STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155696	A. BUILDING 00 B. WING	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEPOINTE HEALTH CAMPUS	1900 COLLEGE AVE VINCENNES, IN 47591

(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, State Licensure Survey and Investigation of Complaints IN00380853, IN00388058, IN00384212, and IN00385977. This visit included a State Residential Licensure Survey. Complaint IN00380853 - Unsubstantiated due to lack of evidence. Complaint IN00388058 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00384212 - Unsubstantiated due to lack of evidence. Complaint IN00385977 - Substantiated. No deficiencies related to the allegations were cited.. Survey dates: November 28, 29, 30, December 1, 2, 5, 2022 Facility number: 003237 Provider number: 155696 AIM number: 200374360 Census Bed Type: SNF/NF: 58 SNF: 26 Residential: 23 Total: 90 Census Payor Type: Medicare: 26 Medicaid: 32 Private: 9 Total: 67	F 0000	The submission of this plan of correction does not indicate an admission by Bridgepointe Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of Bridgepointe Health Campus.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Weber	Executive Director	12/23/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 13, 2022.			
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for			

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	other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview the facility failed to provide the Centers for Medicare and Medicaid Services (CMS) form 10055 (SNF) Advanced Beneficiary Notice (ABN) to 1 of 3 residents reviewed for liability notice. (Resident 16) Findings include: On 12/1/22 at 10:00 A.M., the SNF/ABN form for Resident 16 was received from SSD. Medicare Part A Skilled Services started on 6/16/22 and last day of Part A service was 7/12/2022. The facility initiated the discharge from Medicare Part A Services when benefit days were not exhausted due to her level of function. On 12/2/22 at 11:58 A.M., Resident 16's clinical	F 0582	F582 Medicaid/Medicare/Coverage/Liability Notice Completion Date: 12/31/22 1. Residents #16 suffered no ill effects from the alleged deficient practice. Resident was assessed with no concerns. 2. All residents being discharged from Medicare services have the potential to be affected. The last 30 days of Medicare part A discharges have been assessed for completion of ABN if appropriate. SSD will be educated regarding CMS form 10055 (SNF) Advanced Beneficiary Notice	12/31/2022

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	record was reviewed. Resident 16 was admitted on 6/14/20. Diagnoses included but were not limited to acute respiratory failure with hypoxia, acute and chronic respiratory failure with hypoxia, and unspecified atrial fibrillation. Physical therapy discharged resident from their service due to the resident's achievement of the highest function obtainable. A care conference was completed on 7/12/22 with resident and family present. There was no documentation of an ABN given to the family. During an interview on 12/5/22 at 9:25 A.M., the Infection Preventionist (IP) indicated that no ABN had been given to the family or resident at the care conference. On 12/5/22 at 9:47 A.M., a current (NOMNC Completion SOP) policy, dated 6/22/21 was provided, and indicated " In order to streamline communication for completion ...SNF/ABN, this SOP outlines the expectations for completion. When would we issue...If the resident has Medicare days remaining and is staying on campus...social services will issue the SNF/ABN form..." 3.1-4(f)(2)		(ABN) completion upon changes in covered services. 3. As a measure of ongoing compliance, the ED/SSD or designee will compete an audit of 5 Medicare part A discharges as available to ensure ABN form completed weekly for 4 weeks, biweekly for two months, then monthly for 3 months. 4. As a quality measure, the SSD or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted.	
F 0657 SS=E 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			

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	the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure care plan conferences were completed. A quarterly scheduled care conference were not completed for 3 of 3 residents reviewed for care planning (Resident 19, 35, 11) and for 1 of 1 residents (Resident 45) reviewed for dementia care. Findings include: 1. On 11/29/22 at 2:07 P.M., Resident 45's clinical record was reviewed. Resident 45 was admitted to the facility on 3/3/20. The diagnoses included, but were not limited to, non-Alzheimer's dementia and asthma. The most recent quarterly MDS (Minimum Data Set) assessment, dated 11/10/22, indicated Resident 45 was severely cognitively impaired.	F 0657	F657 Care Plan Timing and Revision Completion Date: 12/31/2022 1. Residents #19, 35, 11 and Resident 45 suffered no ill effects from the alleged deficient practice. Residents #19, 35 and 11 were invited to and had Resident First Meetings completed to update the plan of care. Resident #45 and family were invited and had Resident First Meeting completed to update the plan of care. 2. All residents have the potential to be affected. SSD educated related to Resident First meeting frequency, schedule maintenance and timely completion. All residents reviewed	12/31/2022

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	Resident 45's clinical record lacked any documentation of care plan conferences after 7/21/22. During an interview on 12/1/22 at 3:23 P.M., the Regional Consultant indicated resident 45's last care plan conference was 7/21/22. 2. During an interview on 11/29/22 at 11:38 A.M., Resident 35 indicated they had not been to nor been invited to any care plan conferences. On 11/29/22 at 3:00 P.M., Resident 35's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus type II, chronic kidney disease, and acquired absence of right leg above the knee. Resident 35 was admitted to the facility on 2/24/21. The most recent quarterly MDS assessment, dated 8/23/22, indicated Resident 35 was cognitively intact. The most recent care plan conference was documented on 7/5/22. During an interview on 12/2/22 at 2:00 P.M., the Social Services Director indicated that care plan conferences should be done quarterly and Resident 35's last care plan conference was 7/5/22. 3. The medical record for Resident 11 was reviewed on 11/30/22 at 12:53 P.M. The diagnosis included, but was not limited to, hypertensive heart and chronic kidney disease with heart failure, diabetes, and cardiomyopathy, unspecified. Resident 11 was admitted to the facility on 10/18/19. The quarterly MDS (Minimum Data Set) assessment, completed on 10/28/22, assessed Resident 11 as cognitively intact.		for timeliness of Resident First meeting with meetings scheduled as indicated. 3. As a measure of ongoing compliance, the ED or designee will monitor the Resident First Meeting schedule and completion of meetings for compliance 3x/week for one month, weekly for one month, biweekly for one month then monthly for 3 months. 4. As a quality measure, the SSD will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	During an interview on 11/28/22 at 11:32 A.M., Resident 11 indicated she did not get invited to care plan conferences. She indicated her daughter was in charge of her care. On 11/30/22 at 12:53 P.M., Resident 11's clinical record was reviewed. The latest care plan conference was documented on 6/21/22. 4. During an interview with Resident 19 on 11/29/22 at 9:07 A.M., the resident indicated she had not participated in any care plan conferences. The clinical record was reviewed on 11/30/22 at 2:43 P.M., the resident was admitted 5/20/20. The facility identified care conferences as "Resident First" conferences. Two conferences were documented, dated 2/17/22 and 7/18/22. The records indicated that the resident and/or resident representative were invited to attend. Boxes were checked off to indicate the Social Service Director (SSD), Life Enrichment Director (LED) (activities), MDS coordinator, and resident/representative were in attendance. During an interview with SSD on 12/1/22 2:00 P.M., the SSD indicated that care conferences are supposed to be conducted quarterly. The policy was reviewed on 12/2/22 at 10:15 A.M., the facility policy indicated that care conferences are to be conducted at least quarterly and upon significant change in status. 3.1-35(c)(2)(C) 3.1-35(d)(2)(B)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning			

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	§ 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 received necessary respiratory care and services in accordance with professional standards of practice. The facility failed to follow physician oxygenation orders, date oxygen tubing, and clean the oxygen filter on 1 of 1 residents reviewed for respiratory care. (Resident 59) Finding includes: On 11/28/22 at 12:12 P.M., Resident 59 was out of his room, but the dial on his oxygen machine was set at 2 LPM (liters per minute). The tubing attached to the machine was not dated. On 11/28/22 at 2:20 P.M., Resident 59 was observed laying in bed with nasal cannula in place and the oxygen dial set at 2 LPM. The oxygen tubing was not dated and the machine's filter was observed to have a white layer of dust covering it. On 11/29/22 at 9:32 A.M., Resident 59 was observed laying in bed with nasal cannula in place and the oxygen dial set at 2 LPM. The oxygen tubing was not dated. On 11/30/22 at 9:33 A.M., Resident 59 was observed laying in bed with nasal cannula in place and the oxygen dial set at 2 LPM. The oxygen	F 0695	F695 Respiratory/Tracheostomy Care and Suctioning Completion Date: 12/31/22 1. Resident #59 suffered no ill effects from the alleged deficient practice. Resident was assessed and monitored with no adverse effects noted. All oxygen tubing replaced and dated, physician orders verified, concentrator set to 3 lpm, and filters cleaned immediately. Nursing department staff were immediately educated on Resident 59's oxygen delivery, dating/care of tubing and cleaning of filters/external concentrator. 2. All residents receiving oxygen have the potential to be affected. All nursing staff to be educated, by the infection preventionist, on the oxygen use policy. IP nurse completed visual observation of all residents receiving oxygen to ensure that concentrators are free of dust, oxygen tubing dated, tubing stored appropriately when not in use and that liter flow matched current physician orders.	12/31/2022

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	tubing was not dated. At that time, the resident indicated he doesn't change the setting on the machine. On 11/30/22 at 10:00 A.M., Resident 59's oxygen tubing was observed on the floor after incontinence care. CNA (certified nurse aide) 3 asked him to put the tubing back into his nose and resident did. On 11/30/22 at 8:53 A.M., Resident 59's oxygen tubing was observed on the floor while resident was out of his room. On 12/01/22 at 10:32 A.M., the oxygen machine was observed to have a white layer of dust over the filter. A sticker on the side of the machine and on top indicated it was serviced 6/1/22. The dial was set at 2 LPM and resident was laying in his bed with the nasal cannula in place. At that time, Resident 59 indicated he hasn't seen anyone clean or change the filter. There was no date on oxygen tubing. On 12/1/22 at 2:33 P.M., Resident 59 was observed laying in his bed with nasal cannula in place and the oxygen dial set at 2 LPM. There was no date on oxygen tubing. On 11/29/22 at 2:08 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), emphysema, and lung cancer. The most recent admission MDS Assessment, dated 10/31/22, indicated Resident 59 was cognitively intact and an extensive assist of 2 (two) staff for bed mobility and transfers. Current physician's orders included, but were not		3. As a measure of ongoing compliance, the DHS, IP, or designee, will complete audits of 3 residents to ensure that oxygen concentrators are free from dust, oxygen tubing is dated, tubing is stored appropriately when not in use and oxygen liter flow matches current physicians' orders daily for 4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks, then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	limited to, the following: Oxygen at 3 LPM per nasal cannula continuously three times a day (7:00 A.M.-2:00 P.M., 3:00 P.M. -10:00 P.M., 11:00 P.M.-6:00 A.M.) initiated 10/27/22 and discontinued 11/29/22. Oxygen at 3 LPM per nasal cannula continuously twice a day (6:00 A.M.-6:00 P.M., 6:00 P.M.-6:00 A.M.), initiated 11/29/22. Change oxygen tubing once a day on the first of the month, initiated 10/27/22. Clean external concentrator filter once a day on Sunday every two weeks, initiated 10/27/22. A current ADL's care plan, initiated 10/27/22, included, but was not limited to, the following intervention: Oxygen at 3 LPM continuous, initiated 10/27/22. A current activity intolerance care plan, initiated 11/3/22, included, but was not limited to, the following intervention: Oxygen as ordered by physician, initiated 11/3/22. A current potential for cardiovascular distress care plan, initiated 11/3/22, included, but was not limited to, the following intervention: Administer oxygen per order, initiated 11/3/22. A progress note, dated 11/9/22, indicated chest X-Ray results came back showing pneumonia in right lung and possible left base infiltrate. A new order was received for Doxycycline 100 mg bid (twice a day) for 1 week (7 days). On 11/28/22, documentation in the TAR indicated the resident was on 3 LPM of oxygen at 7:00 A.M. -2:00 P.M., 3:00 P.M.-10:00 P.M., and 11:00 P.M. -6:00 A.M when observed to receive 2 LPM. The following days, documentation in the TAR			

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	indicated the resident was on 3 LPM of oxygen at 6:00 A.M.-6:00 P.M. and 6:00 P.M.-6:00 A.M when observed to receive 2 LPM.: 11/29/22 11/30/22 12/1/22 During an interview on 12/1/22 at 2:35 P.M., RN (Registered Nurse) 2 indicated nursing staff were to set the oxygen machine to the proper LPM and Resident 59 doesn't adjust it. She further indicated the LPM is checked multiple times daily. At this time, RN 2 went into Resident 59's room and indicated the dial on the oxygen machine was on 2 LPM and it should have been at 3 LPM. On 12/2/22 at 10:51 A.M.,RN 2 indicated filters should be cleaned on night shift every 2 (two) weeks and tubing is supposed to be dated when changed. At that time, RN 2 also indicated-if oxygen tubing was observed on the floor, it should be tossed and a new one should be given to the resident. A current Administration of Oxygen policy, reviewed 12/1/21, provided by the DON (Director of Nursing) on 12/5/22 at 10:22 A.M., lacked information about documenting the level of oxygen the resident receives in the TAR, but indicated "guidelines to properly administer oxygen ... verify physician's order for the procedure ...oxygen setting must be set and adjusted by a licensed nurse ... date the tubing for the date it was initiated ... adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is administered" On 12/5/22 at 10:45 A.M., the Regional Consultant indicated it was their policy to follow doctor			

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	orders as written. 3.1-47(a)(6)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review, the facility failed to store and serve food in accordance with professional standards for food service safety for 3 of 3 kitchen observations. Findings include: The Main Dining room and Kitchen tour began on	F 0812	F812 Food Procurement, Store/Prepare/Serve – Sanitary Completion Date: 12/31/22 1. No residents were affected by the alleged deficient practice. Juice machine, coffee machine, coke machine, kitchen floor all immediately cleaned. Expired items, items without dates/labels and items not properly sealed disposed of immediately. Food	12/31/2022

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BRIDGEPOINTE HEALTH CAMPUS	1900 COLLEGE AVE VINCENNES, IN 47591

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	11/28/22 at 8:55 A.M. The following was observed in the main dining room as follows: 1. The juice machine had a sticky substance dripping from the spouts; the area behind spouts was sticky. On 11/29/22, the juice machine was still sticky with juice dripping from one of the dispensers. 2. The coffee machine had brown debris all over the bottom portion of the machine. 3. The Coke machine levers were sticky. The following was observed in the kitchen on 11/28/22 at 9:00 A.M.: 4. Five ice cream containers in a small portable freezer had an expiration date of 11/27/22, all were open to air. Follow up observations on 11/29/22 all the ice cream containers had Saran Wrap on the top to cover them except the strawberry, which was open to air, and orange sherbet that was partially covered. The ice cream containers all had expiration dates of 12/30/22 and 12/28/22 . The name on the new labels was the kitchen manager's name. On 12/02/22 12:11 PM Four of the containers of ice cream in small freezer were uncovered. One newly-opened container of vanilla ice cream was uncovered. 5. The floor throughout the kitchen was observed to have debris. 6. In the walk-in freezer, a bag of frozen onion rings was open to air, a partial bag of chicken was not dated.		temp obtained immediately with no concerns. Dietary staff educated immediately regarding hair net use. 2. All residents have the potential to be affected. All expired items have been discarded, equipment and kitchen environment inspected to ensure cleanliness. The dining services team to be educated on how to store and serve food in accordance with professional standards for food safety. 3. As a measure of ongoing compliance, The Director of Dining Services and/or Designee will verify & document that daily cleaning tasks including all drink stations will be completed. The Director of Dining Services and/or Designee will audit for hair net use, kitchen and drink dispenser cleanliness, labeling of items, food temperature monitoring, food storage and proper disposal of expired items five times weekly for 4 weeks, then 3 x weekly for 4 weeks, then weekly for 4 weeks, then monthly x3 months. 4. As a quality measure, the ED/DFS or designee will review any findings and corrective action weekly in QAPI meetings until 100% compliance achieved, then at least quarterly and ongoing until campus achieves one hundred	

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	7. In the dry food storage area, a bag of dry pasta was open and not dated; a box of sprinkles expired 11/18/22. Dry spices had no observable manufacturer-provided expiration or use-by dates. One side of each container was covered by a large label that covered the whole side and had a delivery date printed on it. The lemon pepper had a delivery date of 7/3/19, thyme delivered 9/24/21, cumin 6/5/19, onion powder label is torn off, rosemary 11/13/19, nutmeg open to air, delivered 3/2/16. When the lemon pepper container was shaken, the contents did not move - it was stuck together and stuck to the sides of the container. On 11/29/22, all the spices had new labels with new expiration dates; a large bin of oatmeal was about half full, dated 11/27/22; on 12/1/22 the new label listed expiration as 12/30/22. On 12/2/22 at 10:30 A.M. during an interview with the kitchen manager and the facility administrator, the kitchen manager indicated that after 6 months the spices lose their potency. He indicated that if the spices appeared fine, they continued to use them because he stated that spices didn't really go bad. A gallon-sized clear food storage bag that contained crushed Oreos was open to air. 8. In the refrigerator there was a cracked brown egg in the back and another cracked brown egg on the side of the shelf. 9. During an interview with kitchen staff in the kitchen at that time, they stated there was no thermometer in the refrigerator; the staff produced a daily log that documented the temperature in the refrigerator that morning was 36 degrees. 10. During observation in the kitchen on 11/28/22 at 9:00 A.M., employees working in the food preparation area were not wearing hairnets, or not		percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	wearing them properly. A woman in an orange shirt had no hairnet, one woman had a hairnet wrapped around only her ponytail with the rest of her hair uncovered, a dark-haired woman had lots of loose hair sticking out of her hairnet around her face. The men working in the kitchen lacked hair nets and proper beard covers, wearing only surgical masks on their faces. 11. During observation in the kitchen on 12/1/22 at 12:15 P.M., the temperature of the food on the serving line steam table was not measured prior to serving. On 12/5/22 at 12:30 P.M. during an interview with the assistant kitchen manager and the facility administrator, the assistant kitchen manager indicated the temperature of the food was measured before staff put it on the serving line steam table. He produced a daily log of food temperatures. The log contained dates but not times indicating when the food temperature was measured, so there was no way to tell when the temperature of the food was taken nor how much time lapsed between taking the temperature and serving the food. On 12/5/22 at 2:15 P.M. the assistant kitchen manager provided the hair restraint policy dated 5/31/16, which indicates that all dining service employees are required to wear hair restraints as required by the 2009 Federal Food Code; hair restraints 2-402.11 Effectiveness. This federal policy requires that "Except as provided in paragraph B of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This section does not apply to food			

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	employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles". On 12/5/22 at 12:54 P.M. the facility administrator provide the hot and cold temperature holding guidelines dated 5/31/16. The guidelines indicated that "hot food on the steam table should be at least 135 degrees Fahrenheit..." The guidelines indicated that "cold foods should be 40 degrees or less when the temperature is taken in the kitchen at the time of service". The guidelines indicated that "thermometers should be in all refrigerators, freezers, and storage areas. 3.1-21(i)(2) 3.1-21(i)(3)			
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. §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			

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	(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 (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;			

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	(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, interview and record review, the facility failed to ensure residents' medical records reflected accurate documentation of current physician's orders and treatments for 1 of 3 residents reviewed for respiratory care and 1 of 1 reviewed for nutrition. A resident's medical record indicated he consumed meals prior to the scheduled meal time and a resident's TAR (Treatment Administration Record) indicated his oxygen was set at 3 LPM (liters per minute) but was observed to receive 2 LPM. (Resident 56, Resident 59) Findings include: 1. On 12/1/22 at 8:48 A.M., Resident 56 was observed sleeping in his bed with his plate appearing untouched in front of him on the bedside table. On 12/2/22 at 11:00 A.M., Resident 56's clinical record was reviewed. Diagnoses included, but were not limited to, CVA (cerebrovascular accident) and malnutrition. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 9/15/22, indicated Resident 56 was 67 inches tall and weighed 145.6 lbs (pounds), severely cognitively impaired, an extensive assist of 1 (one) staff for eating, and had	F 0842	F842 Resident Records Completion Date: 12/31/22 1. Residents #56 and 59 suffered no ill effects from the alleged deficient practice. Resident 59 was assessed and monitored for adverse effects, order for oxygen administration was verified and oxygen liter flow was changed to 3 lpm immediately. Resident 56 was assessed and monitored for side effects. All residents have the potential to be affected. Nursing staff educated by the DHS/designee regarding meal consumption/fluid intake documentation and administration of oxygen per 1. physician's orders. Prior 30 days of meal consumptions for all residents reviewed. IP nurse completed visual observation of all residents receiving oxygen to ensure that liter flow matched current physician orders. Meal consumptions monitored in CCM by DHS/designee and oxygen	12/31/2022

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	a weight loss of 5% or more in last month or loss of 10% or more in 6 months and was not on a physician prescribed wt loss regimen. Current physician's orders included, but were not limited to, the following: Day shift to document intake and output for breakfast, lunch, and A.M. snack, initiated 12/14/21 and evening shift to document intake and output for dinner, P.M. snack, and bedtime snack, initiated 12/14/21. Mechanical soft diet, initiated 8/22/22. A current weight loss care plan, revised 9/28/22, included, but were not limited to, the following interventions: Monitor and record intake of food, initiated 12/15/21 and document and report refusal of meals/liquids, initiated 12/15/21. Resident 56's recorded weights included, but were not limited to, the following: 5/15/2022 9:50 A.M., 176.6 lbs 11/22/22 8:59 A.M., 145.6 lbs (weight loss of 17.55%) A meal time list, provided by the Administrator on 11/28/22, indicated the following times for skilled resident meals: Breakfast 7 A.M.-9 A.M. (open) Lunch 12:00 P.M. Dinner 5:00 P.M. From 10/1/22 to 12/2/22, the following meal consumption's were timestamped win the medical record before they were provided: 10/3/22 2:57 P.M. Dinner 76-100% 10/3/22 4:00 P.M. Dinner 76-100% (duplicate)		administration monitored by IP/designee during daily rounding for accuracy. 2. As a measure of ongoing compliance, the DHS, IP, or designee, will complete audits of 3 residents to ensure that meal consumption and oxygen administration is documented accurately daily for 4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks, then monthly for 3 months. 3. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	10/4/22 3:39 P.M. Dinner 76-100% 10/5/22 8:21 A.M. Lunch 76-100% 10/5/22 3:39 P.M. Dinner 76-100% 10/7/22 11:04 A.M. Lunch 76-100% 10/7/22 3:56 P.M. Dinner 76-100% 10/8/22 9:44 A.M. Lunch 76-100% 10/8/22 3:24 P.M. Dinner 76-100% 10/9/22 10:42 A.M. Lunch 51-75% 10/9/22 3:18 P.M. Dinner 76-100% 10/13/22 10:01 A.M. Lunch 76-100% 10/14/22 3:12 P.M. Dinner 76-100% 10/15/22 9:19 A.M. Lunch 76-100% 10/16/22 9:09 A.M. Lunch 76-100% 10/17/22 10:43 A.M. Lunch 51-75% 10/19/22 10:26 A.M. Lunch 51-75% 10/20/22 9:12 A.M. Lunch 76-100% 10/21/22 10:56 A.M. Lunch 76-100% 10/23/22 10:48 A.M. Lunch 51-75% 10/23/22 3:59 P.M. Dinner 76-100% 10/25/22 8:57 A.M. Lunch 51-75% 10/26/22 9:40 A.M. Lunch 76-100% 10/27/22 10:49 A.M. Lunch 76-100% 10/30/22 10:46 A.M. Lunch 26-50% 10/31/22 9:29 A.M. Lunch 76-100% 11/2/22 10:19 A.M. Lunch 76-100% 11/4/22 9:16 A.M. Lunch 51-75% 11/6/22 8:26 A.M. Lunch 76-100% 11/6/22 4:40 P.M. Dinner 76-100% 11/10/22 8:42 A.M. Lunch 76-100% 11/10/22 3:29 P.M. Dinner 76-100% 11/11/22 9:21 A.M. Lunch 76-100% 11/11/22 3:35 P.M. Dinner 76-100% 11/12/22 8:39 A.M. Lunch 76-100% 11/13/22 7:25 A.M. Lunch 76-100% 11/14/22 8:17 A.M. Lunch 76-100% 11/15/22 11:07 A.M. Lunch 51-75% 11/16/22 10:33 A.M. Lunch 76-100% 11/17/22 9:18 A.M. Lunch 76-100% 11/18/22 9:26 A.M. Lunch 76-100% 11/19/22 10:30 A.M. Lunch 26-50%			

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	11/22/22 8:26 A.M. Lunch 76-100% 11/23/22 8:54 A.M. Lunch 76-100% 11/24/22 8:05 A.M. Lunch 76-100% 11/24/22 4:27 P.M. Dinner 76-100% 11/26/22 9:16 A.M. Lunch "None" 11/27/22 10:24 A.M. Lunch 76-100% 11/28/22 9:10 A.M. Lunch 76-100% 12/2/22 8:19 A.M. Lunch 76-100% The following days, the medical record lacked documentation of meal consumption: 10/1/22 Dinner 10/13/22 Dinner 10/27/22 Dinner 11/15/22 Dinner 11/16/22 Dinner 11/18/22 Dinner 11/19/22 Dinner 11/20/22 Dinner 11/23/22 Dinner 11/25/22 Dinner 11/26/22 Dinner 11/29/22 Dinner 12/1/22 Breakfast 12/1/22 Lunch During an interview on 12/2/22 at 9:40 A.M.,QMA (Qualified Medication Aide) 4 indicated if the resident refused a meal, it should be documented as a refusal. She further indicated meals are usually served between 7:00 A.M.-9:00 A.M. for breakfast, 12:00 P.M.-1:30 P.M. for lunch, and 5:00 P.M.-6:00 P.M. for dinner. During an interview on 12/2/22 at 10:16 A.M., CNA (Certified Nurse Aide) 5 indicated meal consumption documentation should be done after the resident eats.			

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	During an interview on 12/2/22 at 10:22 A.M., CNA 6 indicated lunch was served generally between 12:45 P.M. and 1:00 P.M. and they have until the end of their work shift to document consumption of meals. During an interview on 12/2/22 at 2:05 P.M., the Regional Consultant indicated if it's not documented in the record at all, the staff may not have been able to document meal consumption before leaving the facility. During an interview on 12/5/22 at 9:57 A.M., the Regional Consultant indicated sometimes aides document meals at the same time and if they don't go back and modify the time, it shows the time it was documented. She further indicated training would be given to staff regarding documenting in the residents' medical record. A current Nursing ADL (Activities of Daily Living) Documentation Guidelines policy, reviewed 12/1/21, provided by the DON (Director of Nursing) on 12/5/22 at 10:22 A.M., lacked info related to documentation of meal consumption, but did indicate "ADL services will be conducted and documented by the CNA each shift at the "point of care" or as reasonably possible after care" 2. On 11/28/22 at 12:12 P.M., Resident 59 was out of his room, but the dial on his oxygen machine was set at 2 LPM. On 11/28/22 at 2:20 P.M., Resident 59 was observed laying in his bed with nasal cannula in place and the oxygen dial set at 2 LPM. On 11/29/22 at 9:32 A.M., Resident 59 was observed laying in his bed with nasal cannula in			

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	place and the oxygen dial set at 2 LPM. On 11/30/22 at 9:33 A.M., Resident 59 was observed laying in his bed with nasal cannula in place and the oxygen dial set at 2 LPM. At that time, the resident indicated he doesn't change the setting on the machine. On 12/1/22 at 2:33 P.M., Resident 59 was observed laying in his bed with nasal cannula in place and the oxygen dial set at 2 LPM. On 11/29/22 at 2:08 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), emphysema, and lung cancer. The most recent admission MDS Assessment, dated 10/31/22, indicated Resident 59 was cognitively intact and an extensive assist of 2 (two) staff for bed mobility and transfers. Current physician's orders included, but were not limited to, the following: Oxygen at 3 LPM per nasal cannula continuously three times a day (7:00 A.M.-2:00 P.M., 3:00 P.M. -10:00 P.M., 11:00 P.M.-6:00 A.M.) initiated 10/27/22 and discontinued 11/29/22. Oxygen at 3 LPM per nasal cannula continuously twice a day (6:00 A.M.-6:00 P.M., 6:00 P.M.-6:00 A.M.), initiated 11/29/22. A current ADL's care plan, initiated 10/27/22, included, but was not limited to, the following intervention: Oxygen at 3 LPM continuous, initiated 10/27/22. A current activity intolerance care plan, initiated 11/3/22, included, but was not limited to, the following intervention:			

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	Oxygen as ordered by physician, initiated 11/3/22. A current potential for cardiovascular distress care plan, initiated 11/3/22, included, but was not limited to, the following intervention: Administer oxygen per order, initiated 11/3/22. During observation of resident receiving oxygen at 2 LPM on 11/28/22, 11/29/22, 11/30/22, and 12/1/22 the clinical record contained documentation that the resident was receiving 3 LPM of oxygen. During an interview on 12/1/22 at 2:35 P.M., RN (Registered Nurse) 2 indicated nursing staff were to set the oxygen machine to the proper LPM and Resident 59 doesn't adjust it. She further indicated the LPM was checked multiple times daily. At that time, RN 2 went into Resident 59's room and indicated the dial on the oxygen machine was on 2 LPM and it should have been at 3 LPM. A current Administration of Oxygen policy, reviewed 12/1/21, provided by the DON (Director of Nursing) on 12/5/22 at 10:22 A.M., lacked information about documenting the level of oxygen the resident receives in the TAR, but indicated "guidelines to properly administer oxygen ... verify physician's order for the procedure ...oxygen setting must be set and adjusted by a licensed nurse ... adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is administered" On 12/5/22 at 10:45 A.M., the Regional Consultant indicated it was their policy to follow doctor orders as written. 3.1-50(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155696	A. BUILDING 00 B. WING	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEPOINTE HEALTH CAMPUS	1900 COLLEGE AVE VINCENNES, IN 47591

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Recertification, State Licensure Survey, and the Investigation of Complaints IN00380853, IN00388058, IN00384212 and IN00385977. Survey dates: November 28, 29, 30, December 1, 2, 5, 2022 Facility number: 003237 Residential Census: 23 Bridgepointe Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	The submission of this plan of correction does not indicate an admission by Bridgepointe Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of Bridgepointe Health Campus.	