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	08/21/2024

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		F 0000		

This visit was for the Investigation of Complaints IN00439368 and IN00440821.

This visit was in conjunction with a PSR (Post Survey Revisit) to the Investigation of Complaint IN00437810 completed on July 16, 2024.

Complaint IN00439368 -- Federal/state deficiencies related to the allegations are cited at F584, F600, F610, and F684.

Complaint IN00440821 -- Federal/state deficiencies related to the allegations are cited at F600 and F610.

Survey dates: August 20 and 21, 2024

Facility number: 000050
Provider number: 155120
AIM number: 100266170

Census Bed Type:
SNF/NF: 91
Total: 91

Census Payor Type:
Medicare: 4
Medicaid: 70
Other: 17
Total: 91

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on August 29, 2024.

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

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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F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, interview, and record review, the facility failed to maintain a safe environment regarding use of an outside door for 1 of 3 residents reviewed for environmental hazards. (Resident G) Findings include: The clinical record for Resident G was reviewed on 8/21/24 at 10:58 a.m. The diagnoses included, but were not limited to, borderline personality disorder. An interview was conducted with Resident G on 8/20/24 at 1:45 p.m. He indicated there was a back door at the end of the hallway in the facility that led to the parking lot. The door had sharp edges that cut him several times when he used it. The maintenance staff put a metal piece around the edge of the door, but the piece broke down within months, so now they put duct tape over the broken-down areas on the edge of the door. The duct tape wore through "in no time," and had to be replaced every week or so. He felt they needed to replace the door, instead of continuing to put temporary fixes in place. He used the door numerous times a day to smoke or to spend time outside of the facility. He currently had two cuts, one within the last few days, and the other was within the last two weeks. Resident G informed nursing about his cuts, as they were the ones who supplied him with the band-aid currently covering one of the cuts. An observation of the two areas on Resident G's left forearm was made, on 8/20/24 at 1:45 p.m.,	F 0584	Outside door scheduled to be replaced. All other residents have the potential to be affected. All facility outside doors were audited to ensure the facility has a safe homelike environment. Ongoing audit to be completed by the Executive Director or designee to monitor outside doors. This audit to be completed 5X weekly X 4 weeks, 3 times weekly X 4 weeks, and weekly to completed 6 months. The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.	09/10/2024

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	during the above interview. One of the areas was scabbed in a linear pattern, the diameter of a quarter. The second area had similar attributes with a band-aid covering it, that Resident G partially removed, then reapplied, per his preference. The 8/19/24 nursing note indicated, "Resident came to desk and showed writer area top of left forearm that appears to be an old skin tear that opened up. Resident stated he bumped it on the door coming in from outside. Writer cleaned area with normal saline and applied a bandaid at this time. Resident denies pain at this time. Will continue to monitor." An observation of the above referenced outside door leading to the back parking lot was made with the ED (Executive Director) and Maintenance Supervisor (MS) on 8/21/24 at 11:08 a.m. The MS opened the door, so the edge of the door could be observed. There was a metal door edge protector covering the edge of the entire length of the door that wrapped approximately six inches around the front and back of the door. The door edge protector was held in place with two rows of screws running from the top of the door to the bottom of the door, evenly placed, on each side of the door edge protector. There was silver and red duct tape covering the width of the door edge protector near the handle/latch part of the door. There was a one-and-a-half-inch area on the metal door edge protector, near the handle/latch, where the duct tape had worn away, leaving the area with exposed, torn metal with rough edges. An interview was conducted with the MS, on 8/21/24 at 11:08 a.m., during the observation of the above referenced door. He indicated he put duct tape over the edge of the door two weeks ago. He			

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	parked in the back parking lot, so he was able to notice when it needed taped again. The metal door edge protector was placed sometime in the latter part of 2023, and it lasted a long time. The door edge protector was good until about a month ago, at which time, he started using duct tape. An interview was conducted with the ED, on 8/21/24 at 11:08 a.m., during the observation of the above referenced door. She indicated they had one company come out to look at the door and were waiting on a quote from another company. She started calling to get quotes this month. She was unaware there was a resident who cut his arm on the door. The Safe and Homelike Environment policy was provided by the Director of Nursing Services on 8/20/24 at 12:50 p.m. It indicated, "In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk....'Environment' refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas." This citation relates to Complaint IN00439368. 3.1-19(a)			
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect			

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	Based on interview, observation, and record review, the facility failed to prevent three events of resident-to-resident physical abuse perpetrated by Resident B for 3 of 5 resident reviewed for abuse. This deficient practice resulted in Resident D, Resident G, and Resident E being physically assaulted by Resident B and experiencing negative psychosocial outcomes. Findings include: The facility incident reports, dated from 7/8/2024 through 8/10/2024, indicated Resident B perpetrated resident-to-resident physical abuse on three events as follows: Event 1: 7/8/2024 indicated an event of resident-to-resident physical abuse perpetrated by Resident B occurred at 5:10 p.m. when Resident B was sitting in a wheelchair in the threshold of a staff member's door. The report indicated Resident D attempted to pass through the threshold, Resident B would not move, and Resident B "tapped" Resident D on the shoulder. Interventions for Resident B and Resident D were listed as: head-to-assessments, 15-minute checks, psychosocial follow up, reviewing of care plans, and updating care plans as needed. Event 2: 8/6/2024 indicated an event of resident-to-resident physical abuse occurred at 5:09 p.m., when Resident G attempted to get coffee in the dining room where Resident B was sitting in a wheelchair. Resident G asked Resident B to move multiple times then nudged Resident B's wheelchair. Resident B became agitated and "made contact with" Resident G's forearm with an "open hand." Interventions were listed as: immediately separating Resident B and Resident	F 0600	Resident B no longer resides in the community. All other residents have the potential to be affected. Education completed with all staff regarding the facility policy on Abuse, Neglect, and Exploitation. Audit of all residents to ensure residents feel free of Abuse, Neglect, and Exploitation. Ongoing audit to be completed by the Executive Director or designee to monitor that residents feel free of Abuse, Neglect and Exploitation. This audit to be completed 5X weekly X 4 weeks, 3 times weekly X 4 weeks, and weekly to completed 6 months. The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis. Reason for IDR: Facility has new information.	09/10/2024

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	G, Resident B was placed on "line of site for remainder", Resident G was placed on 15-minute checks, and care plans for Resident B and Resident G were reviewed and updated as needed. Event 3: 8/10/2024 indicated an event of resident-to-resident physical abuse perpetrated by Resident B occurred at 8/5/2024 at 1:30 a.m. Resident E indicated Resident B "made contact" with the right side of Resident E's head. Interventions were listed as: psychosocial support for Resident B and Resident E, Resident B was placed on 15-minute checks, and care plans for Resident B and Resident E reviewed and updated as needed. The follow up on the incident, dated 8/15/2024, indicated Resident B was transferred to a neuropsychological hospital for evaluation. 1. The clinical record for Resident B was reviewed on 8/20/2024 at 11:45 a.m. Medical diagnoses included bipolar disorder, intellectual disabilities, encephalopathy, and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 8/1/2024, indicated Resident B was severely cognitively impaired, exhibited physical and verbal abusive behaviors symptoms directed toward others, and rejected care during the assessment period. A behavior care plan, last revised 5/15/2024, indicated Resident B had a history of exhibiting aggressive behaviors such as hitting, grabbing, pinching and kicking. Intervention included: assist Resident B to not enter other's personal space, redirect away and engage in personal activities as well as providing a quiet environment.			

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	An admission consent, dated 1/22/2024, indicated Resident B's next of kin refused in-house psychiatric services. The progress notes, dated from 2/1/2024 through 7/7/2024 indicated Resident B demonstrated seven events of physically abusive behaviors directed towards others. A psychotherapy note, dated 7/3/2024, indicated Resident B had difficulty trusting male providers. Resident B was also exhibited difficulty concentrating, irritability, grief, and loss of independence. A nursing progress note, dated 7/8/2024, indicated Resident B was " ...in staff office door when another resident was attempting to back out of office. The other resident ask resident to back up so that he could leave the room. This resident tapped the other resident on the shoulder." The behavior care plan, last revised on 5/15/2024, indicated an intervention of 15-minute checks initiated on 7/8/2024. Review of the July treatment administration record for Resident B after indicated 15-minute checks were completed per the physician order from 7/8/2024 through 7/15/2024. A primary care provider note, dated 7/9/2024, indicated Resident B had bipolar disorder with listed interventions to monitor mood, "consult psych" [consult psychological services], currently undergoing and continue group therapy with psychotherapist and next of kin. A social service progress note, dated 7/10/2024, indicated Resident B had no "psychosocial			

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	distress." This note did not include any interventions or recommendations. The interdisciplinary progress notes, dated from 7/9/2024 through 8/6/2024, did not include documentation to indicate staff attempted to obtain a psychiatric consultation for Resident B, or psychiatric care was refused. A psychotherapy note, dated 7/16/2024, indicated a visit was made with Resident B and Resident B's next of kin. During the visit Resident B's next of kin noticed Resident B was more irritable and anxious. Interventions used during the therapy session were listed as exploration of emotions, psych-education, review of treatment, structured problem solving, supportive reflection, and symptom management. Clinical recommendations were "Resume Treatment as Planned" and "Terminate Treatment", but did not include documentation to indicate the clinician recommended interventions to prevent further resident-to-resident physical abuse perpetrated by Resident B. A psychotherapy note, dated 7/18/2024, indicated Resident B was feeling more anxious and fearful. Resident B did not feel comfortable around all the staff and residents in the facility. A psychotherapy note, dated 7/26/2024, indicated Resident B had a dislike for another resident and was afraid of being harmed by another resident. Interventions utilized during the session included: exploration of emotions, interactive feedback, psycho-education, review of treatment, structured problem solving, supportive reflection, symptom management, and motivational interviewing/motivation therapy interventions. Clinical recommendations were "Resume			

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	Treatment as Planned" and "Terminate Treatment", but did not include documentation to indicate the clinician recommended interventions to prevent further resident-to-resident physical abuse perpetrated by Resident B A primary care provider note, dated 8/5/2024, indicated Resident B had bipolar disorder with listed interventions to monitor mood, "consult psych", currently undergoing and continue group therapy with psychotherapist and next of kin. A behavior charting note, dated 8/6/2024, indicated Resident G attempted to get coffee in the dining room. Resident B was in a wheelchair in front of the coffee. Resident G asked Resident B to move. When Resident B did not move, Resident G "nudged" Resident B's wheelchair. Resident B "became agitated and made contact" with Resident G's right forearm with an open hand. Immediate intervention of redirection of Resident B and "line-of-site" supervision were effective. A physician order, dated 8/6/2024, indicated a physician's order for Resident B to have line of sight for the remainder of the shift (continuous observation). A social service progress note, dated 8/8/2024, indicated Resident B had no psychological distress Review of the August 2024 treatment medication records indicated Resident B was on 15-minute checks from 8/6/2024 through 8/14/2024. During an interview with the Executive Director, on 8/21/2024 at 12:20 p.m., indicated part of the process for potential admission was to assure the facility can meet the needs of every admission.			

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	With Resident B's medical diagnosis, the facility anticipated that Resident B would have behaviors and elevated behavioral needs. During an interview with Registered Nurse (RN) 2 on 7/20/2024 at 12:15 p.m., indicated RN 2 was familiar with Resident B. RN 2 worked directly and indirectly with Resident B since admission. Resident B was known to have behaviors while at the facility. RN 2 indicated Resident B had physical behaviors with other residents and staff. Resident B's interventions were "usually" effective, but not always. RN 2 indicated interventions included diversional activities, utilizing Resident B's CD's, and calling Resident B's next of kin. When they were not effective, the staff were to try and eliminate the risk of Resident B harming other residents if possible. During an interview with Licensed Practical Nurse (LPN) 1, on 7/20/2024 at 12:45 p.m., indicated LPN 1 was aware that Resident B had "a lot of behaviors" since Resident B was admitted. LPN 1 had worked indirectly with Resident B since LPN 1 worked on the same unit as Resident B but did not work Resident B's "hall". The staff "try to keep [Resident B] away from others if they can." The only interventions LPN 1 recalled were utilizing Resident B's CD's, and redirection. During an interview with Activities Assistant 4, on 7/20/2024 on 1:25 p.m. indicated Resident B had behaviors. A week after Resident B was admitted, Activity Assistant 4 indicated Resident B had "kicked me in the center of the chest" unprovoked. Since the incident with Resident B, Activities Assistant 4 "avoided" Resident B to the degree of rescheduling or moving activities if Resident B was present. If Resident B had behaviors, Activity Assistant 4 indicated staff			

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	would make sure residents are safe then she would retrieve clinical staff since she was not "comfortable" with Resident B around. During an interview with the Director of Nursing Services, on 7/20/2024 at 2:15 p.m., the primary care physician team was responsible for managing Resident B's behaviors and medications due to the next of kin refusing psychiatric services. All staff were responsible for preventing resident-to-resident abuse. During an interview with the Executive Director, on 8/21/2024 at 2:00 p.m., the interventions implemented after the Event 1, reported on 7/8/2024, were 15-minute checks for the duration of the physician's order, review and update of the care plans, and social services to follow up for psychosocial support for both residents involved. During an interview with the Executive Director, on 8/21/2024 at 2:00 p.m., the interventions implemented, after the Event 2, reported on 8/6/2024, were listed as Resident B was placed line of sight for the remainder of the shift then 15-minute checks, psychological support as needed, and review and update of care plans as needed. A primary care provider note, dated 8/8/2024, indicated Resident B had bipolar disorder with listed interventions to include monitor mood, "consult psych", currently undergoing group therapy with psychotherapist and next of kin. The note stated Resident B was agitated and had a gradual reduction dose failure. A psychotherapy note, dated 8/9/2024, indicated the behavioral psychotherapist spoke with Resident B's next of kin. Resident B's next of kin			

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	was agreeable to Resident B being seen by the in-house psychiatrist. During an interview with the Director of Nursing Services, on 7/20/2024 at 2:15 p.m., indicated the facility was in the process of getting Resident B seen by in house psychological services when Resident B was transferred for a neuropsychological evaluation. The progress note for Resident B, reviewed on 8/20/2024 at 11:45 a.m., did not indicate Event 3. Review of August 2024 treatment administration record after the Event 3, 15-minute checks were initiated on 8/6/2024. A social service progress note, dated 8/12/2024, indicated Resident B had no "psychosocial distress." This note did not include any interventions or recommendations. A nursing progress note, dated 8/12/2024 at 2:15 a.m., indicated that Resident B's next of kin refused to have Resident B sent to a neuropsychiatric hospital for evaluation and treatment. The note did not contain additional interventions for Resident B's physical aggressive behaviors. The comprehensive care plan provided by the Director of Nursing Services (DNS), on 8/21/2024 at 11:15 a.m., did not include documentation to indicate a new intervention to prevent further resident-to-resident physical abuse perpetrated by Resident B after Event 2 or Event 3. During an interview with the Executive Director, on 8/21/2024 at 2:00 p.m., the interventions for the Event 3, reported 8/10/2024, were 15-minute			

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	checks as they worked with Resident B's next of kin about sending Resident B to a neuropsychiatric hospital for evaluation and treatment, 15-minute checks, review and update of the care plans, and social services to follow up for psychosocial assessments for both residents involved. The Executive Director indicated that the new of kin for Resident B refused neuropsychiatric evaluation after this event. An additional physical behavior event with Resident B striking a staff member, on 8/13/2024, was the "deciding factor" to prompt Resident B to be sent out for a neuropsychiatric evaluation and treatment. 2. The clinical record for Resident D was reviewed on 8/20/2024 at 11:27 a.m. The medical diagnoses included post-traumatic stress disorder, major depressive disorder, and anxiety disorder. A Quarterly MDS assessment, dated 6/5/2024, indicated Resident D was cognitively intact and did not exhibit behaviors in the last seven days. During an interview and observation with Resident D, on 8/20/2024 at 1:45 p.m., indicated on 7/8/2024 Resident D was making a phone call in the DNS's office. Resident D was attempting to leave the office when Resident B came in. Resident D stated, "...[Resident B] got mad and slammed his wheelchair into mine, took the DVDs that he carries and threw the box at me then hit me on the head and shoulder with his fist ..." Further Resident D stated, "...It stunned me to get hit with CDs..." and that the punch to Resident D's shoulder "...hurt and made a red mark..." During an interview with the Executive Director, on 8/21/2024 at 2:00 p.m., the interventions implemented after Event 1 were 15-minute checks			

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	155120	A. BUILDING 00 B. WING	08/21/2024

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	for the duration of the physician's order, review and update of the care plans, and social services to follow up for psychosocial assessments. The 15-minute checks were completed per the physician order, psychosocial assessments were completed for Resident D, and care plan was reviewed. 3. The clinical record for Resident G was reviewed on 8/21/2024 at 10:58 a.m. The medical diagnoses included mood disorder and schizophrenia. A Quarterly MDS assessment, dated 8/5/2024, indicated Resident G was cognitively intact and did not exhibit behaviors in the last seven days. During an interview and observation, on 8/21/2024 at 1:45 p.m., Resident G indicated, on 8/6/2024, Resident G had an altercation with Resident B. Resident G was trying to get coffee, but Resident B was sitting in front of the coffee and refused to move. Resident G stated "...I asked him to move three times, and he wouldn't, so I moved his wheelchair just enough to reach the coffee. [Resident B] waited until I was reaching over to get the coffee then punched me in the stomach and the arm..." Resident G reiterated it was a punch with a closed fist. Resident G did not have bruising or redness per recall but was a "little sore". Resident G walked away and told the staff to call the police. Resident G indicated after the incident the Director of Nursing Services and Executive Director told Resident G to "avoid" Resident B. Resident G felt that was impossible since Resident B wanders "all over the facility and into our rooms". Resident G stated, "... I did not feel safe with [Resident B] around after that...", "...I had been spending more time outside where [Resident B] cannot come to try and avoid [Resident B]..." and "[Resident B] has been gone			

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	about a week and I feel much safer. I was afraid [Resident B] would hit me anytime I was around him..." 4. The clinical record for Resident E was reviewed on 8/20/2024 at 2:05 p.m. The medical diagnoses included major depressive disorder, dementia, and mood disturbances. A Quarterly MDS Assessment, dated 8/6/2024, indicated Resident E was cognitively intact and did not exhibit behaviors in the last seven days. During an interview and observation, on 8/21/2024 at 11:10 a.m., Resident E indicated that earlier this month Resident B came up behind Resident E and "hit" Resident E in the side of the head. Resident E stated, "...he hit me so hard that my glasses went flying. They are carbon coated and have a large scratch in them, look at them..." Resident E then took off eyeglasses to show a large scratch on the right lens. Resident E indicated that this was fourth time that Resident B had hit him. Resident E stated, "...[Resident B] has hit me four times that I can remember. I've told staff about it, but they never do anything about it..." When asked what interventions were placed after the 8/10/2024 event, Resident E stated, "...they [the staff] told me to just avoid [Resident B], but I can't. [Resident B] goes anywhere [Resident B] wants. [Resident B] comes in my room, [Resident B] goes into the nurses' station. The staff let [Resident B] do whatever because they [the staff] are scared of [Resident B]. [Resident B] hits the staff and us. [Resident B] hit my roommate just a few weeks ago..." Resident E indicated that he was scared that Resident B would hit Resident E again because Resident B attacked Resident E from behind. Resident E stated since the incident Resident E checked "every room before going in"			

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	to make sure Resident B was not in there and avoided activities if Resident B was around. Resident E indicated Resident B has been "gone" for about a week and Resident E felt that "I can breathe without being afraid I'm going to get hit upside the head for no reason." A policy entitled, "Abuse, Neglect and Exploitation", was provided by the Director of Nursing Services on 8/20/2024 at 12:50 p.m. The policy defined abuse as, "...the willful infliction of injury...with resulting physical harm, pain or mental anguish, which many include...certain resident to resident altercations...Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish..." The policy of the facility indicated the intention was to, "...provide protection for health, welfare and rights of reach resident by developing and implementing written policies and procedures that prohibit and prevent abuse..." The policy further stated, "...The facility will implement policies and procedures to prevent and prohibit all types of abuse..." including, "...identification, ongoing assessment, care planning for appropriate interventions, and monitor of residents with needs and behaviors which might lead to conflict..." This citation relates to Complaints IN00439368 and IN00440821. 3.1-27(a)(1)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based on interview and record review, the facility failed to maintain documentation of a complete	F 0610	All residents identified have been interviewed and state they feel safe in facility.	09/10/2024

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	and thorough investigating to include the identification of potentially vulnerable residents and prevention of further abuse for 3 of 3 investigations reviewed. Findings include: 1. The clinical record for Resident B was reviewed on 8/20/2024 at 11:45 a.m. Medical diagnoses included bipolar disorder, intellectual disabilities, encephalopathy, and anxiety disorder. A Quarterly Minimum Data Set assessment (MDS), dated 8/1/2024, indicated Resident B was severely cognitively impaired, exhibited physical, verbal, and wandering for one to three days of the last seven reviewed, and exhibited rejection of care for four to six of the last seven days reviewed. A behavior care plan, dated 1/24/2024, indicated that Resident B had a history of exhibiting aggressive behaviors such as hitting, grabbing, pinching and kicking. Interventions, dated 1/24/2024, included: Assisting Resident B to not enter other's personal space, redirect away and engage in personal activities as well as providing a quiet environment. Review of incident reports for Resident B indicated that there were three events of resident-to-resident physical alternations. Event 1 was reported on 7/8/2024, Event 2 was reported on 8/6/2024, and Event 3 was reported on 8/10/2024 Review of progress notes for Resident B indicated physical behaviors towards others on the following dates: 2/1/2024, 2/12/2024, 3/26/2024, 3/31/2024, 4/30/2024, 5/17/2024, 6/10/2024, 7/8/2024, 7/23/2024, 8/4/2024, 8/5/2024, and		All other residents have the potential to be affected. Education provided to the Executive Director and Director of Nursing on Conducting Internal Investigations. Audit completed of previous 30 days of incidents to ensure other residents were interviewed. Ongoing audit to be completed by the Executive Director or designee to monitor appropriate individuals are interviewed during an investigation. This audit to be completed 5X weekly X 4 weeks, 3 times weekly X 4 weeks, and weekly to completed 6 months. The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis. IDR Reason: Facility has new information.	

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	8/13/2024. 2. The clinical record for Resident D was reviewed on 8/20/2024 at 11:27 a.m. The medical diagnoses included post-traumatic stress disorder, major depressive disorder, and anxiety disorder. A Quarterly MDS assessment, dated 6/5/2024, indicated Resident D was cognitively intact and did not exhibit behaviors in the last seven days. An incident report and investigative file for Event 1, provided by the Executive Director on 8/21/2024 at 11:53 a.m., indicated, on 7/8/2024, Resident B and Resident D had a physical altercation. The file included an interview from the staff member present during the altercation and a statement from Resident D. The file did not include additional resident interviews, staff interviews, or identification of potentially vulnerable residents. 3. The clinical record for Resident G was reviewed on 8/21/2024 at 10:58 a.m. The medical diagnoses included mood disorder and schizophrenia. A Quarterly MDS assessment, dated 8/5/2024, indicated Resident G was cognitively intact and did not exhibit behaviors in the last seven days. An incident report for Event 2, provided by the Executive Director, on 8/21/2024 at 11:53 a.m., indicated, on 8/6/2024, a physical altercation occurred between Resident B and Resident G. No interviews were included in the file from staff or residents nor were potentially vulnerable residents identified. 4. The clinical record for Resident E was reviewed on 8/20/2024 at 2:05 p.m. The medical diagnoses included major depressive disorder, dementia, and			

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	mood disturbances. A Quarterly MDS assessment, dated 8/6/2024, indicated Resident E was cognitively intact and did not exhibit behaviors in the last seven days. An incident report for Event 3, provided by the Executive Director, on 8/21/2024 at 11:53 a.m., indicated, on 8/10/2024, Resident E reported a physical altercation with Resident B. The file included progress notes and an interview from Resident E. The file did not include additional resident interviews, staff interviews, or identification of potentially vulnerable residents. During an interview with the Executive Director, on 8/21/2024 at 12:29 p.m., indicated she did not interview or identify other residents because it was " ...only them [the residents] directly present and involved ..." During an interview with the Executive Director, on 8/21/2024 at 2:00 p.m., indicated they did not screen or identify additional potentially vulnerable residents. The interventions after the incident reported on 7/8/2024, were 15-minute checks. The interventions for incident, reported 8/6/2024, were line of sight for the remainder of the shift then 15-minutes checks. The interventions for the incident, reported 8/10/2024, were 15-minute checks as they worked with Resident B's next of kin about neuropsychiatric evaluation. The deciding factor for sending Resident B for a neuropsychiatric evaluation was when Resident B hit another staff member on 8/13/2024. A policy entitled, "Abuse, Neglect and Exploitation", was provided by the Director of Nursing Services on 8/20/2024 at 12:50 p.m. The policy defined abuse as, " ...the willful infliction of			

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	injury ...with resulting physical harm, pain or mental anguish, which many include ...certain resident to resident altercations ...Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish ..." The policy of the facility indicated the intention was to, " ...provide protection for health, welfare and rights of reach resident by developing and implementing written policies and procedures that prohibit and prevent abuse ..." The policy further stated, " ...The facility will implement policies and procedures to prevent and prohibit all types of abuse ..." including, " ...identification, ongoing assessment, care planning for appropriate interventions, and monitor of residents with needs and behaviors which might lead to conflict..." This citation relates to Complaints IN00439368 and IN00440821. 3.1-28(d)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, the facility failed to complete a resident's dressing changes timely, as ordered, for 1 of 3 residents reviewed for skin conditions. (Resident D) Findings include: The clinical record for Resident D was reviewed on 8/20/24 at 11:27 a.m. The diagnoses included, but were not limited to, lymphedema, peripheral vascular disease, hypertension, and type 2 diabetes mellitus. He was readmitted to the facility	F 0684	Resident D dressing was changed. All residents with skin conditions have the potential to be affected. Facility provided education to nursing employees on following Medication Orders. Facility completed an audit on residents to ensure all dressing changes were timely. Ongoing audit to be completed by the DNS or designee to monitor	09/10/2024

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	from the hospital on 8/11/24. The 6/5/24 Quarterly MDS (Minimum Data Set) assessment indicated he was cognitively intact. The 8/11/24, 2:22 p.m. Nursing Clinical Admission Note indicated, "Skin note: cellulitis left leg, weeping and red in appearance. Special Care: ...Resident currently on antibiotics. Antibiotic name: cefuroxime Dx [Diagnosis:] cellulitis." The 8/11/24, revised 8/12/24, physician's order indicated, "Wound Care: left lateral leg: Cleanse with wound cleanser and pat dry. Apply collagen to wound bed and cover with border gauze. Change every other day and PRN [as needed] if soiled or dislodged. One time a day every other day for wound care." The 8/11/24, revised 8/12/24, physician's order indicated, "Wound Care: Left lower lateral leg: Cleanse with wound cleanser and pat dry. Apply collagen to wound bed and cover with border gauze. Change every other day and PRN if soiled or dislodged. One time a day every other day for wound care." The 8/11/24, revised 8/12/24, physician's order indicated, "Wound care: left medial leg: Apply skin prep and allow to dry. Leave open to air. Complete daily. One time a day for wound care." The 8/14/24 skin and wound note, written by NP (Nurse Practitioner) 5, referenced Resident D's left lateral leg venous wound, left lower lateral leg venous wound, and left medial leg venous wound with treatment recommendations that corresponded with the above physician's orders for these wounds. The note also referenced a fourth venous wound to Resident D's left lateral		timely dressing changes. This audit to be completed 5X weekly X 4 weeks, 3 times weekly X 4 weeks, and weekly to completed 6 months. The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.	

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	leg with a treatment recommendation to cleanse with wound cleanser; apply collagen to base of the wound; secure with bordered gauze; and to change daily and PRN. Resident D's 8/14/24 Wound Assessment Reports also indicated four venous wounds with treatments corresponding with NP 5's, 8/14/24, skin and wound note. Resident D's physician's orders and, August 2024, MAR (medication administration record) did not include daily treatments to a venous wound of the left lateral leg, as referenced in NP 5's, 8/14/24, skin and wound note and, 8/14/24, Wound Assessment Reports. The 8/19/24, 11:51 a.m. nurse's note indicated, "Resident c/o [complained of] yellow-green exudates from left lower extremity. NP notified, new order for wound culture. Specimen obtained and transported to lab." The 8/19/24, 11:52 a.m. nurse's note indicated, "Wound cultures from LLE [lower left extremity] sent to lab this morning awaiting results." An observation of Resident D was made on 8/20/24 at 12:15 p.m. He was sitting on the side edge of his bed with his bare legs visible from the knees down. There were no dressings on his lower left leg. An interview and observation was conducted with Resident D on 8/20/24 at 1:45 p.m. He was still sitting on the side edge of his bed with his bare legs visible from the knees down. There were no dressings on his lower left leg. He indicated he'd been waiting since 5:00 a.m. this morning to have his treatments completed to his			

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	legs, but no one had come in to do them. On 8/20/24 at 2:01 p.m., an interview was conducted with QMA (Qualified Medication Aide) 6. She indicated Resident D's legs should be wrapped. The nurse on another hall "agreed to do his legs," but they weren't done yet. On 8/21/24 at 10:15 a.m., the DNS (Director of Nursing Services) provided a signed, written statement, dated 8/20/24, that indicated, "Around 1045 [a.m.,] DNS notified by QMA regarding residents dressing change. QMA stated nurse on her hall was 'swamped.' DNS instructed QMA to inform nurse on opposite hall to do dressing change on resident as DNS was addressing a more urgent matter at time of notification." The Clean Dressing Change policy was provided by the DNS on 8/20/24 at 12:50 p.m. It indicated, "It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes...Each wound will be treated individually." This citation relates to Complaint IN00439368. 3.1-37(a)			