STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155120	A. BUILDING 00 B. WING	06/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00408932. Complaint IN00408932. Federal/state deficiencies related to the allegations are cited at F607, F609 and F610 Unrelated deficiency is cited. Survey dates: May 31 and June 1, 2023 Facility number: 000050 Provider number: 155120 AIM number: 100266170 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 5 Medicaid: 70 Other: 27 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 2, 2023	F 0000	Preparation, submission and implementation of the plan of Corrections does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to the survey.	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,			

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

Rena Whichard | DNS | 06/17/2023

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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	neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.			
	Based on interview and record review, the facility failed to ensure their polices and procedures related to abuse were followed for an allegation of physical and verbal abuse for 1 of 3 residents reviewed for abuse. (Resident D) Findings include: On 6-1-23 at 11:30 a.m., the Administrator provided a copy of an abuse allegation for Resident D, alleging CNA 4 and CNA 5 had applied a skin barrier cream to his sacral and scrotal area that had a burning sensation to him	F 0607	p paraid="1128052048" paraeid="{ff7f33ed-33a9-4ebf-9e3d-df8baab4912c}{168}" >What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The DCE is no longer with the company. Resident D had no negative	06/30/2023

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	and the same staff members spoke to Resident D rudely and used profanity during the time of incontinence care. The abuse allegation copies included a copy of the report the facility sent to IDOH-LTC. The report indicated the incident between Resident D and the two CNA's occurred on 5-10-23 at/around 6:30 a.m. The report indicated the Administrator was not made aware of the abuse allegations until 5-11-23 at/around 9:35 a.m. The accompanying fax cover sheet indicated the abuse allegation notification was not sent to IDOH-LTC until 5-11-23 at 4:45 p.m. In an interview with the Administrator on 6-1-23 at 1:00 p.m., she indicated she did not receive the report of the alleged abuse until the next morning during the morning meeting on 5-11-23. "I immediately stopped the morning meeting and assigned different staff members to different tasks in order to get as much done as possible towards the investigation. Our DCE (Director of Clinical Education) at the time...was aware of the situation the day before and I was very disappointed she did not report to me immediately. It ended up that I didn't get the report sent to state until later in the afternoon." She indicated the DCE was relatively new to the position and was very concerned as to what was going to happen to her. "I explained the first thing we needed to do was resident safety and investigate the allegation." She indicated two days later on 5-13-23 at approximately 3:00 a.m., she received a text message from the DCE that she was ill and would not be into work that day. On the following Monday, 5-15-23, when the Administrator returned to work, she indicated had received a letter of resignation from the DCE, effective immediately. A review of the employee record of the DCE, indicated she began employment with the facility		outcomes related to the alleged deficient practice. How be identified and what corrective action will be put into place? All residents have the potential for being affected by the same alleged deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Staff will be in serviced on the policies and procedures on Abuse, Neglect, and Exploitation that prohibit and prevent abuse to include reporting to the Administrator and responding within specific timeframes per the guidelines. How the corrective action will be monitored to ensure the deficient practice will not recur, ., What quality assurance program will be put into place? DNS/designee to randomly interview 5 residents and 5 staff members per week for 4 weeks then 3 residents and 3 staff members per week for 2 months then 1 resident and 1 staff member weekly for 3 months to determine if a violation was reported or suspected to	

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	on 3-28-23. It indicated she had completed abuse and neglect training, including abuse reporting training on the same date. In an interview on 6-1-23 at 1:23 p.m., with CNA 4, she indicated she and a co-worker went into Resident D's room on 5-10-23 before breakfast to get him cleaned up for the morning. She indicated Resident D requested a specific cream to be placed on his "privates" area, as he "had some raw places there for a long time. We didn't have it, but we used the purple tube of a barrier cream and when he said it wasn't the right one, then the co-worker washed it off. The nurse, when we went asked her about the cream, she said he had a new cream and it hadn't come in yet." CNA 4 indicated she did not recall any inappropriate words or elevated voice tones being used by she or the other CNA during this time, but did recall Resident D was yelling and cursing at she and the other CNA. CNA 4 recalled Resident D later apologized and said he really appreciated everything we do. "He has a history of telling stories that aren't true, he even was moved from one room to another because of stuff like this. He has been a "care in pairs" person for a long time. I don't take care of him anymore because of this." In an interview on 6-1-23 at 2:17 p.m., with CNA 5, she indicated on the morning of 5-10-23, she and another CNA had gone into Resident D's room to get him ready for the day. "He was yelling and cussing at us the whole time. "He [later]went around telling everyone he could find in the building that we put some cream on him that was burning him and we hadn't cleaned it off. That was not true at all. When we got him cleaned up, because he has some incontinence problems and some reddened areas to his bottom, and he doesn't like to lay down during the day, we tried		determine if the reported violation was reported immediately to the Administrator. Any deficiencies identified will be corrected immediately. The results of the audits will be reviewed by the QAPI committee to determine the need for further monitoring	

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	to tell him how important it was to make sure he had some barrier cream on his bottom. As soon as we put the cream on his bottom and privates, and they were red-looking, he started yelling and cussing at us that we did it wrong and it was burning. So, I went and got the stuff to wash his bottom and privates with soap and water and rinsed and dried it good." CNA 5 indicated, "The next day, me and [name of CNA 4] got called into the office by [name of the Administrator] and it scared me to death. I've been doing this for 20 years and never had anybody accuse me of abusing them. We were put on suspension immediately, until they got their investigation done and was able to come back to work. That resident has a long history of saying things about people that aren't true. That's why we went in there with two of us to get him cleaned up and dressed for the day." In an interview with Resident D on 5-31-23 at 2:05 p.m., he indicated he has been at the facility since last fall. Resident D indicated he is treated, "overall pretty good. I can't say I have ever had anyone intentionally be rude or treat me bad or speak to me hatefully...the situation a few weeks ago," was a misunderstanding between him and the nursing staff and was dealt "fine" by the administrative team. A review of the clinical record of Resident D was conducted on 6-1-23 at 9:59 a.m. His most recent Minimum Data Set (MDS) assessment, dated 4-3-23, indicated he is cognitively intact. A review of his current, but undated care plans indicated he has made false accusations about staff and he sometimes yells at staff. The Administrator provided a copy of a policy entitled, "Abuse, Neglect and Exploitation," on			

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	5-31-23 at 10:16 a.m. This policy had a copyright date of 2023 and was indicated to be the current policy utilized by the facility. This policy indicated, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect and exploitation and misappropriation of resident property...The facility will develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property; Establish policies and procedures to investigate any such allegations...The components of the facility abuse prohibition plans are discussed herein: I. Screening...II. Employee Training...III. Prevention of Abuse, Neglect and Exploitation...IV. Identification of Abuse, Neglect and Exploitation...V. Investigation of Alleged Abuse, Neglect and Exploitation...VI. Protection of Resident...VII. Reporting/Response...VIII. Coordination with QAPI. This Federal tag relates to Complaint IN00408932. 3.1-28(a)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2			

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	hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure an allegation of staff to resident physical and verbal abuse was reported to the Administrator within 2 (two) hours of becoming aware of the allegation by a facility staff member, as well as the facility reporting the allegation of abuse to the Indiana Department of (IDOH) Long Term Care Division (LTC), within 2 (two) hours of being made aware of the allegation of abuse. (Resident D) Findings include: On 6-1-23 at 11:30 a.m., the Administrator provided a copy of an abuse allegation for Resident D, alleging CNA 4 and CNA 5 had applied a skin barrier cream to his sacral and scrotal area that had a burning sensation to him and the same staff members spoke to Resident D	F 0609	p paraid="919960926" paraeid="{89e7f3e3-77fa-4608-952a-592b8f317c77}{63}" >What corrective actions will be accomplished for those residents found to be affected by the deficient practices? Resident D had no negative outcomes related to the alleged deficient practice. How be identified and what corrective action will be taken? All residents have the potential for being affected.	06/30/2023

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	and neglect training, including abuse reporting training on the same date. In an interview on 6-1-23 at 1:23 p.m., with CNA 4, she indicated she and a co-worker went into Resident D's room on 5-10-23 before breakfast to get him cleaned up for the morning. She indicated Resident D requested a specific cream to be placed on his "privates" area, as he "had some raw places there for a long time. We didn't have it, but we used the purple tube of a barrier cream and when he said it wasn't the right one, then the co-worker washed it off. The nurse, when we went asked her about the cream, she said he had a new cream and it hadn't come in yet." CNA 4 indicated she did not recall any inappropriate words or elevated voice tones being used by she or the other CNA during this time, but did recall Resident D was yelling and cursing at she and the other CNA. CNA 4 recalled Resident D later apologized and said he really appreciated everything we do. "He has a history of telling stories that aren't true, he even was moved from one room to another because of stuff like this. He has been a "care in pairs" person for a long time. I don't take care of him anymore because of this." In an interview on 6-1-23 at 2:17 p.m., with CNA 5, she indicated on the morning of 5-10-23, she and another CNA had gone into Resident D's room to get him ready for the day. "He was yelling and cussing at us the whole time. "He [later]went around telling everyone he could find in the building that we put some cream on him that was burning him and we hadn't cleaned it off. That was not true at all. When we got him cleaned up, because he has some incontinence problems and some reddened areas to his bottom, and he doesn't like to lay down during the day, we tried to tell him how important it was to make sure he		determine if a violation was reported or suspected to determine if the reported violation was reported immediately to the Administrator. The Area Vice President or designee will audit all reportable events x 4 weeks then 4 a month x 5 months to determine if the Administrator or designee reported per the required time frame to the IDOH. Any deficiencies identified will be corrected immediately. The results of the audits will be reviewed by the QAPI committee to determine the need for further monitoring	

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	had some barrier cream on his bottom. As soon as we put the cream on his bottom and privates, and they were red-looking, he started yelling and cussing at us that we did it wrong and it was burning. So, I went and got the stuff to wash his bottom and privates with soap and water and rinsed and dried it good." CNA 5 indicated, "The next day, me and [name of CNA 4] got called into the office by [name of the Administrator] and it scared me to death. I've been doing this for 20 years and never had anybody accuse me of abusing them. We were put on suspension immediately, until they got their investigation done and was able to come back to work. That resident has a long history of saying things about people that aren't true. That's why we went in there with two of us to get him cleaned up and dressed for the day." In an interview with Resident D on 5-31-23 at 2:05 p.m., he indicated he has been at the facility since last fall. Resident D indicated he is treated, "overall pretty good. I can't say I have ever had anyone intentionally be rude or treat me bad or speak to me hatefully...the situation a few weeks ago," was a misunderstanding between him and the nursing staff and was dealt "fine" by the administrative team. A review of the clinical record of Resident D was conducted on 6-1-23 at 9:59 a.m. His most recent Minimum Data Set (MDS) assessment, dated 4-3-23, indicated he is cognitively intact. A review of his current, but undated care plans indicated he has made false accusations about staff and he sometimes yells at staff. The Administrator provided a copy of a policy entitled, "Abuse, Neglect and Exploitation," on 5-31-23 at 10:16 a.m. This policy had a copyright			

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	date of 2023 and was indicated to be the current policy utilized by the facility. This policy indicated, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect and exploitation and misappropriation of resident property...The facility will develop and implement written policies and procedures that...Establish policies and procedures to investigate any such allegations...The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency...and all other required agencies...Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury..." This Federal tag relates to Complaint IN00408932. 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law,			

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	including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of staff to resident physical and verbal abuse was reported to the Administrator within 2 (two) hours of becoming aware of the allegation by a facility staff member, which in turn resulted in the facility failing to institute safeguards for the resident's safety during the 27 hours in which the resident was not being potentially protected from the alleged perpetrators. (Resident D) Findings include: On 6-1-23 at 11:30 a.m., the Administrator provided a copy of an abuse allegation for Resident D, alleging CNA 4 and CNA 5 had applied a skin barrier cream to his sacral and scrotal area that had a burning sensation to him and the same staff members spoke to Resident D rudely and used profanity during the time of incontinence care. The abuse allegation copies included a copy of the report the facility sent to IDOH-LTC. The report indicated the incident between Resident D and the two CNA's occurred on 5-10-23 at/around 6:30 a.m. The report indicated the Administrator was not made aware of the abuse allegations until 5-11-23 at/around 9:35 a.m. The accompanying fax cover sheet indicated the abuse allegation notification was not sent to IDOH-LTC until 5-11-23 at 4:45 p.m. In an interview with the Administrator on 6-1-23 at 1:00 p.m., she indicated she did not receive the report of the alleged abuse until the next morning during the morning meeting on 5-11-23. "I immediately stopped the morning meeting and	F 0610	p paraid="520444264" paraeid="{cc70037b-b696-4dc6-afc3-b69cb55ea7e8}{16}" >What corrective action will be accomplished for the residents found have been affected by the deficient practice? The DCE is no longer employed with the company. Resident D had no negative outcomes related to the alleged deficient practice. How be identified and what corrective action will be taken? All residents have the potential from being affected by the deficient practice. What measures are being put into place and what systemic changes will be made to ensure that deficient practice does not recur? Staff will be in serviced on Abuse, Neglect, Exploitation, injuries of unknown source and misappropriation of resident's property are reported immediately, but not later than 2 hours after the allegation is made to the Executive Director. If an allegation	06/30/2023

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	assigned different staff members to different tasks in order to get as much done as possible towards the investigation. Our DCE (Director of Clinical Education) at the time...was aware of the situation the day before and I was very disappointed she did not report to me immediately. It ended up that I didn't get the report sent to state until later in the afternoon." She indicated the DCE was relatively new to the position and was very concerned as to what was going to happen to her. "I explained the first thing we needed to do was resident safety and investigate the allegation." She indicated two days later on 5-13-23 at approximately 3:00 a.m., she received a text message from the DCE that she was ill and would not be into work that day. On the following Monday, 5-15-23, when the Administrator returned to work, she indicated had received a letter of resignation from the DCE, effective immediately. A review of the employee record of the DCE, indicated she began employment with the facility on 3-28-23. It indicated she had completed abuse and neglect training, including abuse reporting training on the same date. In an interview on 6-1-23 at 1:23 p.m., with CNA 4, she indicated she and a co-worker went into Resident D's room on 5-10-23 before breakfast to get him cleaned up for the morning. She indicated Resident D requested a specific cream to be placed on his "privates" area, as he "had some raw places there for a long time. We didn't have it, but we used the purple tube of a barrier cream and when he said it wasn't the right one, then the co-worker washed it off. The nurse, when we went asked her about the cream, she said he had a new cream and it hadn't come in yet." CNA 4 indicated she did not recall any inappropriate words or elevated voice tones being used by she		of abuse is involved safeguards will be put into place to protect the resident. How be monitored to ensure the deficient practice will not , what quality assurance program will be put into place? DNS/designee to randomly interview 5 residents and 5 staff members per week for 4 weeks then 3 residents and 3 staff members per week for 2 months then 1 resident and 1 staff member weekly for 3 months to determine if a violation was reported or suspected to determine if the reported violation was reported immediately and that were put in place to maintain resident safety. Any deficiencies identified will be corrected immediately. The results of the audits will be reviewed by the QAPI committee to determine the need for further monitoring	

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	or the other CNA during this time, but did recall Resident D was yelling and cursing at she and the other CNA. CNA 4 recalled Resident D later apologized and said he really appreciated everything we do. "He has a history of telling stories that aren't true, he even was moved from one room to another because of stuff like this. He has been a "care in pairs" person for a long time. I don't take care of him anymore because of this." In an interview on 6-1-23 at 2:17 p.m., with CNA 5, she indicated on the morning of 5-10-23, she and another CNA had gone into Resident D's room to get him ready for the day. "He was yelling and cussing at us the whole time. "He [later]went around telling everyone he could find in the building that we put some cream on him that was burning him and we hadn't cleaned it off. That was not true at all. When we got him cleaned up, because he has some incontinence problems and some reddened areas to his bottom, and he doesn't like to lay down during the day, we tried to tell him how important it was to make sure he had some barrier cream on his bottom. As soon as we put the cream on his bottom and privates, and they were red-looking, he started yelling and cussing at us that we did it wrong and it was burning. So, I went and got the stuff to wash his bottom and privates with soap and water and rinsed and dried it good." CNA 5 indicated, "The next day, me and [name of CNA 4] got called into the office by [name of the Administrator] and it scared me to death. I've been doing this for 20 years and never had anybody accuse me of abusing them. We were put on suspension immediately, until they got their investigation done and was able to come back to work. That resident has a long history of saying things about people that aren't true. That's why we went in there with two of us to get him cleaned up and			

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	dressed for the day." She indicated she could not recall if she interacted with Resident D at any point later on the date of 5-10-23, but she recalled on 5-11-23 both she and CNA 4 were not scheduled to work on Resident D's hallway and did not interact with him prior to being removed from her work assignment. In an interview with Resident D on 5-31-23 at 2:05 p.m., he indicated he has been at the facility since last fall. Resident D indicated he is treated, "overall pretty good. I can't say I have ever had anyone intentionally be rude or treat me bad or speak to me hatefully...the situation a few weeks ago," was a misunderstanding between him and the nursing staff and was dealt "fine" by the administrative team. A review of the clinical record of Resident D was conducted on 6-1-23 at 9:59 a.m. His most recent Minimum Data Set (MDS) assessment, dated 4-3-23, indicated he is cognitively intact. A review of his current, but undated care plans indicated he has made false accusations about staff and he sometimes yells at staff. The Administrator provided a copy of a policy entitled, "Abuse, Neglect and Exploitation," on 5-31-23 at 10:16 a.m. This policy had a copyright date of 2023 and was indicated to be the current policy utilized by the facility. This policy indicated, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect and exploitation and misappropriation of resident property...The facility will develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect and exploitation and			

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	misappropriation of resident property; Establish policies and procedures to investigate any such allegations...The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include, but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation; Examining the alleged victim for any sign of injury, including physical examination or psychosocial assessment if needed; Increased supervision of the alleged victim and residents; Room or staffing changes, if necessary, to protect the resident(s) from the perpetrator; Protection from retaliation; Providing emotional support and counseling to the resident during and after the investigation, as needed; Revision of the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of the incident of abuse..." This Federal tag relates to Complaint IN00408932. 3.1-28(a) 3.1-28(d)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must			

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	provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on observation, interview and record review, the facility failed to ensure a staff member did not allow a resident's medication to come in contact with their bare hands during the preparation of medication for administration for 1 of 1 resident's reviewed for medication preparation. (Resident C) Findings include: During a tour of the facility on 5-31-23 at 10:25 a.m., RN 2 was observed to prepare medications for administration to Resident C. RN 2 was observed to obtain medication cards for simethicone and dicyclomine (medications used for gastric discomfort) and pop those medications directly into his bare hand and then into the	F 0755	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? RN2 was counseled, re-educated and verbalized understanding of the importance not medications to touch their bare hands. How be identified and what corrective action(s be taken? All residents that receive medication administration have the potential to be affected by the	06/30/2023

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	medication cup. RN 2 was interviewed at this time, regarding the practice of placing the medication into his bare hand, prior to placing the medication directly into the medication cup. RN 2 reiterated multiple times that it was an acceptable practice to place the medications into his bare hands, "because they [his hands] are sanitized." In an interview with the Director of Nursing on 5-31-23 at 10:45 a.m., she indicated staff should not place medications into their bare hands. A review of Resident C's clinical record was conducted on 5-31-23 at 1:03 p.m. Her diagnoses included, but were not limited to, multiple sclerosis and GERD (gastroesophageal reflux disease). A review of her current medications included, but were not limited to, dicyclomine 20 mg (milligrams) four times daily and simethicone 250 mg, 2 capsules every 8 hours. On 6-1-23 at 8:55 a.m., the Administrator provided a copy of a policy entitled, "Medication Administration." This policy had a copyright date of 2023, and was indicated to be the policy currently in use by the facility. This policy indicated, "Medications are administered by licensed nurses, or other staff who are legally authorized to do in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection...Remove medication from source, taking care not to touch medication with bare hand." On 6-1-23 at 8:55 a.m., the Administrator provided a copy of a policy entitled, "Infection Prevention and Control Program." This policy had a copyright date of 2023, and was indicated to be the policy currently in use by the facility. This		deficient practice. What measure will be put into place and what systemic changes will be made to ensure that deficient practice does not recur? Nursing staff will be educated on the importance of not allowing medications to touch bare hands and the importance of infection control when administering medications. How be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place? Medication Administration Observations to ensure that medications are not touched with bare hands will be completed on various shifts on 4 Random residents weekly x 4 weeks, then 3 residents weekly x 4 weeks then 2 resident weekly x 4 months. All deficient practices will be reported to the DNS/designee immediately and deficiencies will be corrected immediately. Results of all audits will be reviewed by the QAPI committee to determine the need for further monitoring.	

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	policy indicated, "The facility has established and maintains an 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 as per accepted national standards and guidelines...Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies." 3.1-25(b) 3.1-25(e)(1) 3.1-18(a)			