| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155834 | A. BUILDING 00<br>B. WING | 06/28/2024 |

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| BRICKYARD HEALTHCARE - WILLOW SPRINGS CARE CENTEI | 2002 WEST 86TH STREET<br>INDIANAPOLIS, IN 46260 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00433369.<br><br>Complaint IN00433369 - No deficiencies related to the allegations are cited.<br><br>Survey dates: June 24, 25, 26, 27 and 28, 2024.<br><br>Facility number: 013738<br>Provider number: 155834<br>AIM number: 100272170<br><br>Census Bed Type:<br>SNF/NF: 54<br>Total: 54<br><br>Census Payor Type:<br>Medicare: 2<br>Medicaid: 38<br>Other: 14<br>Total: 54<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review was completed on July 8, 2024. | F 0000 | | |
| F 0557<br>SS=D<br>Bldg. 00 | 483.10(e)(2)<br>Respect, Dignity/Right to have Prsnl Property<br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do | | | |

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

Sonia Patel | Executive Director | 07/21/2024

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| | so would infringe upon the rights or health and safety of other residents.<br>Based on observation, interview and record review, the facility failed to ensure residents were dressed in their own clothing instead of hospital gowns and to ensure the residents' clothing were located or replaced for 2 of 3 residents reviewed for resident rights. (Resident 46 and 42)<br><br>Findings include:<br><br>1. During an observation and interview, on 6/25/24 at 10:50 a.m., Resident 46 was sitting up in his bed and was wearing a hospital gown. He indicated the only clothing he had now was the hospital gowns. He did not put his name on his clothes, and they were missing from laundry.<br><br>During an interview, on 6/25/24 at 4:07 p.m., the Social Services Designee (SSD) indicated she was not aware the resident was wearing hospital gowns.<br><br>The clinical record for Resident 46 was reviewed on 6/26/24 at 1:28 a.m. The diagnoses included, but were not limited to, cerebral infarction due to occlusion or stenosis of small arteries, generalized muscle weakness, generalized anxiety disorder, and major depressive disorder.<br><br>A personal inventory list for Resident 46, dated 5/20/24, indicated the resident had two pairs of blue sweatpants, one yellow shirt, one pair of navy-blue shorts and one pair of gray shorts. The inventory list was not in the electronic health record (EHR) and the Clinical Support Nurse indicated the form was in the Medical Records room and had not been scanned into the EHR yet.<br><br>The personal inventory list showed the resident | F 0557 | Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits the Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.<br>We would like to respectfully request a desk review.<br><br>The facility does ensure that residents receive their personal items back from Laundry Services.<br>Personal items for Resident 46 were returned to the resident, and additional personal items were provided by the facility. Personal items for Resident 42 were returned to the resident.<br>All residents have the potential to be affected.<br>Admissions Director educated on completion of inventory sheets upon admission. All new admission will be provided a brochure on Laundry Services. An audit of all residents was conducted to ensure all personal | 07/26/2024 |

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| | had clothes at admission.<br><br>During an observation, on 6/26/24 at 10:26 a.m., Resident 46 was wearing a yellow shirt and blue pants and was standing next to the window in his room.<br><br>During an observation, on 6/27/24 at 2:09 p.m., Resident 46 was propelling himself in his wheelchair in the hallway and was wearing a white t-shirt and green plaid pants.<br><br>During an interview, on 6/26/24 at 10:24 a.m., the SSD indicated the resident's clothes were in the laundry and they had not been labeled yet.<br><br>During an interview, on 6/27/24 at 2:12 p.m., the Director of Nursing (DON) indicated the facility had clothes which did not belong to any resident, and they were able to use those clothes for Resident 46. The resident did not have clothes for a long time and wore hospital gowns until someone finally brought the resident clothes. The resident did not have a care plan to wear hospital gowns.<br><br>During an interview, on 6/27/24 at 4:31 p.m., the Executive Director (ED) indicated the resident's clothes were labeled when he arrived at the facility and the labels fell off. The SSD went to the laundry and found the resident's clothes. Today, he was wearing clothing which was not on his inventory list. They were able to find clothes in his size today.2. During an observation, on 6/26/28 at 11:00 a.m., the resident was sitting in his wheelchair wearing shorts and a hospital gown. The resident indicated he did not have any clean shirts because his new shirts had been missing for at least 3 weeks. He indicated he really wanted his shirts back because they were all wicking fabric | | belongings have been returned from Laundry Services. Any missing items were addressed accordingly.<br><br>Admission Director or designee will audit 2 residents daily x5 days for 4 weeks to ensure all personal belongings have been returned from Laundry Services. Admissions Director or designee will then audit 2 residents daily x3 days for 4 weeks. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. | |

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| | rather than cotton.<br><br>The clinical record for Resident 42 was reviewed on 6/26/24 at 11:18 a.m. The diagnoses included, but were not limited to, anoxic brain damage, stage 4 pressure ulcer of sacral region, diabetes mellitus with diabetic neuropathy, muscle weakness, old myocardial infarction, mild cognitive impairment, history of other mental and behavioral disorders, and vascular disorder of intestine with colostomy.<br><br>There was no inventory sheet in the electronic medical record.<br><br>An undated inventory sheet, provided by Clinical Support Nurse on 6/28/24 at 8:15 a.m., indicated the resident had 8 shirts, 8 shorts, and 5 pairs of socks.<br><br>A second inventory sheet, dated 6/27/27, provided by Clinical Support Nurse on 6/28/24 at 8:15 a.m., indicated the resident currently had 7 shirts, 1 pair of shorts, and 2 pairs of socks.<br><br>During an interview, on 6/26/24 at 11:06 a.m., the resident indicated his clothing was labeled with his name on admission and many items were missing for about 3 weeks. He received one shirt back on Friday. His mother had started doing his laundry to try to decrease the missing items. He had to wear a hospital gown whenever he did not have clean clothes, and he preferred his own clothes because he only liked wicking material because he was frequently hot in the facility.<br><br>During an interview, on 6/27/24 at 1:24 p.m., the resident's mother indicated a staff member from laundry took the clothing she had brought in for him on admission, on 5/30/24, to label the items with the facility's labels. All the clothing already | | | |

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| | had his name on it when they went down to the laundry. Most of his shirts had been missing since shortly after admission. She had gone down to laundry with staff to look for the items, on 6/17/24, but did not find anything. She had inquired again about the clothing on 6/21/24 and was told she would need to bring in receipts to show what she had spent on the items.<br><br>During an interview, on 6/28/24 at 11:47 a.m., the Executive Director (ED) and Clinical Support Nurse indicated all but 2 shirts had been found on 6/27/24, and a new inventory sheet had been completed. The facility would be reimbursing the mother for the remaining missing items.<br><br>A current policy, titled "Resident Personal Belongings," not dated and received from the Clinical Support Nurse on 6/28/24 at 12:25 p.m., indicated "...It is the policy of this facility to protect the resident's rights to possess personal belongings such as clothing and furnishings for their use while in the facility and assure the personal belongings and/or possessions are rightfully returned to the resident, or to the resident's representative in the event of the resident's death or discharge from the facility...All resident possessions, regardless of their apparent value to others, will be treated with respect...The facility will support the resident's right to retain and use personal possessions to promote a homelike environment and maintain their independence...All resident personal items will be inventoried at the time of admission by the social services designee, or another designated staff member and documentation shall be maintained in the medical record...Additional possessions brought in during the duration of the individual's stay shall be added to the existing personal belongings inventory listing...The facility will | | | |

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| | ensure resident belongings are kept in a neat and orderly fashion and maintained in each resident's room...The facility will exercise reasonable care for the protections of the resident's property from loss or theft...."<br><br>3.1-3(t)<br>3.1-3(v)(1) | | | |
| F 0578 SS=D Bldg. 00 | 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. | | | |

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| | (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>Based on interview and record review, the facility failed to ensure a resident's code status was reviewed and updated after returning from an inpatient hospitalization for 1 of 4 residents reviewed for advanced directives. (Resident 39)<br><br>Finding includes:<br><br>The clinical record for Resident 39 was reviewed on 6/26/24 at 10:43 a.m. The diagnoses included, but were not limited to, muscle atrophy, type 2 diabetes mellitus, diabetic polyneuropathy, depressive disorder, bipolar disorder, generalized anxiety disorder, and agoraphobia with panic disorder.<br><br>A hospital discharge summary, dated 3/12/24, indicated the resident was a full code.<br><br>A POST (Physician Orders for Scope of Treatment) form, dated 4/4/23, indicated the resident was a no code.<br><br>The resident's face sheet showed the resident was a full code | F 0578 | The facility does ensure residents' code status is reviewed and updated upon admission.<br>The advanced directive for Resident 39 was immediately updated in the electronic health record and the resident's care plan.<br>All residents have the potential to be affected.<br>All licensed staff were educated on the Advanced Directives policy to include all admissions/readmission should have code status verified and order input upon admission. An audit of all residents was conducted to ensure the current advance directive is reflected in the electronic health record and care plan. Any negative findings were corrected immediately.<br>For a period of 60 days, Director of Nursing or designee will audit all admissions/readmission to determine if the advance directive | 07/26/2024 |

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| | During an interview, on 6/26/24 at 10:55 a.m., the Director of Nursing (DON) indicated the resident was listed as a full code when she returned from the inpatient hospitalization. The electronic health record did not include information if the resident's code status and POST form were reviewed when the resident returned from the hospitalization. The resident was interviewed and wanted to be a no code as the POST form on 4/4/23 had indicated.<br><br>A current policy, titled "Residents' Rights Regarding Treatment and Advance Directives," not dated and received from the Clinical Support Nurse on 6/28/24 at 4:56 p.m., indicated "...It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive...'Advance directive' is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law...relating to the provision of health care when the individual is incapacitated...On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive...During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives...."<br><br>3.1-4(f)(4)(A)(ii)<br>3.1-4(f)(5) | | is reflected correctly in the electronic health record and the care plan. Then the Director of Nursing or designee will audit 2 admissions each week for 4 weeks. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. | |
| F 0623<br>SS=D<br>Bldg. 00 | 483.15(c)(3)-(6)(8)<br>Notice Requirements Before Transfer/Discharge<br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a | | | |

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| | resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days. | | | |

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| | §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the | | | |

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| | facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>Based on interview and record review, the facility failed to notify the ombudsman when a resident was hospitalized and discharged for 1 of 3 residents reviewed for hospitalization. (Resident 254)<br><br>Finding includes:<br><br>The clinical record for Resident 254 was reviewed on 6/25/24 at 2:44 p.m. The diagnoses included, but were not limited to, respiratory failure with hypoxia (absence of enough oxygen to sustain bodily functions), unstageable pressure ulcer of sacral region, anxiety disorder, depression, bradycardia (slow heart rate), and anemia.<br><br>A nursing progress note, dated 6/14/24 at 5:58 a.m., indicated the resident was transferred to the hospital. The Nurse Practitioner (NP) and the Director of Nursing (DON) were notified.<br><br>The electronic medical record did not include notification or indicate a copy of the notice was sent to the Office of the State Long-Term Care | F 0623 | The facility does notify the Ombudsman of all transfers and discharges.<br><br>The Ombudsman was notified of the transfer of Resident 254.<br><br>All residents that are transferred/discharged can be affected.<br><br>Social Services Director educated on transfer/discharge requirements including notification of the Ombudsman. An audit was conducted of all residents that were transferred/discharged from the facility in the last 60 days to ensure the Ombudsman was notified of each transfer/discharge. | 07/26/2024 |

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| | Ombudsman at the time of the transfer to the hospital or later when the resident was discharged.<br><br>During an interview, on 6/28/24 at 11:52 a.m., the Clinical Support Nurse indicated the facility had provided all the transfer and discharge paperwork and no notice to the ombudsman was found or provided.<br><br>A current policy, titled "Transfer and Discharge (Including AMA) Policy," not dated and received from the Clinical Support Nurse on 6/27/24 at 2:20 p.m., indicated "...will provide copies of notices for emergency transfers to the Ombudsman...In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility will send a notice of discharge to the resident and must also send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman...."<br><br>3.1-12(a)(6)(A)(iv) | | Social Services or designee will audit all transfers/discharges monthly to ensure notification of Ombudsman monthly for 6 months. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.<br><br>="" p=""><br>="" p=""> | |
| F 0625 SS=D Bldg. 00 | 483.15(d)(1)(2)<br>Notice of Bed Hold Policy Before/Upon Trnsfr<br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; | | | |

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| | (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br>Based on interview and record review, the facility failed to provide the facility's bed hold policy to 2 of 3 residents reviewed for discharge. (Residents 254 and 154)<br><br>Findings include:<br><br>1. The clinical record for Resident 254 was reviewed on 6/25/24 at 2:44 p.m. The diagnoses included, but were not limited to, respiratory failure with hypoxia (absence of enough oxygen to sustain bodily functions), unstageable pressure ulcer of sacral region, anxiety disorder, depression, bradycardia (slow heart rate), and anemia.<br><br>A nursing progress note, dated 6/14/24 at 5:58 a.m., indicated the resident was transferred to the hospital. The Nurse Practitioner (NP) and the Director of Nursing (DON) were notified.<br><br>The electronic medical record did not include the facility's bed hold policy was provided to the | F 0625 | The facility does provide the facility's bed hold policy to residents who discharge.<br><br>Residents 154 and 254 were provided a copy of the bed hold policy.<br><br>All residents who transfer/discharge from the facility have the potential to be affected.<br><br>Licensed staff educated on the bed hold policy. An audit was conducted of all residents that were transferred/discharged in the last 30 days to ensure a copy of the bed hold policy was provided. | 07/26/2024 |

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| | resident or resident's representative at the time of the transfer to the hospital or later when the resident was discharged.<br><br>During an interview, on 6/28/24 at 11:52 a.m., Clinical Support Nurse indicated the facility had provided all the transfer and discharge paperwork, and a facility bed hold policy was not found in the paperwork or provided to the resident.2. The clinical record for Resident 154 was reviewed on 6/25/24 at 4:01 p.m. The diagnoses included, but were not limited to, dementia unspecified severity without behavioral disturbance, mood disturbance and anxiety, atherosclerosis of the native arteries of the left leg with ulceration of heel and mid foot, type 2 diabetes with foot ulcer and circulatory complications, dysphagia, morbid severe obesity due to excess calories, and pneumonia.<br><br>A progress note, dated 6/7/2024 at 11:01 a.m., indicated the resident was noted to have coffee ground emesis and bowel movement. The resident was sent to the local emergency room for further evaluation.<br><br>A hospital note, dated 6/17/24, indicated the resident had bilateral pneumonia and was treated and returned to the facility.<br><br>The electronic medical record did not include the facility's bed hold policy was provided to the resident or resident's representative at the time of the transfer to the hospital.<br><br>During an interview, on 6/28/24, the Clinical Support Nurse indicated there were no transfer documents or bed hold policy found in the electronic health record. A facility bed hold policy was not found in the paperwork or provided to the resident. | | DNS or designee will audit discharges ensure a copy of the bed hold policy is provided and documented in the electronic health record. These audits will be conducted daily x 5 days for 4 weeks, then daily x 3 days for 4 weeks, then daily x 2 days for 4 weeks. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.<br><br>="" p=""><br>="" p=""> | |

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| | A current policy, titled "Transfer and Discharge (including AMA)," not dated and received from the Clinical Support Nurse on 6/27/24 at 2:20 p.m., indicated "...emergency transfers or discharges...initiated by the facility or medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified)...obtain physicians' orders for emergency transfer or discharge is necessary on an emergency basis...the original copies of the transfer form and Advanced Directives accompany the resident...copies are retained in the medical record...provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated...the social services director, or designee, will provide copies of notices for emergency transfers to Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, long as the list meets all the requirements for content of such notices...."<br><br>3.1-12(a)(25(A)<br>3.1-12(a)(25(B) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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.<br>Based on interview and record review, the facility | F 0684 | The facility does obtain routine | 07/26/2024 |

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| | failed to ensure routine blood sugars for an insulin dependent diabetic were obtained for 1 of 2 residents reviewed for quality of care. (Resident 260)<br><br>Findings include:<br><br>During an interview, on 6/28/24 at 8:48 a.m., Resident 260 indicated her glucose monitoring system sensor had not been in place for over a week and no staff had been checking her blood sugar. The resident indicated she had been trying to watch what she ate since she did not know what her blood sugar was running.<br><br>The clinical record for Resident 260 was reviewed on 6/26/24 at 12:41 p.m. The diagnoses included, but were not limited to, periprosthetic fracture around the internal prosthetic right hip joint, stage 4 pressure ulcer of sacral region, and type 2 diabetes mellitus.<br><br>Physician's orders, dated 6/7/24, included, but were not limited to, the following:<br>a. To apply a Freestyle Libre 2 Reader Device (Continuous Blood Glucose System Receiver) sensor to the upper extremity topically on the day shift every 14 days and as needed for diabetic monitoring, and to call the provider for a blood sugar less than 60 and greater than 400.<br>b. Lantus Solostar Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine), inject 12 units subcutaneously at bedtime.<br>c. Metformin (a medication for diabetes) HCl 500 mg, 1 tablet by mouth two times a day.<br><br>A vitals record, dated 6/1/24 through 6/27/24, indicated the resident had a blood sugar of 139 on 6/8/2024 at 12:14 p.m., and 181 on 6/22/2024 at 3:57 p.m. | | blood sugars for insulin dependent diabetics.<br><br>Blood sugar orders updated for Resident 260.<br><br>All insulin dependent diabetics have the potential to be affected.<br><br>Licensed staff educated on insulin administration and blood sugar. An audit of all insulin dependent diabetic residents conducted to ensure blood sugar orders in place.<br><br>DNS or designee will audit insulin dependent diabetic admissions daily x 5 days for 4 weeks, then daily x 3 days for 4 weeks to ensure blood sugar orders are in place. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. | |

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| | There were no other blood sugars documented in the electronic medical record.<br><br>During an interview, on 6/28/24 at 11:09 a.m., LPN 12 (Unit Manager for the 200 hall) indicated she was calling the pharmacy to check on obtaining a sensor for the resident. She was unaware it had been over a week since the resident had a sensor in place and the staff should have assessed her blood sugar with the facility glucometer in the meantime. Routine glucose monitoring was typical for residents on insulin and blood sugars should be recorded in the electronic medical record.<br><br>During an interview, on 6/28/24 at 11:50 a.m., the Clinical Support Nurse indicated she could only find 2 blood sugars recorded for the resident for the month of June. There was no order for routine glucose checks or to use the glucometer when the sensor was unavailable. She indicated there was no documentation of the physician being notified of the sensor being unavailable or the lack of glucose monitoring orders for the resident while on daily insulin with a stage 4 pressure ulcer.<br><br>A current policy, titled "Continuous Glucose Monitors," not dated and received from the Clinical Support Nurse on 6/28/24 at 8:15 a.m., indicated "...Continuous glucose monitor values will be recorded as part of daily vital signs...An adequate supply of CGM sensors/transmitters will be kept on hand for a resident with physician orders. CGM sensors/transmitters will be reordered and stored...."<br><br>3.1-37(a) | | | |
| F 0691 SS=D | 483.25(f)<br>Colostomy, Urostomy, or Ileostomy Care | | | |

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| Bldg. 00 | §483.25(f) Colostomy, urostomy,, or ileostomy care.<br>The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.<br>Based on observation, interview, and record review, the facility failed to address the incontinence care of a resident with a colostomy in a timely manner for 1 of 1 resident reviewed for colostomy care. (Resident 42)<br><br>Finding includes:<br><br>During an observation, on 6/25/24 at 11:35 a.m., Resident 42 returned from therapy where his colostomy bag had ruptured. The resident was in his wheelchair with a foul smelling, stool-stained shirt. Licensed Practical Nurse (LPN) 8 came into his room and acknowledged the resident's need for a colostomy bag and clothing change, his discomfort, and his need to get back into bed. LPN 8 indicated she would be back as soon as the Certified Nursing Assistant (CNA) was available. The resident indicated to please hurry because he was very uncomfortable with the bowel movement on his abdomen.<br><br>During an observation, on 6/25/24 at 11:45 a.m., the resident pushed his call light and called out for help. He indicated the smell was bothering him, he was very uncomfortable, and indicated again to please hurry. LPN 8 was at the computer in the nurses' station. CNA 9 was with Resident 30 with the door closed.<br><br>During an observation, on 6/25/24 at 12:02 p.m., CNA 9 got on the elevator to go to laundry to get | F 0691 | The facility does ensure timely incontinence care for residents with colostomies.<br><br>Colostomy care was provided to Resident 42.<br><br>All residents with colostomies have the potential to be affected.<br><br>Licensed staff educated on colostomy care. All staff educated on call light timeliness. Interviews conducted with all residents with colostomies to ensure timeliness of care.<br><br>DNS or designee will randomly audit colostomy bag fullness daily x 5 days for 4 weeks, then daily x 3 days for 4 weeks. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. | 07/26/2024 |

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| | clothes for Resident 30. She did not indicate she was aware of Resident 42's situation, or the LPN needed her assistance.<br><br>During an observation, on 6/25/24 at 12:07 p.m., Resident 42 continued to loudly call out for help and indicated he could not wait any longer. LPN 8 went back into the room and indicated the CNA was still with another resident. LPN 8 returned to the nurse's station. The resident continued to yell for help, express his discomfort, and for staff to hurry up until 12:17 p.m., when CNA 9 entered his room with the Hoyer lift (mechanical lift device).<br><br>The clinical record for Resident 42 was reviewed on 6/26/24 at 11:18 a.m. The diagnoses included, but were not limited to, anoxic brain damage, stage 4 pressure ulcer of sacral region, diabetes mellitus with diabetic neuropathy, muscle weakness, old myocardial infarction, mild cognitive impairment, history of other mental and behavioral disorders, and vascular disorder of intestine with colostomy.<br><br>A Minimum Data Set (MDS) assessment, dated 6/7/24, indicated the resident was dependent for transfers, toileting hygiene, and dressing.<br><br>A physician's order, dated 5/30/24, indicated to change the colostomy bag every 3 days and as needed (PRN).<br><br>A physician's order, dated 5/30/24, indicated ileostomy care every shift and PRN.<br><br>A care plan, dated 5/31/24 and revised on 6/14/24, indicated the interventions were to observe the ostomy bag for leakage or a broken seal, to provide ostomy care daily and PRN, toileting assistance of extensive assist of 1-2 as needed, transfers with a total assist of 2 staff utilizing | | | |

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| | mechanical lift, and to provide thorough skin care after incontinent episodes.<br><br>During an interview, on 6/25/24 at 11:25 a.m., Resident 42 indicated the staff were often too busy and could not get to him quickly since there were usually only 2 staff on the floor.<br><br>During an interview, on 6/28/24 at 11:18 a.m., CNA 9 indicated the resident required the assistance of 2 staff members with the Hoyer lift for all transfers. She indicated if they really needed extra help on the unit there were always other staff they could call from the other unit.<br><br>The facility indicated they did not have a bladder program and/or incontinence program policy they could provide.<br><br>3.1-47(a)(3) | | | |
| F 0695<br>SS=D<br>Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>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.<br>Based on observation, record review and interview, the facility failed to ensure a resident received the ordered oxygen flow and the portable oxygen tank contained oxygen for 1 of 2 residents reviewed for respiratory care. (Resident 10) | F 0695 | The facility does ensure residents receive oxygen at the ordered oxygen flow and does ensure the portable oxygen tank is filled. | 07/26/2024 |

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| | Finding includes:<br><br>During an observation, on 6/24/24 at 2:46 p.m., the resident was sitting in her wheelchair in her room with her nasal cannula attached to a portable tank. The tank was empty.<br><br>During an observation, on 6/27/24 at 10:36 a.m., the resident was resting in bed and watching tv. The oxygen tubing was off the resident and on the floor.<br><br>The clinical record for Resident 10 was reviewed on 6/26/24 at 9:59 a.m. The diagnoses included, but were not limited to, heart failure, atrial septal defect (heart defect) cardiomegaly, hypertension (high blood pressure), chronic respiratory failure with hypoxia, pulmonary embolism (blood clot) without acute cor-pulmonale, chronic pain, and TIA (trans ischemic attack).<br><br>A physician's order, dated 5/14/24, indicated continuous oxygen at 2 liters per nasal cannula. Call the physician if the oxygen saturations were below 90%.<br><br>During an interview, on 6/24/24 at 2:46 p.m., CNA 10 indicated the resident's portable tank was empty and she was to receive 1.5 liters per nasal cannula.<br><br>During an interview, on 6/27/24 at 10:37 a.m., Nurse 7 indicated she had not noticed the oxygen was off on the resident when she was in the room.<br><br>A current policy, titled "Oxygen Administration," dated 2024 and received from the Clinical Support Nurse on 6/27/24 at 11:00 a.m., indicated "...oxygen is administered under orders of a physician, except in the case of emergency...in | | Resident 10's portable oxygen tank was filled and set to the correct liter flow.<br><br>All residents who receive oxygen have the potential to be affected.<br><br>Licensed staff educated on oxygen administration. An audit was conducted of all residents with oxygen orders to ensure the concentrator is set to the correct oxygen flow and the portable oxygen tank is filled and set to the correct oxygen flow.<br><br>DNS or designee will randomly oxygen concentrator for oxygen flow rate and portable oxygen tanks for fullness and oxygen flow rate daily x 5 days for 4 weeks, then daily x 3 days for 4 weeks. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. | |

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| | such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control...."<br><br>3.1-47(a)(6) | | | |
| F 0700<br>SS=D<br>Bldg. 00 | 483.25(n)(1)-(4)<br>Bedrails<br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>Based on observation, interview and record review, the facility failed to ensure side rail assessments and consents were completed prior to the use of side rails for 2 of 2 residents reviewed for accident hazards. (Resident 46 and 22)<br><br>Findings include: | F 0700 | The facility does ensure bed rail assessments and consents are completed prior to using them.<br><br>Resident 46 and Resident 22 no longer reside at the facility. | 07/26/2024 |

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| BRICKYARD HEALTHCARE - WILLOW SPRINGS CARE CENTEI | 2002 WEST 86TH STREET<br>INDIANAPOLIS, IN 46260 |

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| | 1. During an observation, on 6/25/24 at 10:38 a.m., Resident 46 was sitting up in his bed and indicated he did not use the two upper quarter side rails which were in the raised position.<br><br>The clinical record for Resident 46 was reviewed on 6/26/24 at 10:28 a.m. The diagnoses included, but were not limited to, generalized anxiety disorder, major depressive disorder, and cerebral infarction due to an occlusion or stenosis of small arteries.<br><br>The physician's orders did not include an order for side rails.<br><br>The electronic health record did not include a side rail assessment or consent.<br><br>During an interview, on 6/28/24 at 11:35 a.m., the Clinical Support Nurse indicated there was no side rail consent or assessment for Resident 46 because he was not supposed to have side rails. She thought maybe the staff switched beds and sometimes the Certified Nursing Assistants (CNAs) would put the residents in a different bed although she was not sure what happened. 2. During an observation, on 6/26/24 at 9:39 a.m., Resident 22 was lying in bed with a quarter upper side rail on both sides of the bed in the raised position.<br><br>During an observation, on 6/27/24 at 1:59 p.m., the resident was lying in bed with both upper side rails in the raised position.<br><br>The clinical record for Resident 22 was reviewed on 6/26/24 at 9:18 a.m. The diagnoses included, but were not limited to, fracture of left femur with routine healing, difficulty in walking, unsteadiness on feet, lack of coordination, unspecified fall, | | All residents who require bedrails have the potential to be affected.<br><br>All staff educated on the bed rail policy. An audit was conducted of all residents with bed rails to ensure there is a completed assessment and consent form on file.<br><br>DNS or designee will new admissions who need bedrails daily x 5 days for 4 weeks, then daily x 3 days for 4 weeks to ensure assessments and consents are completed. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. | |

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| | chronic peripheral venous insufficiency, history of traumatic brain injury, asthma, dementia with anxiety, depression, and aggression, and nontraumatic chronic subdural hemorrhage.<br><br>A care plan, initiated on 6/13/24 and revised on 6/23/24, did not include side rails.<br><br>The electronic medical record did not include a physician's order or consent for side rails.<br><br>During an interview, on 6/28/24 at 11:45 a.m., the Clinical Support Nurse indicated the facility did not have a signed consent or an order for the bed rails and they were unable to provide a copy.<br><br>A current policy, titled "Proper Use of Bed Rails," not dated and received by the Clinical Support Nurse on 6/28/24 at 12:57 p.m., indicated "...It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails...As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meets those needs...Informed consent from the resident or resident representative must be obtained...Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail...."<br><br>3.1-45(a)(1) | | | |
| F 0756<br>SS=D<br>Bldg. 00 | 483.45(c)(1)(2)(4)(5)<br>Drug Regimen Review, Report Irregular, Act On<br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. | | | |

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| | §483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>Based on interview and record review, the facility failed to ensure a clinical rationale was provided | F 0756 | The facility does ensure a clinical rationale is provided when a | 07/26/2024 |

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| | for a decline of a gradual dose reduction of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 37)<br><br>Finding includes:<br><br>The clinical record for Resident 37 was reviewed on 6/25/24 at 3:45 p.m. The diagnoses included, but were not limited to, malignant neoplasm of prostate, type 2 diabetes with other diabetic kidney complications, dysphagia, dementia in other diseases with anxiety and behavioral disturbances, bilateral osteoarthritis of the hip, and depression.<br><br>A physician's order, dated 12/5/23, indicated Seroquel (quetiapine) (an antipsychotic medication) 25 mg (milligrams) twice daily.<br><br>A pharmacist report provided to the Medical Director and DON (Director of Nursing), dated 6/4/24, indicated a dose reduction of quetiapine was recommended. There were 2 choices to complete for the provider to decline or to agree with the dose reduction. If the reduction was declined due to contraindication the clinical rationale was to be provided. A handwritten note on the right side of the form indicated contraindicated per nurse practitioner. There was no clinical rationale for the contraindication.<br><br>There were no progress notes with clinical rationale to support the contraindication of the dosage reduction.<br><br>During an interview, on 6/28/24 at 3:04 p.m., the Clinical Support Nurse indicated there was no clinical rationale to support the contraindication of the dosage reduction. | | gradual dose reduction is declined.<br><br>A clinical rationale was provided for the declined gradual dose reductio for Resident 37.<br><br>Director of Nursing and Social Services educated on gradual dose reductions and clinical rationale. An audit of GDR recommendations for the last 60 days was conducted to ensure clinical rationale was provided for each declination.<br><br>DNS will audit all GDR recommendations monthly to ensure that clinical rationale is provided. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.<br>="" p=""> | |

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| | A current policy, titled "Use of Psychotropic Medication," not dated and received from the Clinical Support Nurse on 6/28/24 on 3:10 p.m., indicated "...Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs...."<br><br>3.1-48(b)(2) | | | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. | | | |

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| | Based on observation, interview and record review, the facility failed to ensure medications were labeled with an open date, to ensure medication labels were legible, to dispose of expired medications, and to return or dispose of medications after a resident discharged for 3 of 3 medication carts reviewed for medication storage and labeling. (second and third floor carts)<br><br>Findings include:<br><br>1. During an observation, on 6/26/24 at 8:35 a.m., with the Director of Nursing present, one second floor medication cart was found to have an open bottle of amantadine (a medication used for Parkinson's disease) 50 milligrams/milliliter. The bottle had approximately 75 milliliters (ml) of 200 ml left in the bottle. The Director of Nursing was observed to write an open date on the bottle at the time, she dated the bottle as opened 6/1/24.<br><br>An open bottle of Nystatin (an antifungal) 100000 units was found open without an open date. There was approximately 95 ml of 100 ml left in the bottle.<br><br>During an interview, on 6/26/24 at 8:35 a.m., the Director of Nursing indicated liquid medications should be dated when they are opened.<br><br>2. During an observation, on 6/26/24 at 8:52 a.m., with LPN 5 in attendance, the third-floor north cart was found to have a 100 ml bottle of diazepam. The bottle had been opened and was found without a date when it was opened. The bottle contained approximately 70 ml of 100 ml left in the bottle. The label was found to be illegible. Upon receipt of a copy of the label, the facility had blackened out the name of the resident. The resident was discharged from the facility on | F 0761 | The facility does ensure medications are labeled with an open date, medication labels are legible, the destruction of expired medications, and removal of medications for discharged residents.<br><br>All unlabeled and expired medication was destroyed immediately.<br><br>All residents have the potential to be affected.<br><br>All licensed staff educated on proper storage of medication and disposal/destruction of expired medication or medication for discharged residents.<br><br>For four weeks, Director of Nursing or designee will audit each medication cart weekly x 4 weeks to ensure all medication is stored properly and expired medication or medication of discharged residents is properly disposed. Then for the next 4 weeks, Director of Nursing or designee will audit 1 medication cart weekly. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. | 07/26/2024 |

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| | 5/29/24.<br><br>During an interview, on 6/26/24 at 8:52 a.m., LPN 5 indicated the bottle should have been labeled with an open date.<br><br>3. During an observation, on 6/26/24 at 8:59 a.m., with LPN 4, the third-floor west medication cart was found to have at 160 ml bottle of Tussin (a cough medication) opened and without an open date. The bottle had close to 138 ml remaining.<br><br>A 30 ml bottle of morphine sulfate (a narcotic) was found open with approximately 30 ml remaining in the bottle. The manufacturers expiration date was 1/14/24.<br><br>A 30 ml bottle of morphine sulfate was found sealed and with a manufacturer's expiration date of 6/11/24.<br><br>During an interview, on 6/26/24 at 8:59 a.m., LPN 4 indicated open bottles should be labeled with an open date and the expired medications should have been removed from the medication cart.<br><br>A current facility policy, titled "Medication Storage," dated as revised in 2/24 and received from the Director of Nursing on 6/26/24 at 9:20 a.m., indicated "...discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy...."<br><br>3.1-25(j)<br>3.1-25(o)<br>3.1-25(p)<br>3.1-25(q)<br>3.1-25(r) | | | |

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| F 0791 SS=D Bldg. 00 | 483.55(b)(1)-(5)<br>Routine/Emergency Dental Srvcs in NFs<br>§483.55 Dental Services<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(b) Nursing Facilities.<br>The facility-<br><br>§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:<br>(i) Routine dental services (to the extent covered under the State plan); and<br>(ii) Emergency dental services;<br><br>§483.55(b)(2) Must, if necessary or if requested, assist the resident-<br>(i) In making appointments; and<br>(ii) By arranging for transportation to and from the dental services locations;<br><br>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;<br><br>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and | | | |

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| | §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.<br>Based on interview and record review, the facility failed to follow up with dental recommendations for oral hygiene and the resident's request to obtain dentures for 1 of 4 residents reviewed for dental services. (Resident 39)<br><br>Finding includes:<br><br>During an interview, on 6/25/24 at 11:01 a.m., Resident 39 indicated she was on the list to get her teeth done. She had broken teeth and did not know what the dental plan included. She wanted to get her teeth pulled and have dentures held in place by a few dental implants.<br><br>The clinical record for Resident 39 was reviewed on 6/26/24 at 10:43 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, depressive disorder, agoraphobia, and diabetic polyneuropathy.<br><br>A dental note, dated 5/21/24, indicated the resident was missing 19 teeth, had one fractured tooth with an abscess and had two teeth with mobility. The resident had poor oral hygiene and needed assistance to brush her teeth twice daily. The resident wanted a full mouth extraction and dentures retained by implants. The dentist advised against a full mouth extraction. The resident was adamant she wanted dentures. The dentist spoke with the Social Services Designee (SSD) at check out. The plan was routine exams and to have 3 hygiene visits in the next 6 months without the dentist present. | F 0791 | The facility does follow up with dental recommendations for oral hygiene.<br><br>The care plan and Kardex were updated to reflect dental recommendations for Resident 39.<br><br>All residents have the potential to be affected.<br><br>Director of Nursing and Social Services educated on dental services policy. An audit was conducted to review all dental recommendations for the last 60 days to ensure all recommendations are in place.<br><br>DNS or designee will review dental recommendations monthly to ensure all recommendations are in place. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. | 07/26/2024 |

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A physician's note, dated 5/24/24, indicated the resident had right jaw and ear pain during chewing. The resident indicated the pain was better when not chewing. The resident had gingivitis and dental caries. The dental caries affected most of the teeth on the lower jaw and was worse on the right side.

A care plan, dated 4/14/24 and last revised on 6/19/24, indicated the resident had a physical functioning deficit related to mobility impairment and self-care impairment related to muscle weakness. The interventions included, but were not limited to, oral care assistance as needed and dental exams as necessary.

The care plans did not include the resident's need to have assistance with brushing her teeth twice daily and the request for her to have her teeth extracted. The care plans did not include the resident's pain while chewing and the dental caries.

There were no social services notes to document the findings or the recommendations from the dental appointment on 5/21/24.

During an interview, on 6/26/24 at 11:16 a.m., the SSD indicated she was not aware of the dentist not wanting to pull the resident's teeth. She did not look at the dental notes after the visits and the notes went to the medical record department. The medical records staff would follow up with dental recommendations and upload the notes to the electronic health record.

During an interview, on 6/26/24 at 2:58 p.m., the Clinical Support Nurse indicated the SSD should follow up after the dental appointments for any

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| | recommendations.<br><br>During an interview, on 6/26/24 at 2:59 p.m., the Director of Nursing (DON) indicated if she had known the resident wanted her teeth pulled, she would have made sure the resident had a dental appointment. There was no care plan in place for the missing teeth, fractured teeth and need to have assistance with brushing her teeth twice daily due to the poor oral hygiene.<br><br>A current policy, titled "Dental Services," not dated and received from the Clinical Support Nurse on 6/27/24 at 11:55 a.m., indicated "...It is the policy of this facility to assist residents in obtaining routine...and emergency dental care...'Routine dental services' means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings...minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures...taking dental impressions for dentures and fitting dentures...The dental needs of each resident are identified through the physical assessment and MDS assessment processes, and are addressed in each resident's plan of care...Oral/dental status shall be documented according to assessment findings...Oral and denture care shall be provided in accordance with identified needs and as specified in the plan of care...The Social Services Director maintains contact information for providers of dental services that are available to facility residents at a nominal cost...The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location...All actions and information regarding dental services, including any delays related to | | | |

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| | obtaining dental services, will be documented in the resident's medical record...."<br><br>3.1-24(a)<br>3.1-24(b) | | | |
| F 0812 SS=D Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, interview and record review, the facility failed to ensure refrigerator temperatures were monitored and remained below 41 degrees Fahrenheit for 2 of 3 refrigerators in the kitchen.<br><br>Finding includes:<br><br>During an observation, on 6/24/24 at 11:09 a.m., | F 0812 | The facility does ensure refrigerator temperatures are monitored and below 41°.<br><br>The refrigerator was serviced, and the temperature log was updated accordingly.<br><br>All residents have the potential to | 07/26/2024 |

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| | the temperature in the refrigerator across from the walk-in refrigerator had a temperature of 48 degrees Fahrenheit. A refrigerator across from the dishwasher area had no internal thermometer and the inside temperature was warm to touch. The refrigerator was storing drinks.<br><br>The temperature logs on the refrigerators indicated missing temperatures on 6/19/24, 6/20/24, 6/21/24, 6/22/24, 6/23/24, and 6/24/24.<br><br>During an interview, on 6/26/24 at 10:16 a.m., the Dietary Manager and Dietitian indicated the drinks were removed from the refrigerator. The refrigerator was having issues. A pan under the unit was collecting a clear fluid.<br><br>A current policy, titled "Food Safety Requirements," dated 2024 and received from the Clinical Support Nurse on 6/27/24 at 11:53 a.m., indicated "...facility staff shall inspect all food, food product and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage...foods that require refrigeration shall be refrigerated immediately upon receipt or placed in the freezer, whichever is applicable...practices to maintain safe refrigerated storage include: monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation...."<br><br>3.1-21(i)(3) | | be affected.<br><br>Dietary staff educated on food safety and temperature logs. An audit was conducted to ensure all thermometers are in place, functioning properly and temperatures are logged accurately.<br><br>ED or designee will audit temperature logs daily x 5 days for 4 weeks to ensure accuracy and completion. ED or designee will then audit temperature logs daily x 3 days for 4 weeks to ensure accuracy and completion. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. | |
| F 0842<br>SS=D<br>Bldg. 00 | 483.20(f)(5), 483.70(i)(1)-(5)<br>Resident Records - Identifiable Information<br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is | | | |

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| | 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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records,<br>regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, | | | |

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| | destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. | | | |
| | Based on interview and record review, the facility failed to ensure documentation in the Medication and Treatment Administration Record (MAR/TAR) was accurate and correct for 2 of 2 residents reviewed for documentation. (Residents 6 and 45)<br><br>Findings include:<br><br>1. The clinical record for Resident 6 was reviewed on 6/26/24 at 3:24 p.m. The diagnoses included, but were not limited to, personal history of other mental and behavioral disorders, type 2 diabetes, psychotic disturbance, mood disturbance, and anxiety. | F 0842 | The facility does ensure documentation on the MAR/TAR is accurate.<br><br>The orders were updated for Resident 6. The documentation for Resident 45 was corrected.<br><br>All residents have the potential to be affected.<br><br>Licensed staff educated on documentation policy. MAR/TAR documentation has been reviewed for past 30 days to ensure completion | 07/26/2024 |

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| | A physician's order, initiated on 3/29/24, indicated to give 7 units of insulin and it should be given at the start of the nocturnal tube feeding.<br><br>A physician's order, initiated on 4/1/24, indicated to change the tube feeding administration every night shift.<br><br>A physician's order, initiated on 4/1/24, indicated to check residual (amount of food/nutrition formula left in the stomach) every shift.<br><br>A physician's order, initiated on 4/1/24, indicated to check the G-tube placement every day and night shift.<br><br>A physician's order, initiated on 4/4/24, indicated to flush the G-tube before and after enteral feeding (feeding through the G-tube) twice a day.<br><br>A progress note, dated 6/17/24 and documented by the Nurse Practitioner (NP) indicated the reason for the visit was G-tube dislodgement. The note indicated the resident reported the tube fell out.<br><br>The MAR indicated the above physician's orders related to the G-tube were signed off as completed from 6/18/24 through 6/24/24 when the resident no longer had a G-tube in place.<br><br>During an interview, on 6/24/24 at 8:37 a.m., LPN 7 indicated she signed off the MAR/TAR because she did not want to go against the MAR. It was brought to her attention on 6/24/24 and she was aware the G-tube had been pulled out.<br><br>During an interview, on 6/26/24 at 8:34 a.m., LPN 6 indicated she must have been moving too fast. The resident did not let anyone touch or see the | | DNS or designee will review MAR/TAR documentation for 10 residents daily x 5 days for 4 weeks, then 5 residents daily x 5 days for 4 weeks, then 5 residents daily x 3 days for 4 weeks. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. | |

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| | G-tube site. She indicated she did not think he had a G-tube anymore. She charted in error on the G-tube orders.<br><br>During an interview, on 6/26/24 at 8:50 a.m., LPN 5 indicated she was moving too fast, and the documentation was an error for all the G-tube entries. The resident did not have a G-tube presently. It had been dislodged.<br><br>During an interview, on 6/27/24 at 10:10 a.m., the NP indicated she did not discontinue the G-tube orders because she did not see them.<br><br>2. The clinical record for Resident 45 was reviewed on 6/24/24 at 11:57 a.m. The diagnoses included, but were not limited to, burns involving less the 10% of the body surface, skin transplant status, and personal history of physical injury and trauma.<br><br>A physician's order, initiated on 4/19/24, indicated to give two (2) Melatonin (a supplement to help with sleep) 3 milligrams (mg) tablets at bedtime for insomnia. There was no documentation of administration on 6/18/24.<br><br>A physician's order, initiated on 4/8/24, indicated to give Tamsulosin 0.4 mg for benign prostatic hyperplasia. The medication was scheduled to be administered at bedtime. There was no documentation of administration on 6/18/24.<br><br>A physician's order, initiated on 4/17/24, indicated to give Trazadone 150 mg for insomnia. The medication was scheduled to be administered at bedtime. There was no documentation of administration on 6/18/24.<br><br>A physician's order, initiated on 4/16/24, indicated | | | |

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| | to give two (2) acetaminophen (Tylenol) 500 mg for pain. The medication was scheduled to be administered at 8:00 p.m. There was no documentation of administration on 6/18/24.<br><br>A physician's order, initiated on 4/26/24, indicated to give oxycodone 10 mg three times a day. The medication was scheduled to be administered at 8:00 a.m., 3:00 p.m., and 10:00 p.m. There was no documentation of administration on 6/18/24 and 6/19/24 at 10:00 p.m.<br><br>During an interview, on 6/28/24 at 8:22 a.m., the Corporate Support Nurse indicated medication was to be documented after administration, unless an urgent issue came up, but it did need to be documented.<br><br>A facility policy, titled "Documentation in Medical Record," dated 2024 and received from the Corporate Support Nurse on 6/26/24 at 2:25 p.m., indicated "...Documentation shall be completed at the time of service, but no later than the shift in which the...care service occurred...False information shall not be documented...Documentation shall be timely...."<br><br>3.1-50(a)(2) | | | |
| F 0849<br>SS=D<br>Bldg. 00 | 483.70(o)(1)-(4)<br>Hospice Services<br>§483.70(o) Hospice services.<br>§483.70(o)(1) A long-term care (LTC) facility may do either of the following:<br>(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.<br>(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist | | | |

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| | the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.<br><br>§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:<br>(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.<br>(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:<br>(A) The services the hospice will provide.<br>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.<br>(C) The services the LTC facility will continue to provide based on each resident's plan of care.<br>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.<br>(E) A provision that the LTC facility immediately notifies the hospice about the following:<br>(1) A significant change in the resident's physical, mental, social, or emotional status.<br>(2) Clinical complications that suggest a | | | |

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| | need to alter the plan of care.<br>(3) A need to transfer the resident from the facility for any condition.<br>(4) The resident's death.<br>(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.<br>(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.<br>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.<br>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.<br>(J) A provision stating that the LTC facility must report all alleged violations involving | | | |

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| | mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.<br>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.<br><br>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.<br>The designated interdisciplinary team member is responsible for the following:<br>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.<br>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.<br>(iii) Ensuring that the LTC facility communicates with the hospice medical | | | |

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| | director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.<br>(iv) Obtaining the following information from the hospice:<br>(A) The most recent hospice plan of care specific to each patient.<br>(B) Hospice election form.<br>(C) Physician certification and recertification of the terminal illness specific to each patient.<br>(D) Names and contact information for hospice personnel involved in hospice care of each patient.<br>(E) Instructions on how to access the hospice's 24-hour on-call system.<br>(F) Hospice medication information specific to each patient.<br>(G) Hospice physician and attending physician (if any) orders specific to each patient.<br>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.<br><br>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.<br>Based on interview and record review, the facility | F 0849 | The facility does effectively | 07/26/2024 |

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| BRICKYARD HEALTHCARE - WILLOW SPRINGS CARE CENTEI | 2002 WEST 86TH STREET<br>INDIANAPOLIS, IN 46260 |

| (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 |
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| | failed to ensure staff effectively transcribed a pain medication ordered by the hospice provider and failed to communicate when the resident was found on the floor after a possible fall during end-of-life care for 1 of 1 resident reviewed for hospice. (Resident 53)<br><br>Finding includes:<br><br>The clinical record for Resident 53 was reviewed on 6/26/24 at 12:29 p.m. The diagnoses included, but were not limited to, malignant neoplasm of the esophagus, emphysema, anxiety disorder, and osteoarthritis.<br><br>A care plan, dated 4/5/24, indicated the resident was at risk for falls related to deconditioning and gait and balance problems associated with weakness related to the cancer process. The interventions included, but were not limited to, assessing for pain, assessing for medication side effects, keeping personal items available and in easy reach or provide a Reacher, and keep the environment well-lit and free of clutter.<br><br>A hospice order sheet, dated 4/5/24, indicated to give morphine concentrate 20 milligram(mg)/milliliter(ml) 15 mg every 6 hours as needed for pain.<br><br>A facility medication administration record (MAR), dated 4/5/24, indicated to give morphine concentrate solution 20 mg/ml, 15 mg by mouth every 2 hours as needed for pain.<br><br>The hospice orders and the facility orders for the morphine concentrate solution did not match. The resident had received 4 doses of the as needed morphine concentrate, on 4/7/24 between 4:46 a.m. and 3:20 p.m. This was a time span of 10 and a half | | transcribe orders for pain medication from hospice services.<br><br>Resident 53 no longer resides at the facility.<br><br>All residents receiving hospice services have the potential to be affected.<br><br>Licensed staff educated on hospice services and physician orders. An audit was conducted of all pain medication orders for hospice residents to ensure accuracy.<br><br>DNS or designee will audit all new hospice orders for accuracy. Audits will occur daily x 5 days for 4 weeks, then daily x3 days for 4 weeks. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.<br><br>="" p=""> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155834 | A. BUILDING 00<br>B. WING | 06/28/2024 |

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| | hours, and the resident should have only received 2 doses of the as needed morphine according to the hospice orders.<br><br>A hospice note, dated 4/7/24 at 3:07 p.m., indicated a visit was made to assess the resident. The resident was sitting in her bed and had oxygen at 3 liters per nasal cannula. Her respirations were 22 and labored. The physician was called to discuss the conflicting physician orders on the facility MAR and the hospice documentation. New orders for morphine concentrate and lorazepam were given to the facility. At the end of the visit, the resident was talking and smiling at the hospice nurse. The facility staff were informed to call the hospice with any questions or new symptoms.<br><br>A facility progress note, dated 4/7/24 at 9:30 p.m., indicated the resident was found deceased on the floor next to her bed at 8:50 p.m. Prior to passing, the resident had used the bed side commode with the Certified Nursing Assistant (CNA) and was trying to use her tablet.<br><br>The progress note did not include what position the resident was found on the floor and if this could have been a fall.<br><br>A hospice note, dated 4/7/24 at 9:11 p.m., indicated the facility nurse reported the resident had expired.<br><br>The hospice note did not include the facility found the resident on the floor.<br><br>During an interview, on 6/28/24 at 10:54 a.m., the hospice nurse indicated she did not recall the resident falling or being told the resident was on the floor. The hospice staff would do an | | | |

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| | assessment for a fall follow up if there was a suspected fall and a death visit.<br><br>During an interview, on 6/28/24 at 10:59 a.m., the hospice clinical manager indicated the hospice notes did show the morphine solution was ordered for 15 mg every 6 hours as needed. When the facility reported the resident's death on 4/7/24, they just reported the resident died and did not report the resident was on the floor.<br><br>During an interview, on 6/28/24 at 2:08 p.m., Licensed Practical Nurse (LPN) 8 indicated she worked the evening Resident 53 died. The resident was found during rounds and was on the floor next to her bed. She was lying on her back next to the bed. She had been on her tablet and looked like she slid out of the bed.<br><br>During an interview, on 6/28/24 at 3:56 p.m., the Clinical Support Nurse indicated the order for morphine 15 mg every 2 hours prn had been transcribed incorrectly and should have been morphine 15 mg every 6 hours as needed for pain according to the hospice notes.<br><br>A current policy, titled "Coordination of Hospice Services," not dated and received from the Clinical Support Nurse on 6/28/24 at 12:55 p.m., indicated "...When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental and psychosocial well-being...The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care...The facility and | | | |

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| | hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible...The hospice provider retains primary responsibility for the provision of hospice care and services that are necessary for the care of the resident's terminal illness and related conditions...The facility retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice...The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility...The plan of care will include directives for managing pain and other uncomfortable symptoms and will be revised and updated as necessary...The facility will monitor for medications and medical supplies to ensure they are provided by hospice as indicated in the plan of care for palliation and management of terminal illness...All residents receiving hospice will continue to receive the same facility services as residents who have not elected hospice. This includes but is not limited to the following...medication regimen review...."<br><br>3.1-37(a) | | | |