2:40 p.m. indicated they are in the process to get consistency with staff to ensure completion of the EMARs and ETARs. A policy titled "Documentation in Medical Record", undated, was provided by the Executive Director on 10/24/22 at 9:25 a.m. The policy indicated the following, "...2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred...3. Principles of documentation include, but are not limited to...b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care...c. Documentation shall be timely and in chronological order...." 3.1-50(a)(1) 3.1-50(a)(2)			