STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155252	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - WOODLANDS CARE CENTER	4088 FRAME RD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00434672. Complaint IN00434672-Federal/State deficiencies related to the allegations are cited at F921. Survey dates: June 23, 24, 25, 26, 27, & 28 2024 Facility number: 000155 Provider number: 155252 AIM number: 100266830 Census Bed Type: SNF/NF: 120 Total: 126 Census Payor Type: Medicare: 6 Medicaid: 69 Other: 29 Total: 104 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 11, 2024.	F 0000	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 this 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.	
F 0583 SS=E Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maribeth Donaldson	Executive Director	07/24/2024

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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	accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation and record review, the facility failed to ensure dignity for 2 of 2 observations of meal service. Staff did not knock or announce themselves before delivering meal trays to resident rooms. (Resident 9, Resident 14, Resident 66, Resident 75, Resident 78, Resident 84, Resident 96) Findings include:	F 0583	F583E -What corrective actions will be accomplished for those residents found to have been affected by the deficient practice CNA's #2 and #3 were in-serviced on knocking and announcing themselves prior to entering resident's rooms. Privacy policy	07/31/2024

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	On 6/23/24 during observation of the noon meal the following was observed: 1. At 11:34 a.m., CNA 2 entered Resident 96's room to deliver a beverage without knocking or announcing self. 2. At 11:52 a.m., CNA 2 entered Resident 66's room to deliver a beverage without knocking or announcing self. 3. At 11:53 a.m., CNA 3 entered Resident 84's room, walked back out and got a beverage, walked back in the room to deliver the beverage without knocking or announcing self. 4. At 11:55 a.m., CNA 3 entered Resident 75's room to deliver a meal tray, walked back out and got a beverage, walked back in to deliver the beverage without knocking or announcing self. 5. At 11:57 a.m., CNA 2 entered Resident 9's room to deliver a meal tray without knocking or announcing self. 6. At 11:59 a.m., CNA 3 entered Resident 84's room to deliver a beverage without knocking or announcing self. On 6/27/24 during observation of the noon meal the following was observed: 7. At 11:49 a.m., CNA 2 walked in Resident 78's room to deliver a meal tray without knocking or announcing self. 8. At 11:50 a.m., CNA 2 walked in Resident 14's room to deliver a meal tray without knocking or announcing self.		reviewed with the medical director. LPN #21 was in-serviced on dignity and applying clothing protectors on residents prior to meals. -How other residents have the potential to be affected will be identified. All residents have the potential to be affected. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All staff were in-serviced on knocking and announcing themselves before entering residents' rooms as well as the proper method for applying clothing protectors. DCE/Designee will observe staff entering resident rooms monitoring for knocking/announcing self applying clothing protectors 2x per week x 4 weeks, 1x per week x 4 weeks and 1x per month x 4 months. DCE/Designee will monitor privacy during medical visits 2x per month x 2 months and 1x per month x 4 months. -How the corrective action will be monitored to ensure the deficient	

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	On 6/23/24 at 12:00 p.m., CNA 3 indicated when delivering meal trays to a resident's room, staff should knock on the door, tell the resident nursing, let them know why you are there. 9. During a random observation on 6/27/24 at 9:58 A.M., Physician 2 was sitting on the couch in a resident common area, where additional staff, residents, and resident family were present, asking residents medical questions and taking a resident's blood pressure. 10. During a meal observation on 6/26/24 at 7:48 A.M., Licensed Practical Nurse (LPN) 21 was observed to apply clothing protectors to two of four residents at a table on the ACU (Alzheimer's Care Unit). LPN 21 applied the clothing protectors from behind the residents without asking permission, and without explaining what she was doing. On 6/28/24 at 1:46 P.M., LPN 17 indicated staff should ask residents before putting on a clothing protector if they wanted one or not, as well as explain what they were doing. On 6/27/24 at 2:38 p.m., the Regional Nurse Consultant provided the current policy on promoting/maintaining resident dignity with a copyright date of February 2023. The policy included, but was not limited to: It is the practice of this facility to protect and promote resident rights and treat each other with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights...12. Maintain resident privacy... 3.1-3(a)		practice will not recur, what QA program will be put into place. Findings will be reviewed in QAA x 6 months unless further monitoring is deemed necessary. -Systemic changes will be completed by 7/31/2024 Requesting paper compliance for F583 E	

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	3.1-3(p)(3)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the			

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	community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review and interview, the facility failed to develop a care plan for 2 of 5 resident reviewed for care plan intervention. Resident fall interventions and head of bed elevation not being in place. (Resident 24, Resident 351)1. On 6/24/24 at 2:14 p.m., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia, unspecified severity, without behavioral disturbance, abnormal gait and mobility, displaced supracondylar fracture without intracondylar extension of lower end of left femur, subsequent encounter for closed fracture with routine healing. A Quarterly MDS (Minimum Data Set) assessment, dated 5/7/24, indicated Resident 24's cognition was moderately impaired, bed mobility extensive, one staff assist, transfer extensive two staff assist. A care plan for falls indicated: At risk for falls related to: History of falls. Use of medication, gout, dementia, osteoarthritis macular degeneration right eye, polymyalgia rheumatic, ulcer, abnormal gait and mobility. HTN (hypertension), muscle weakness. Interventions included, but were not limited to:	F 0656	F656 -What corrective actions will be accomplished for those residents found to have been affected by the deficient practice Resident #24 wedged pillows in the recliner as a post fall intervention was DC'd. RN #3 and LPN #2 were in-serviced on elevating the head of bed at all times when a res c/o dyspnea. -How other residents have the potential to be affected will be identified. All residents have the potential to be affected. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.	07/31/2024

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	wedge pillows on sides of recliner to prevent resident from rolling out, date initiated, 6/22/24. A progress note dated 6/22/24 at 7:00 a.m., indicated : " ...Situation: Resident sleeping in recliner in common area in front of nurses station. Heard resident say " oh God damn". Noted resident on floor between the 2 recliners. Background: Hx (history) dementia, repeated falls and decreased safety awareness...Response: [name of physician] triage notified as well as RR (resident representative). Intervention to use pillows on sides of recliner to prevent further rolling out... On 6/27/24 at 9:19 a.m., QMA 2 was observed to transfer Resident 24 from his wheelchair to a recliner, put the foot of the recliner up, walk away and return with a cover and lay across Resident 24. No pillows were placed beside Resident 24. On 6/27/24 at 10:07 a.m., Resident 24 was observed asleep in the recliner, no pillows were beside him. On 6/27/24 at 10:09 a.m., LPN 3 was sitting at the nurses station in front of the common area. She indicated Resident 24 was supposed to have pillows beside him in the recliner to help prevent him from falling out. On 6/27/24 at 10:10 a.m., QMA 2 indicated usually the charge nurse will let staff know of any fall and new fall interventions, it is also on their assignment sheet. QMA 3 indicated she was not sure what Resident 24's fall interventions were, she didn't work with him everyday. 2. On 6/27/24 at 12:13 P.M. RN (Registered Nurse) 3 and LPN (Licensed Practical Nurse) 2 were observed performing a treatment on Resident 351. Resident		All nursing staff will be in-serviced regarding following post fall interventions and keeping head of bed elevated to alleviate shortness of breath. DNS/Designee will monitor post fall interventions on residents and elevating head of bed on x per week x 4 1x per week x 4 1x per month x 4 months. -How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place. Will review in QAA monthly x 6 months. -Systemic changes will be completed by 7/31/2024 Requesting paper compliance for F656	

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	had slid down in bed, stated could not breathe and needed to sit up. Two minutes passed before LPN 2 and RN 3 used the bed pad under resident to pull up higher in bed. The bed remained flat during treatment. Resident was visualized breathing with pursed lips. Treatment completed at 12:26 P.M. Head of the bed was then raised. On 6/27/24 at 12:13 P.M. Resident 351's clinical record was reviewed. Diagnosis included but was not limited to Chronic Lung Disease. The most recent MDS (Minimum Data Set) Assessment, dated 6/17/24, indicated Resident was cognitively intact, required set up and clean up assistance with eating, substantial or maximum assistance with toileting, substantial or maximum assistance with showering or bathing, and substantial or maximum assistance with bed mobility. Physician orders included but were not limited to head of bed elevated to alleviate/avoid shortness of breath when lying flat every shift related to chronic obstructive pulmonary disease, dated 6/10/24. Care plan for Resident, dated 6/11/24, alteration in respiratory status due to Chronic Obstructive Pulmonary Disease, due to Congestive Heart Failure indicated an intervention but was not limited to elevate head of bed to alleviate/avoid shortness of breath while lying flat. 6/28/24 10:24 A.M. LPN 4 indicated that usually Resident 351 tolerates bed being flat for treatments, but if resident became short of breath or verbalized not being able to breathe staff should stop the treatment so the resident can recover.			

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	On 6/28/24 at 2:30 P.M., the Regional Nurse supplied a current, nonrated policy " Comprehensive Care Plans." The policy indicated "... it was the policy of the facility of develop and implement a comprehensive person-centered care plan for each resident....that includes measurable objectives and timeframes...the objectives will be utilized to monitor the resident's progress. Alternative interventions documented, as needed..." On 6/28/24 at 2:38 p.m., the Regional Nurse Consultant provided the current accidents and supervision policy with a copyright date of 2023. The policy included, but was not limited to: ...Implementation of Interventions- a. Communicate the interventions to all relevant staff, e. Ensuring that the interventions are put into action...Monitoring and Modification- a. Ensuring that interventions are implemented correctly and consistently..." 3.1-35(a) 3.1-35(d)(2)(B)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.			

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	(D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure care plans were revised in 1 of 2 residents reviewed for care plans. (Resident 45) Findings include: On 6/25/24 at 9:03 A.M., Resident 45's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety The most current Quarterly MDS (Minimum Data Set) Assessment dated 4/10/24 indicated Resident 45 was severely cognitively impaired. The resident need supervision for transfer and mobility with substantial help for mobility Current physician orders included but were not limited to: Weekly weights every day shift every Sunday for	F 0657	F657 -What corrective actions will be accomplished for those residents found to have been affected by the deficient practice Resident #45's care plan was updated to include interventions related to wound care and weekly weights x4 weeks -How other residents have the potential to be affected will be identified. All residents have the potential to be affected. -What measures will be put into place or what systemic changes will be made to ensure that the	07/31/2024

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	4 weeks ordered 6/14/24 Vaseline Pure Ultra White External Gel (White Petroleum) Apply to right cheek topically every day shift for wound care cleanse facial biopsy site to right cheek with normal saline. Pat dry, apply thin layer of Vaseline to wound bed. Cover with dry dressing dated 6/19/24. There was a current care for a seborrheic lesion to the right cheek dated 8/8/23. Resident had a biopsy done on 6/19/24. The care plan lacked revision of interventions related to wound care. There was a current care plan of nutritional risk for inadequate food/beverage intake with dementia and triggered for 10% weight loss dated 6/17/24. Current interventions indicated monthly weights but lack revision for weekly weights. During an interview on 6/25/24 at 10:07 A.M., MDS RN (Registered Nurse) indicated if a resident had an open area, they would document a care plan and update as needed for surgeries and biopsies On 6/28/24 at 2:30 P.M., the Regional Nurse supplied a current, nondated policy " Comprehensive Care Plans." The policy indicated "... it was the policy of the facility of develop and implement a comprehensive person-centered care plan for each resident....that includes measurable objectives and timeframes...the objectives will be utilized to monitor the resident's progress. Alternative interventions will documented, as needed..." 3.1-35(d)(2)(B)		deficient practice does not recur. Nursing staff were in-serviced regarding updating the interventions on care plans. -How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place. DNS/Designee will monitor wound care plans and weight monitoring accuracy 2x per week x 4 weeks, 1x per week x 4 weeks and 1x per month x 4 months. -Systemic changes will be completed by 7/31/2024 Requesting paper compliance for F657	

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F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to provide care through maintenance of a PICC (peripherally inserted central catheter) line for 1 of 1 residents reviewed for IV therapy. (Resident 302) Findings include: On 6/25/24 at 1:14 P.M., Resident 302's clinical record was reviewed. Resident 302 was admitted on 6/10/24. Diagnoses included, but were not limited to, infection of joint prosthesis, anxiety, and hypertension. The Admission MDS (Minimum Data Set) Assessment, dated 6/17/24 was not completed. Current physician orders included, but were not limited to: PICC (peripherally inserted central catheter) line dressing change every Tuesday. Start date 6/18/24. Current care plans included, but were not limited to: I have a PICC line (in my) right arm and have the potential risk of infection at the site. Do not take blood pressure on arm of access site. Encourage patient not to sleep on arm with access site. Date Initiated: 6/12/24. Dressing change as ordered with measurements of the length of the external catheter and the	F 0694	F694 -What corrective actions will be accomplished for those residents found to have been affected by the deficient practice Resident #302's PICC dressing was changed. Nurses/QMA's were in-serviced to not take BP in the same arm as a PICC line. -How other residents have the potential to be affected will be identified. All residents have the potential to be affected. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Nursing staff were in-serviced regarding PICC line weekly dressing changes, measurements and not taking or documenting BP	07/31/2024

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	155252	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - WOODLANDS CARE CENTER	4088 FRAME RD NEWBURGH, IN 47630

(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
	circumference of arm 10 cm above insertion site. Date Initiated: 6/12/24. On 6/28/24 at 9:15 A.M., Resident 302's electronic medication administration record was reviewed. The following dates/times indicated staff obtained a blood pressure reading in Resident 302's restricted limb: 6/26/24 10:34 A.M. sitting right arm 6/24/24 8:18 A.M. lying right arm 6/22/2024 2:25 P.M. lying right arm 6/17/2024 8:24 A.M. sitting right arm 6/16/2024 8:40 A.M. sitting right arm 6/15/2024 8:16 A.M. sitting right arm 6/14/2024 8:29 A.M. lying right arm 6/10/2024 6:25 P.M. lying right arm During an interview on 6/27/24 9:40 A.M., RN 3 indicated she was the nurse covering nursing duties for the 600 hall today and indicated staff should not be taking blood pressure in Resident 302's right arm because of the PICC line and that it was not policy for PICC line measurements, but if there was conflicting information in the policy and care plan, staff should use the care plan since it is specific to each resident. During an observation on 6/27/24 at 3:19 P.M., Resident 302's PICC line dressing was observed. The dressing read "6-11 1555 CD". During an interview on 6/27/24 3:25 P.M., the Director of Nursing indicated there was no documentation of catheter length in Resident 302's clinical record and she doesn't know why Resident 302 was care planned for her PICC line to be measured during dressing changes because the facility doesn't do that. On 6/28/24 at 2:38 P.M., the clinical regional nurse		on an arm that has a PICC line. DNS/Designee will monitor PICC line dressing changes and measurements, BP check observations/documenting 2x per week x 4 weeks, 1x per week x 4 weeks and 1x per month x 4 months. -How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place. Will review monthly in QAA x 6 months. -Systemic changes will be completed by 7/31/2024 Requesting paper compliance for F694	

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	provided a policy titled PICC/Midline/CVAD Dressing Change, dated 2023, that indicated It is the policy of this facility to changes peripherally inserted central catheters (PICC) dressing weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. 13. Use sterile measuring tape to measure external length of the catheter from hub too skin entry to ensure that it has not migrated. 3.1-47(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident was receiving oxygen as physician ordered for 1 of 2 residents reviewed for respiratory care. (Resident 39) Finding includes: During an observation on 6/27/24 at 11:36 A.M., Resident 39 was receiving oxygen via nasal cannula from an oxygen concentrator in her room. The oxygen concentrator was set at two liters. RN 3 observed the oxygen concentrator at two liters, checked the resident's orders and confirmed the orders stated three liters, and turned the oxygen	F 0695	F695 -What corrective actions will be accomplished for those residents found to have been affected by the deficient practice Resident #39's oxygen was increased to 3 liters. Nursing staff were in-serviced on not taking BP in the arm that has a fistula and the importance of accurate documentation.	07/31/2024

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	up to three liters. On 6/28/24 at 10:09 A.M. Resident 39's clinical record was reviewed. Resident 39 was admitted on 5/28/24. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. The most recent Admission MDS (Minimum Data Set) Assessment, dated 6/4/24, indicated resident 39 was cognitively intact, required maximal assistance from staff for toileting, bathing, and transfers, and was receiving oxygen therapy and dialysis therapy. Current physician orders included, but were not limited to: Supplementary oxygen continuously via nasal cannula at 3 L (three liters) every shift for to prevent/relieve hypoxia related to chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia. Start date 6/4/24. Check fistula to right arm for bruit and thrill every shift for fistula care. Start date 5/29/24. Current care plans included, but were not limited to: Oxygen as ordered. Date Initiated: 5/29/24. I have a fistula RUE (right upper extremity) and have the potential risk of infection at the site. Date Initiated: 5/29/24. Do not take blood pressure on arm of access site. Encourage patient not to sleep on arm with access site. Date Initiated: 5/29/24. On 6/28/24 at 10:09 A.M., Resident 39's electronic medication administration record was reviewed. The following dates/times indicated staff obtained a blood pressure reading in Resident 39's restricted limb:		-How other residents have the potential to be affected will be identified. Any resident with a fistula or on oxygen has the potential to be affected. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Staff educated in monitoring the correct oxygen liter setting, documenting correct arm for BP and to not take a BP reading on an arm that has a fistula. DNS/Designee will monitor oxygen settings and BP observations/documentation 2x per week x 4 weeks, 1x per week x 4 weeks and 1x per month x 4 months -How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place. Will monitor in 6 months. -Systemic changes will be	

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	6/22/24 12:23 P.M. sitting right arm 6/20/24 11:55 A.M. standing right arm 6/18/24 4:09 P.M. lying right arm 6/16/24 12:22 P.M. standing right arm 6/15/24 9:38 A.M. sitting right arm 6/3/24 4:42 P.M. sitting right arm 6/2/24 12:07 P.M. sitting right arm 6/1/24 10:01 A.M. lying right arm On 6/28/24 at 2:38 P.M., the Regional Clinical Nurse provided a policy titled Oxygen Administration, dated 2024, that indicated Oxygen is administered under orders of a physician. The resident's care plan shall identify the interventions for oxygen therapy, based on resident's assessment and orders, such as, but not limited to: equipment setting for the prescribed flow rate. 3.1-47(a)(2)		completed by 7/31/2024 Requesting paper compliance for F695	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review, interview, and observation, the facility failed to ensure care and services were implemented for 1 of 2 residents reviewed for dialysis. (Resident 75) Findings include: On 6/25/24 at 8:44 A.M., Resident 75's clinical record was reviewed. Resident 75 was admitted on 2/3/23. Diagnoses included, but were not limited to, end stage renal disease and diabetes	F 0698	F698D -What corrective actions will be accomplished for those residents found to have been affected by the deficient practice Nursing staff in-serviced on not taking BP in the arm with fistula and the importance of accurate documentation.	07/31/2024

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	mellitus. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/17/24, indicated Resident 75 was moderately cognitively impaired and was dependant on staff for assistance with bathing and transfers, and was receiving dialysis therapy. Current physician orders included, but were not limited to, Dialysis Monday, Wednesday, Friday at 11:20 (A.M.) (arrival time) at (dialysis center) 11: 40 A.M. chair time one time a day every Monday, Wednesday, Friday for dialysis. Start date 5/13/24. Check Bruit and Thrill to fistula to LUE (left upper extremity) every shift for fistula care. Start date 4/15/24. 1800 cc (equivalent to mL) fluid restriction per 24 hours as follows: Nursing to provide a total of 480 cc/24 hr as follows: Days=180 cc Evening=180 cc Nights=120 cc. every shift for fluid restriction. Start date 2/27/23. Current care plans included, but were not limited to: I have a new fistula to LUE (left upper extremity) and have the potential risk of infection at the site. Dated 4/16/24. I have a perma-cath left side of chest and have the potential risk of infection at the site. Dated 5/13/24. Alteration in kidney function evidenced by hendiadys CKD III (chronic kidney disease stage three), acute kidney failure dialysis 3 x a week due to End Stage Renal Disease (ESRD). Date Initiated: 12/4/23. Do not take blood pressure, on arm of access site. Encourage patient not to sleep on arm with access site Date Initiated: 4/16/24.		An order was initiated and on the chart since 2/2/2023 for monthly weights. CNA #6 was in-serviced to ensure assignment sheets are kept on their person. -How other residents have the potential to be affected will be identified. All residents who receive Dialysis have the potential to be affected. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. -Staff educated on the correct procedure to take BP on a resident with a fistula. DNS/Designee will observe BP being taken and documented for Dialysis BP 2x per week x4 weeks, 1x per week x4 weeks and 1x per month x4 months. -How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.	

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	Weights per MD (doctor) order. Date Initiated 7/10/23. The clinical record lacked an order to obtain Resident 75's weight. On 6/25/24 at 8:44 A.M., Resident 75's electronic medication administration record was reviewed. The following dates/times indicated staff obtained a blood pressure reading in Resident 75's restricted limb: 6/21/24 12:21 P.M. sitting left arm 5/24/24 8:07 A.M. sitting left arm 5/19/24 9:19 A.M. sitting left arm During an interview on 6/27/24 2:15 P.M. CNA 6 indicated she was the CNA for the 500 hall today but did not know who was on fluid restrictions. The CNA then went to nurses desk, found CNA assignment sheets and looked for residents who were on fluid restrictions. During an interview on 6/28/24 at 9:35 A.M., LPN 17 indicated nurses and CNA's should be recording fluid amount delivered to residents on fluid restrictions throughout the day and after meals, the nurse then enters the total amount at end of shift, and would expect the CNA's assigned to the hall to know who is on fluid restrictions. On 6/28/24 at 2:38 P.M., the Regional Clinical Nurse provided a policy titled Hemodialysis, dated 2023, that indicated The facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. 3.1-37(a)		Findings will be reviewed in QAA x6 months unless further monitoring is deemed necessary. -Systemic changes will be completed by 7/31/2024 Requesting paper compliance for F698 D.	

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F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §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. §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. Based on observation and interview the facility failed to provide proper storage of medications in 1 of 1 treatment carts located in the ACU (Alzheimer Care Unit) for 9 of 9 residents reviewed. Unlabeled and undated medications were found in the treatment cart. (Resident 12, Resident 15, Resident 22, Resident 25, Resident 45, Resident 47, Resident 49, Resident 57, Resident 88, Findings include:	F 0761	F761E -What corrective actions will be accomplished for those residents found to have been affected by the deficient practice Staff ensured proper storage of treatment supplies/medications. All unlabeled medications and undated items were discarded.	07/31/2024

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	On 6/26/24 at 12:35 P.M., the locked nightstand/treatment cart was observed to have the following: 1 tub of Curad petroleum jelly lacked a prescription label and an open date 1 tub of petroleum jelly for Resident 45 has prescription label but lacked an open date 1 tube of Diclofenac cream (analgesic cream) lacked a label and an open date 1 glass case with unreadable name and no glasses 1 tube of Volteran cream Resident 47 with a prescription label but lacked an open date 1 tub of Sombra (analgesic cream) Resident 49 with a prescription label but lacked an open date 1 tube of Aspercreme (analgesic cream) Resident 25 with a prescription label but lacked an open date 1 tube of Aspercreme (analgesic cream) Resident 25 with a prescription label but lacked an open date 1 tube of arthritis pain medication Resident 12 with a prescription label but lacked an open date 1 tube of Diclofenac (analgesic cream) Resident 57 with a prescription label but lacked an open date 1 tube of Aspercreme (analgesic cream) lacked a prescription label and an open date 1 bottle of fungal powder with Resident 22 with a prescription label but lacked an open date 2 bottles of fungal powder with Resident 88 with a prescription label but lacked an open date 1 tube of arthritis cream with Resident 57 with a prescription label but lacked an open date 1 tub of Sombra (analgesic cream) Resident 49 with a prescription label but lacked an open date 1 tub of Sombra (analgesic cream) without a prescription label and lacked an open date 1 bottle of Nystatin Powder (fungal powder) Resident 15 with a prescription label but lacked an		-How other residents have the potential to be affected will be identified. All residents on the Alzheimer's Care Unit have the potential to be affected. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All nurses and QMA's will be in-serviced on proper storage, labeling and dating of medications/supplies DNS/Designee will monitor treatment medications for proper labeling, storage and 2x per week x 4 weeks, 1x per week x 4 weeks and 1x per month x4 months. -How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place. Findings will be reviewed in QAA x 6 months unless further monitoring is necessary.	

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	open date During an interview on 6/26/24 at 12:40 P.M., the DON (Director of Nursing) indicated the medications should not be in the nightstand/ treatment cart and be in the medication room. During an interview on 6/28/24 at 9:26 A.M., LPN (Licensed Practical Nurse) 22 indicated medication are to be labels with a resident name, medical doctor, medication name on the prescription. All medications such as ointments creams, and powders should be dated with open date. On 6/28/24 at 2:38 P. M., the Regional Nurse provided a current, non-dated policy "Medication Storage." The policy indicated "...it was the policy of this facility to ensure all medications housed on the premises will be stored ....medication rooms...all drugs and biologicals will be stored in locked compartments... only authorized personal will have access to the keys to the locked compartments..." 3.1-25(k) 3.1-25(m)		-Systemic changes will be completed by 7/31/2024 Requesting paper compliance for F761 E.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.			

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	§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or			

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	(iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, record review, and interview, the facility failed to document assessment for symptoms of urinary tract infection for 1 of 1 residents reviewed for IV therapy. (Resident 302) Findings include: On 6/25/24 at 1:14 P.M., Resident 302's clinical record was reviewed. Resident 302 was admitted on 6/10/24. Diagnoses included, but were not limited to, infection of joint prosthesis, anxiety, and hypertension. The Admission MDS (Minimum Data Set) Assessment, dated 6/17/24 was not completed. Current care plans included, but were not limited to: Observe for signs and symptoms of UTI (urinary tract infection). Date initiated: 6/11/24. A progress note dated 6/24/24 at 12:23 P.M., indicated Resident 302 complained of lower back	F 0842	F842 -What corrective actions will be accomplished for those residents found to have been affected by the deficient practice UA C&S completed and was negative for resident 302. -How other residents have the potential to be affected will be identified. All residents have the potential to be affected -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All nursing staff on the S/S of a UTI, timely follow up with MD and continued documentation of resident S/S in the medical record DNS/Designee will review resident progress notes for S/S of UTI and for follow up on timely MD orders 2 x / x 4 weeks, 1x per week x 4 weeks, and 1x per	07/31/2024

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	155252	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - WOODLANDS CARE CENTER	4088 FRAME RD NEWBURGH, IN 47630

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	pain, received pain medication that was ineffective, peri-area (was) red, blanchable but irritated, barrier cream applied, and (resident) having increased confusion and irritability. Triage (physician phone line) notified and requested urinalysis, awaiting response. The clinical record lacked follow-up of signs and symptoms of a possible urinary tract infection (UTI) or follow up of order request from 6/24/24 at 12:23 P.M. until 6/28/24 at 10:54 A.M. when a progress note was entered that indicated a new order from nurse practitioner for a UA C&S (urinalysis with culture and sensitivity). The record lacked a bowel assessment and need for the administration of Miralax. During an interview on 6/28/24 at 10:20 A.M., the Regional Clinical Nurse indicated the resident received an order for PRN (as needed) Miralax for the possible UTI symptoms. On 6/28/24 at 2:38 P.M., the Regional Clinical Nurse provided a policy titled Documentation in Medical Records, dated 2024, that indicated Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3.1-50(a)		month x 4 months -How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place. Will review monthly in QAA x 6 months. -Systemic changes will be completed by 7/31/2024 Requesting paper compliance for F842	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an			

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	infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or			

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	organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure a resident was on EBP (enhanced barrier precautions) for open wounds, PPE was worn during wound care for a resident who required EBP, and that wound dressings were changed as ordered for 1 of 2 residents observed for wound care and contact precautions . (Resident 352, Resident 45) Findings include: 1. During an observation of wound care on	F 0880	F880 -What corrective actions will be accomplished for those residents found to have been affected by the deficient practice Resident #352 placed in EBP. Signs posted on the door of resident #352. Resident #352 care plan was updated to include EBP for surgical incision and former JP drain sites. Resident #45s care	07/31/2024

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	6/27/24 at 10:37 A.M., RN 3 and LPN 2 entered Resident 352's room. LPN 2 closed Resident 352's door and pulled the privacy curtain. RN 3 and LPN 2 washed their hands and put gloves on. Resident 352 had two dressings on the middle and lower right abdomen dated 6/25/24 and initials .. (initials of nurse); RN 3 removed the dressings from Resident 352's abdomen. LPN 2 sat up supplies on the bedside table and dated the new dressings 6/27/24. RN 3 cleansed wounds on Resident 352's abdomen, washed her hands, then applied one dressing covering the open wound on the upper middle abdomen, one dressing covering the open wound on the lower middle abdomen, and two dressings covering the open wounds on the lower right abdomen. RN 3 gathered the trash and removed gloves. RN 3 and LPN 2 washed their hands and exited the room. There was not an EBP (enhanced barrier precaution) sign on Resident 352's door. During an interview on 6/27/24 at 10:40 A.M., LPN 2 indicated Resident 352's dressings covering open wounds were ordered to be changed daily. On 6/27/24 at 1:30 P.M., Resident 352's clinical record was reviewed. Resident 352 was admitted on 6/21/24. Diagnoses included, but were not limited to, infection following a procedure surgical site, chronic obstructive pulmonary disease, and sepsis. An Admission MDS (Minimum Data Set) Assessment was not complete. Current physician orders included, but were not limited to: Cleanse 2 (two) open lesion on RLQ (right lower quadrant) of abdomen with wound cleanser, pat dry, cover with dry bordered dressing, every day shift for wound care. Start date 6/25/24. Cleanse open lesion to middle lower abdomen		plan was updated to include contact precautions. -How other residents have the potential to be affected will be identified. All residents that require EBP and contact precautions. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. staff - on care plan revisions and EBP requirements. DNS/Designee will monitor care plan revisions and signage of doors that require EBP/contact precautions 2x per week x 4 weeks, 1x per week x 4 weeks and 1x per month x 4 -How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place. Will review monthly in QAA x 6 months. -Systemic changes will be	

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	with wound cleanser, pat dry, cover with dry bordered dressing every day shift for wound care. Start date 6/24/24. Cleanse navel with wound cleanser, pat dry, apply foam bordered dressing, every day shift for wound care. Start date 6/24/24. Cleanse open lesion on RUQ (right upper quadrant) of abdomen with wound cleanser, pat dry, cover with dry bordered dressing, every day shift for wound care. Start date 6/24/24. Current care plans included, but were not limited to: Altered skin integrity non-pressure related to: 2 (two) JP (Jackson-Pratt; a surgical suction drain) drainage to RUQ (right upper quadrant of abdomen) and RLQ (right lower quadrant of abdomen). Resident noted to have eschar (dead skin tissue) from a surgical incision in medial abdominal region. Resident noted to have a previously noted area from JP site removal. Date Initiated: 06/10/24. Enhanced Barrier Precautions when providing any JP drain care and any high contact Resident care activities, See sign on door. Date Initiated: 06/10/24. During an interview on 6/28/24 at 11:47 A.M., RN 12 indicated staff performing high contact activities should wear gown and gloves, and depending on what they are doing should wear masks and goggles if needed with risk of splashes; Resident's with open wounds should have EBP sign posted on their door. 2. On 6/25/24 at 9:22 A.M., a Contact Precautions sign was observed on Resident 45's door. On 6/25/24 at 9:03 A.M., Resident 45's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia,		completed by 7/31/2024 Requesting paper compliance for F880	

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	unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety The most current Quarterly MDS (Minimum Data Set) Assessment dated 4/10/24 indicated Resident 45 was severely cognitively impaired. The resident need supervision for transfer with substantial help for mobility. Current physician orders included but not limited to: Apply skin prep to shingles on pelvic area and keep covered with dry dressing until crusted every day shift for shingles ordered on 6/19/24. Acyclovir HCl Oral Tablet 500 MG (Valacyclovir HCl) (medication for shingles), Give 2 tablets by mouth every 8 hours for Shingles for 7 Days ordered on 6/19/24. Contact Isolation due to shingles every shift ordered 6/18/24. The current care plan lacked a care plan for Contact Precautions. On 6/28/24 at 2:30 P.M., the Regional Nurse supplied a current, nondated policy " Comprehensive Care Plans." The policy indicated "... it was the policy of the facility of develop and implement a comprehensive person-centered care plan for each resident....that includes measurable objectives and timeframes...the objectives will be utilized to monitor the resident's progress. Alternative interventions will documented, as needed On 6/28/24 at 2:38 P.M., the Regional Nurse			

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	consultant provided a policy titled Wound Treatment Management, dated 2023, that indicated: Wound treatments will be provided in accordance with physician orders, including method, type of dressing, and frequency of dressing change. On 6/28/24 at 2:38 P.M., the Regional Nurse consultant provided a policy titled Enhanced Barrier Precautions, dated 2024, that indicated: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wound (e.g., (for example) ...unhealed surgical wounds...). 3.1-18(b) 3.1-18(j)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe and sanitary environment for residents, staff, and the public for 11 random observations for environment for 3 of 3 days. Food debris on resident wheelchair and dusty and debris found on a mechanical lift and sit to stand in unit hallways. (Resident 24, Resident 27, 100 Hallway, 300 Hallway, 600 Hallway) Findings include:	F 0921	F921-E. ENVIRONMENT -What corrective actions will be accomplished for those residents found to have been affected by the deficient practice All mechanical lifts and sit to stand devices were cleaned. Residents #24 and #27 ‘s wheelchairs were cleaned. -How other residents have the potential to be affected will be identified. All residents have a potential to be	07/31/2024

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	1. On 6/26/24 at 2:16 P.M., a sit to stand device on the 600 Hall was observed to have dust on the seat and white residue on the handles. On 6/27/24 at 9:10 A.M., a sit to stand device on the 600 Hall was observed to have dust on seat and white residue on the handles. On 6/27/24 at 10:10 A.M., a mechanical lift on the 100 Hall was observed to have dust, fiber debris, and white spots on the base. On 6/28/24 at 8:45 A.M., a sit to stand device on the 600 Hall was observed to have dust on the seat and white residue on the handles. On 6/28/24 at 8:46 A.M., a sit to stand device on 100 Hall was observed to have dust on the seat. On 6/28/24 at 8:51 A.M., a mechanical lift on the 300 hall was observed to have dust with fiber debris on the seat. 2. On 6/27/24 at 10:12 A.M., Resident 24's wheelchair was observed to have food debris scattered in front of the cushion while the resident was sitting in it. 3. On 6/28/24 at 8:57 A.M., Resident 27's wheelchair was observed to have chocolate milk splattered on the tires. 4. During an interview on 6/27/24 at 11:33 A.M., Resident 30 indicated the staff does not regularly wipe off or clean the wheelchairs. During an interview on 6/28/24 at 9:00 A/M., CNA (Certified Nursing Aide) 10 indicated the wheelchairs are cleaned weekly and as needed.		affected -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Nursing staff were in-serviced on cleaning of mechanical lifts, sit to stand devices and resident's wheelchairs. DCE/Designee will observe lifts to stand devices weekly x and monthly x4 months. -How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place. Findings will be reviewed in QAA x 6 months unless further monitoring is deemed necessary. -Systemic changes will be completed by 7/31/24 Requesting paper compliance for F921 E	

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	During an interview on 6/28/24 at 9:02 A/M., Resident 74 indicated they did not know if the wheelchair was wiped off. During an interview on 6/28/24 A.M., Housekeeper 32 indicated the night shift CNAs are the ones that will clean the equipment such as mechanical lifts Ashley spoke with supervisor and the housekeeping staff does not clean the equipment CNA's do. On 6/28/24 at 2:38 P.M., the Regional Nurse provided a current non-dated policy "Cleaning and Disinfection of Resident-Care Equipment." The policy indicated "...resident-care equipment can be a source of indirect transmission of pathogens...Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. General guidelines include...each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident..." This citation relates to complaint IN00434672. 3.1-19(f)			