STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING 00 B. WING	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

(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 IN00444281. Complaint IN00444281 - No deficiencies related to the allegations are cited. Survey dates: October 16, 17, 18, 21, and 22, 2024 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 2 Medicaid: 63 Other: 10 Total: 75 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 25, 2024.	F 0000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record review, the facility failed to ensure a self medication administration assessment was completed for 1 of 1 residents randomly observed	F 0554	**Immediate action(s) taken for the resident(s) found to have been affected include:** Resident 30 has been deemed safe and capable of	11/11/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thomas Johnson	Executive Director	11/11/2024

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	with medications left at bedside. Finding includes: During an observation on 10/16/24 at 9:38 a.m., Resident 30 was sitting up on the side of the bed. The following items were observed sitting on top of table in front of television: - One medication bottle of Simbrinza Ophthalmic Suspension 1-0.2%, for the treatment of glaucoma. - One medication bottle of Lantanoprost Solution 0.0005%, for the treatment of glaucoma. During an observation on 10/17/24 at 8:38 a.m., a small plastic medication cup with multiple unidentified tablets and capsules were observed sitting on the table in front of the television. During an interview at that time, Resident 30 indicated that he had to eat breakfast before he could take his medication, so the nurse left them for him. During an observation on 10/21/24 at 10:50 a.m., the following was observed sitting on top of refrigerator in Resident 30's room: - One medication bottle of Simbrinza Ophthalmic Suspension 1-0.2%, for the treatment of glaucoma. - One medication bottle of Lantanoprost Solution 0.0005%, for the treatment of glaucoma. On 10/21/24 at 11:03 a.m., Resident 30's clinical record was reviewed. The clinical record lacked a self-administration medication assessment. During an interview on 10/21/24 at 10:55 a.m., Qualified Medication Aide (QMA) 5 indicated medications should not be left in resident rooms.		self-administering meds. All assessments and orders have been updated. Resident's care plan has been updated as well. **Identification of other residents having the potential to be affected was accomplished by:** The facility determined that all residents have the potential to be affected. An audit was completed to determine which residents are appropriate to be assessed for self-administration of medications. All residents were evaluated for self-administering of medication. **Actions taken/systems put into place to reduce the risk of future occurrence include:** All clinical staff were in-service regarding the facility policy for Resident Rights and Medication Administration. Education was provided by DNS and DCE on 10-31-2024. **How the corrective action(s) will be monitored to ensure the practice will not recur:** DNS or designee will audit all new admissions to ensure that they are assessed as appropriate for the ability to self-administer their medications. This audit will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4	

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	During interview on 10/21/24 at 11:30 a.m., the Director of Nursing indicated that it was not acceptable for staff to leave medication in resident rooms. The DON indicated Resident 30 did not have a medication self-administration assessment. On 10/21/24 at 11:30 a.m., the Director of Nursing provided a policy titled Medication Administration Policy, dated 2024, and indicated it was the policy currently in use for the facility. The policy indicated, 18. "Observe resident consumption of medication". 3.1-11(a)		weeks, then monthly thereafter to complete 6 months. Results of all audits will be reviewed monthly at QAPI to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure that written Notice of Transfer and Discharge was provided to the resident's representative and to the Office of the State Long-Term Ombudsman for 1 of 6 residents reviewed for written transfer and discharge notification. (Resident 31) Finding includes: On 10/17/24, at 2:00 p.m., Resident 31's clinical record was reviewed. The diagnoses included, but were not limited to, congestive heart failure and type 2 diabetes. The face sheet indicated Resident 31 had a resident representative. The Annual Minimum Data Set (MDS) assessment, dated 8/22/24, indicated Resident 31 was cognitively intact.	F 0623	**Immediate action(s) taken for the resident(s) found to have been affected include:** Notice of transfer/discharge sent to Ombudsman and resident representative for Resident 31 **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all discharging residents have the potential to be affected. Audit completed of discharges in past 30 days to ensure that all hospital transfers and discharges have notice of transfer and discharge sent to resident representative and to Ombudsman.	11/11/2024

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	The clinical record's census tab indicated Resident 31 was transferred to the hospital emergency department on 8/5/24. The Notice of Transfer or Discharge document, dated 8/5/24, indicated Resident 31 was transferred to the hospital emergency department for a facility-initiated hospital transfer on 8/5/24. Resident 31 was provided a copy of the transfer document at the time of his transfer. On 10/21/24 at 1:45 p.m., the Administrator provided a copy of the facility's August 2024 monthly report submitted to the Office of the State Long-Term Ombudsman. The report indicated Resident 31 was transferred to the hospital on 8/5/24. The monthly report did not included a copy of Resident 31's Notice of Transfer and Discharge document. The monthly report lacked specific details for the transfer including the reason for transfer, bed hold policy, and appeal rights. The clinical record lacked documentation that the written Notice of Transfer and Discharge document was provided to the resident's representative and to the Office of the State Long-Term Ombudsman for the facility-initiated hospital transfer on 8/5/24. During an interview on 10/16/24 at 1:17 p.m., Resident 31 indicated he was transferred to the hospital "this past August." During an interview on 10/18/24 at 8:43 a.m., the Director of Nursing Services (DNS) indicated Resident 31 was transferred to the hospital emergency department on 8/5/24. The facility lacked verification that the written Notice of		**Actions taken/systems put into place to reduce the risk of future occurrence include:** All licensed nursing staff and Director of Social Services were educated regarding the facility policy for Transfer and Discharge and sending information to Resident/Resident representative and Ombudsman on 10-31-2024. **How the corrective action(s) will be monitored to ensure the practice will not recur:** DNS or designee will audit all discharges to ensure that written notice of transfer and discharge was provided to resident/resident representative and to Office of the State Long Term Ombudsman. This audit will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then monthly thereafter to complete 6 months. Results of all audits will be reviewed monthly at QAPI to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

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	Transfer and Discharge document was provided to the resident's representative and to the Office of the State Long-Term Ombudsman for the facility-initiated hospital transfer on 8/5/24. During an interview on 10/21/24 at 2:05 p.m., the Social Service Director indicated the Notice of Transfer and Discharge document was not included in the monthly report that was sent to the Ombudsman. The monthly report provided to the ombudsman only included the date and location of the transfer. On 10/21/24 at 9:12 a.m., the Regional Director of Clinical Operations provided a copy of the Transfer and Discharge (including AMA [Against Medical Advice]) policy, dated 2024, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand...copies of notices for emergency transfers to the Ombudsman..." 3.1-12(a)(6)(A)(iii)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record review, the facility failed to implement the comprehensive care plan for 1 of 2 residents reviewed for falls. (Resident 7) Finding includes: On 10/16/24 at 10:00 a.m., observed Resident 7's in bed. The bed was observed to be elevated	F 0656	**Immediate action(s) taken for the resident(s) found to have been affected include:** Resident 7's bed was immediately placed in low position **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all	11/11/2024

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	(approximately 4 feet from the floor) and was not in the the lowest position. On 10/17/24 at 11:23 a.m., observed Resident 7's in bed. The bed was observed to be elevated (approximately 4 feet from the floor) and was not in the lowest position. On 10/21/24 at 8:45 a.m., observed Resident 7 in bed. The bed was observed to be elevated and was not in the lowest position. During an interview on 10/21/24 at 8:45 a.m., RN 4 indicated Resident 7's bed should always be in the lowest position. On 10/21/24 at 9:30 a.m., the clinical record for Resident 7 was reviewed. The diagnosis included, but was not limited to, dementia. The Annual Minimum Data Set assessment, dated 9/11/24, indicated Resident 7 required extensive assist with bed mobility and transfers. A Care plan, dated 2/20/23, indicated Resident 7 was at risk for falls. The interventions included, but were not limited to, keep bed in low position, dated 9/18/24. On 10/21/24 at 9:05 a.m., the Regional Director of Clinical Operations provided a policy titled Comprehensive Care Plans, dated 2024, a review of the policy indicated "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident ...3. The comprehensive care plan will describe, at minimum, the following... a. The services that are to be furnished to attain or maintain the resident's highest practicable physical,...well being."		residents at risk for falls have the potential to be affected. All residents were audited and fall care plans were reviewed for residents at risk for falls and updated as needed by 11-11-2024. **Actions taken/systems put into place to reduce the risk of future occurrence include:** All nursing staff were in-serviced regarding the facility policy for Comprehensive Care Plans and fall interventions. Education provided by DNS and DCE on 10-31-2024. All residents at risk for falls will have their care plans reviewed updated quarterly, with significant change, and as needed. **How the corrective action(s) will be monitored to ensure the practice will not recur:** DNS or designee will audit 3 resident's fall care plans daily to ensure completion. This audit will be conducted 5 days/week for 4 weeks, then 3 times/week for 4 weeks, then monthly thereafter to complete 6 months. Results of all audits will be reviewed monthly at QAPI to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

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F 0755 SS=D Bldg. 00	3.1-35(g)(2) 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to document the drug dispositions for 1 of 3 closed record residents reviewed. (Resident 49) Finding includes: On 10/18/24 at 10:35 a.m., the clinical record of Resident 49 was reviewed. The diagnoses included, but were not limited to, paraplegia (paralysis of the legs and lower body), hepatitis C (a viral infection that affects the liver), and acquired absence of bilateral legs above the knee. A physician's order summary report of medications, dated for active orders as of 10/14/24, included, but were not limited to: - acidophilus probiotic blend 1 mcg (microgram) for probiotic - atorvastatin calcium 20 mg (milligram) for hyperlipidemia (high levels of fat in blood) - bacitracin ointment 500 unit/gm (gram) for wound care - benzocaine-menthol-zinc chloride gel 20-0.26-0.15 % for tooth pain - diazepam 5 mg for anxiety/seizures - docusate sodium 100 mg for constipation	F 0755	**Immediate action(s) taken for the resident(s) found to have been affected include:** Disposition of medications confirmed with resident 49's representative. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all discharging residents have the potential to be affected. Audit completed of all discharged residents over the past 30 days to ensure discharge medication disposition was completed. **Actions taken/systems put into place to reduce the risk of future occurrence include:** All licensed nursing staff were in-serviced regarding the documentation of drug dispositions. Education provided by DNS and DCE on 10-31-2024. All residents discharging will have their charts reviewed the following business day to ensure appropriate disposition of medications was completed.	11/11/2024

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	- ferrous sulfate 325 mg for iron supplementation - fluticasone propionate nasal suspension 93 mcg for nasal congestion - gabapentin 600 mg for pain - ibuprofen 400 mg for pain - Lidoderm patch 5 % for costochondritis (inflammation of the cartilage that connects your ribs to your breastbone) - linaclotide 145 mcg for irritable bowel syndrome - methadone hydrochloride 5 mg for substance abuse/pain - oxybutynin chloride extended release 5 mg for urinary incontinence - oxycodone hydrochloride 5 mg for spinal cord injury - oyster shell calcium 500 mg for supplement - sofosbuvir-Velpatasvir 400-100 mg for viral hepatitis C - trazodone hydrochloride 50 mg for depression - vitamin D3 1.25 mg for supplement A progress note, dated 10/14/24 at 5:47 p.m., indicated Resident 49 left the facility via bus and had been discharged with medication to home. Resident 49's record lacked documentation listing any name, type, or amount of medications that were sent home with the resident or resident's		**How the corrective action(s) will be monitored to ensure the practice will not recur:** DNS or designee will audit all discharged residents' charts weekly x4 weeks to ensure documentation of drug disposition is completed. Then 3 discharged residents monthly x5 months. Results of all audits will be reviewed monthly at QAPI to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

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	representative. During an interview on 10/18/24 at 10:50 a.m., the Regional Director of Clinical Operations (RDOC) indicated that the facility lacked documentation for drug dispositions for Resident 49. During an interview on 10/18/24 at 1:10 p.m., the RDOC indicated that the facility lacked a specific policy for drug dispositions. 3.1-25(s)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure a medication cart was locked for 1 of 4 medication carts observed. (B Hall Medication Cart) Finding includes: On 10/16/24 from 9:25 a.m. until 9:40 a.m., observed an unlocked medication cart on the B hall. The cart was easily opened and no staff were visible in the area. The medication cart contained multiple resident's medications. The medications located inside the medication cart, included but was not limited to: - haloperidol 5 mg (milligram), a medication used to treat nervous, emotional and mental conditions. - metronidazol, a medication used to treat infections. - metoprolol 2.5 mg, a medication used to treat	F 0761	**Immediate action(s) taken for the resident(s) found to have been affected include:** Medication cart was immediately locked and audit was completed of all carts in facility to ensure locking. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents have the potential to be affected. All medication carts audited to ensure their locking mechanisms are functioning appropriately. **Actions taken/systems put into place to reduce the risk of future occurrence include:** All licensed nursing and QMA staff were in-serviced regarding the	11/11/2024

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	high blood pressure. - Eliquis 2.5 mg, a medication used to prevent blood clots from forming. During an interview on 10/16/24 at 9:45 a.m., the Medical Records Director indicated the medication cart should have been locked. On 10/17/24 at 10:53 a.m., the Regional Director of Clinical Services provided a policy titled Medication Storage, dated February, 2024, and indicated it was the current policy being used by the facility. A review of the policy indicated "...1. a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts...)." 3.1-25(m)		facility policy titled Medication Storage. Education provided by DNS and DCE on 10-31-2024. **How the corrective action(s) will be monitored to ensure the practice will not recur:** DNS or designee will audit all medication carts on a rotating basis on various shifts to ensure that they are kept locked and medications are secure. This audit will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then monthly thereafter to complete 6 months. Results of all audits will be reviewed monthly at QAPI to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was prepared in a sanitary manner for 2 of 2 kitchen observations. Hair was not covered. (Dietary Manager) Findings include: On 10/16/24 from 9:08 a.m. to 10:00 a.m., observed the Dietary Manager in the kitchen food preparation area where food had been prepared	F 0812	**Immediate action(s) taken for the resident(s) found to have been affected include:** Hair nets were immediately put on by all staff cooking, preparing, or assembling food. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents have the potential to be	11/11/2024

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	for the morning meal and shipment of supplies were being put away. The Dietary Manager was observed to be lacking a hair net with hair measuring approximately one forth of an inch over the entire head. On 10/16/24 from 11:45 a.m. to 12:45 p.m., the Dietary Manager was observed in the kitchen assisting with food preparation for the noon meal. The Dietary Manager was observed to be lacking a hair net. During an interview on 10/16/24 at 12:45 p.m., the Dietary Manager indicated hair nets should be worn. During an interview on 10/17/24 at 2:58 p.m., the Regional Director for Clinical Operations indicated all kitchen staff preparing food should have been wearing hair nets. On 10/16/24 at 12:46 p.m., the Regional Director of Clinical Operations provided a copy of Food Safety requirement, dated 2024, and indicated it was the current policy in use by the facility. A review of the policy indicated, page 3 section 7.e "... Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad, ..." On 10/17/24 at 2:00 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, (b)"food employees shall wear hair restraints, such as hats, hair coverings or nets ...that are designed and worn to effectively keep their hair from contacting...exposed food ..." 3.1-21(i)(2) 3.1-21(i)(3)		affected. **Actions taken/systems put into place to reduce the risk of future occurrence include:** All dietary staff were in-serviced regarding the facility policy for Food Safety. Education was provided by DNS and dietary manager on 10-31-2024. Visual aides and hair net supplies placed at all entrances to kitchen. **How the corrective action(s) will be monitored to ensure the practice will not recur:** Dietary Manager or designee will audit alternating shifts and dates to ensure hair nets are being worn. This audit will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then monthly thereafter to complete 6 months. Results of all audits will be reviewed monthly at QAPI to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

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(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 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on interview and record review, the facility failed to ensure residents were provided a two-step Mantoux skin test (tool used for screening for tuberculosis) upon admission for 3 of 5 residents reviewed for tuberculosis skin tests. (Resident 32, Resident 33, and Resident 44) Findings include: 1. On 10/16/24 at 10:30 a.m., Resident 32's clinical record was reviewed. Resident 32's diagnoses included, but were not limited to, COPD, chronic kidney disease, and type 2 diabetes. Resident 32's clinical record lacked any documentation of a first step or a second step Mantoux skin test upon admission. 2. On 10/16/24 at 11:15 a.m., Resident 33's clinical record was reviewed. Resident 33's diagnoses included, but were not limited to, COPD, encephalopathy (a syndrome of brain dysfunction), and alcoholic liver disease. Resident 33's clinical record lacked any documentation of a first step or a second step Mantoux skin test upon admission. 3. On 10/16/24 at 11:00 a.m., Resident 44's clinical record was reviewed. Resident 44's diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, and type 2 diabetes. Resident 44's clinical record lacked any documentation of a first step or a second step	F 0880	**Immediate action(s) taken for the resident(s) found to have been affected include:** All resident without TB test have been given one and will be followed by 2nd step. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents that did not receive the Mantoux skin test, or have a contraindication, have the potential to be affected. Audit completed of all residents to ensure all residents have appropriate Mantoux skin tests being done. **Actions taken/systems put into place to reduce the risk of future occurrence include:** All licensed nursing staff were in-serviced regarding the facility policy for Resident Screening for Tuberculosis. Education was provided by DNS and DCE on 10-31-2024. All residents without an admission TB test will have a TB test done by 11-11-2024 unless contraindicated and risk assessment will be completed.	11/11/2024

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	155138	A. BUILDING 00 B. WING	10/22/2024

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	Mantoux skin test upon admission. During an interview on 10/18/24 at 1:40 p.m., the RDCO (Regional Director of Clinical Operations) indicated that Mantoux skin tests should be given upon admission. On 10/21/24 at 1:30 p.m., the Administrator provided an undated policy titled, "Resident Screening for Tuberculosis", and indicated it was the policy currently in use by the facility. A review of the policy indicated that the facility screens for tuberculosis in accordance with state requirements and tuberculin skin tests must be completed within three months prior to admission or upon admission. 3.1-18(b)(1)		**How the corrective action(s) will be monitored to ensure the practice will not recur:** **The IP nurse/DON/Designee will monitor all new admissions for 4 weeks then 3 new admissions monthly x 5months. Results of all audits will be reviewed monthly at QAPI for no less than 6 months to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.**	
F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Based on interview and record review, the facility failed to have residents sign the appropriate consent or refusal forms for pneumococcal vaccinations upon admission for 4 of 5 residents reviewed for immunization records. (Resident 3, Resident 32, Resident 33, and Resident 44) Findings include: 1. On 10/16/24 at 10:45 a.m., Resident 3's clinical record was reviewed. Resident 3's diagnoses included, but were not limited to, COPD (a lung disease that makes it difficult to breathe), chronic hepatitis C (a viral infection that affects the liver), and unspecified kidney injury. On 10/17/24 at 8:30 a.m., the DON (Director of	F 0883	**Immediate action(s) taken for the resident(s) found to have been affected include:** All residents were offered pneumococcal vaccine as appropriate. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents without appropriate vaccinations or contraindications have the potential to be affected. Audit completed of all residents to ensure all residents have appropriate pneumococcal	11/11/2024

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	Nursing), provided a copy of Resident 3's pneumococcal vaccine consent form. A review of the form indicated it was signed as "verbal from POA [Power of Attorney]" and was undated. 2. On 10/16/24 at 10:30 a.m., Resident 32's clinical record was reviewed. Resident 32's diagnoses included, but were not limited to, COPD, chronic kidney disease, and type 2 diabetes. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 32's pneumococcal vaccine consent form. A review of the form indicated it was signed by the resident and was undated. 3. On 10/16/24 at 11:15 a.m., Resident 33's clinical record was reviewed. Resident 33's diagnoses included, but were not limited to, COPD, encephalopathy (a syndrome of brain dysfunction), and alcoholic liver disease. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 33's pneumococcal consent form. A review of the form indicated it was signed by the DON "for [Resident 33]" and was dated 10/16/24. 4. On 10/16/24 at 11:00 a.m., Resident 44's clinical record was reviewed. Resident 44's diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, and type 2 diabetes. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 44's pneumococcal consent form. A review of the form indicated it was signed by two staff witnesses and was dated for 10/16/24. During an interview on 10/18/24 at 1:40 p.m., the RDCO (Regional Director of Clinical Operations) indicated that the forms should have been signed		vaccinations offered, consents are being signed and being given, and if resident refuses, they are given education and refusal form is signed and education documented. **Actions taken/systems put into place to reduce the risk of future occurrence include:** All licensed nursing staff were in-serviced regarding the facility policy for Pneumococcal Vaccine. Education provided by DNS and DCE on 10-31-2024. All residents offered vaccines and were given, and consents signed by 11-11-2024. If resident refuses, they are given education ad refusal form is signed and education documented. **How the corrective action(s) will be monitored to ensure the practice will not recur:** Executive Director or designee will audit new admissions to ensure that they are offered appropriate Pneumonia vaccine upon admission and consent form signed and vaccination given or refusal signed and education documented. This audit will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then monthly thereafter to complete 6 months. Results of all audits will be reviewed monthly at QAPI to identify any trends or	

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	upon admission. The consent forms records were requested on 10/16/24 at the end of the first day of the survey and were provided on the morning of 10/17/24. All of the forms were dated for 10/16/24 or were undated, and the RDCO indicated that any undated areas on forms were also from 10/16/24. On 10/16/24 at 10:15 a.m., the DON provided an undated policy titled, "Pneumococcal Vaccine (Series)" and indicated it was the policy currently in use by the facility. A review of the policy indicated that each resident is to be assessed for pneumococcal immunizations upon admission and that a consent form shall be signed prior to the administration of the vaccine. 3.1-13(a)		patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	
F 0887 SS=E Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization Based on interview and record review, the facility failed to have residents sign the appropriate consent or refusal forms for Covid-19 (SARS-CoV-2) vaccinations upon admission for 4 of 5 residents reviewed for immunization records. (Resident 3, Resident 32, Resident 33, and Resident 44) Findings include: 1. On 10/16/24 at 10:45 a.m., Resident 3's clinical record was reviewed. Resident 3's diagnoses included, but were not limited to, COPD (a lung disease that makes it difficult to breathe), chronic hepatitis C (a viral infection that affects the liver), and unspecified kidney injury. On 10/17/24 at 8:30 a.m., the DON (Director of	F 0887	**Immediate action(s) taken for the resident(s) found to have been affected include:** All residents offered, and obtaining signatures on the the appropriate consent or refusal forms for Covid-19 (SARS-CoV-2) vaccines. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents that are not up to date on COVID-19 vaccinations have the potential to be affected. Audit completed of all residents to ensure all residents have appropriate COVID-19	11/11/2024

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	Nursing), provided a copy of Resident 3's Covid-19 vaccine consent form. A review of the form indicated it was signed as "verbal from POA [Power of Attorney]" and was undated. 2. On 10/16/24 at 10:30 a.m., Resident 32's clinical record was reviewed. Resident 32's diagnoses included, but were not limited to, COPD, chronic kidney disease, and type 2 diabetes. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 32's Covid-19 vaccine consent form. A review of the form indicated it was signed by the resident and was dated 10/16/24. 3. On 10/16/24 at 11:15 a.m., Resident 33's clinical record was reviewed. Resident 33's diagnoses included, but were not limited to, COPD, encephalopathy (a syndrome of brain dysfunction), and alcoholic liver disease. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 33's Covid-19 consent form. A review of the form indicated it was signed by the DON "for [Resident 33]" and was dated 10/16/24. 4. On 10/16/24 at 11:00 a.m., Resident 44's clinical record was reviewed. Resident 44's diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, and type 2 diabetes. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 44's Covid-19 consent form. A review of the form indicated it was signed by two staff witnesses and was undated. During an interview on 10/18/24 at 1:40 p.m., the RDCO (Regional Director of Clinical Operations) indicated that the forms should have been signed		vaccinations are being offered, consents are being signed and being given, and if resident refuses, they are given education and refusal signed and education documented. **Actions taken/systems put into place to reduce the risk of future occurrence include:** All licensed nursing staff were in-serviced regarding the facility policy for Covid-19 Vaccine. Education provided by DNS and DCE on 10-31-2024. All residents offered vaccines, consent forms are signed and vaccines given. If resident refuses, they are given education and refusal form is signed and education documented by 11-11-2024. **How the corrective action(s) will be monitored to ensure the practice will not recur:** Executive Director or designee will audit new admissions to ensure that they are offered COVID-19 vaccine upon admission and consent form or refusal and education is documented. This audit will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then monthly thereafter to complete 6 months. Results of all audits will be reviewed monthly at QAPI to identify any trends or patterns. If	

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	upon admission. The consent forms records were requested on 10/16/24 at the end of the first day of the survey and were provided on the morning of 10/17/24. All of the forms were dated for 10/16/24 or were undated, and the RDCO indicated that any undated areas on forms were also from 10/16/24. On 10/16/24 at 10:15 a.m., the DON provided an undated policy titled, "Covid-19 Vaccination" and indicated it was the policy currently in use by the facility. A review of the policy indicated residents are to be offered immunizations for Covid-19 and that a consent form shall be signed prior to the administration of the vaccine.		any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to ensure biohazard materials were stored behind a locked door for 1 of 1 biohazard rooms observed. (B Hall) Finding included: On 10/16/24 at 10:45 a.m., observed an unlocked biohazard room located on the B hall. No staff were present in the area. A sign posted on the door indicated caution biohazard materials, soiled utility, keep door locked. The door was unlocked and easily opened. Inside the room observed a large canister full of soiled linen. The room had a strong odor of urine. During an interview on 10/16/24 at 11:00 a.m., the Medical Records Director indicated the biohazard room should be locked. On 10/17/24 at 10:53 a.m., the Regional Director of	F 0921	**Immediate action(s) taken for the resident(s) found to have been affected include:** All biohazard room doors were immediately locked. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents have the potential to be affected. All biohazard doors in facility were audited to ensure their locking mechanisms are functioning properly. **Actions taken/systems put into place to reduce the risk of future occurrence include:** All staff were in-serviced regarding	11/11/2024

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	Clinical Operations provided a copy of a policy titled Medical Waste, dated 2024, and indicated it was the current policy being used by the facility. A review of the policy indicated "Policy: It is the policy of this facility to ensure that regulated medical waste is managed, handled, stored, and transported as per Federal, State and local guidance and regulations." 3.1-19(f)		the facility policy for Medical Waste and keeping biohazard materials secure. Education was provided by DNS and DCE on 10-31-2024. **How the corrective action(s) will be monitored to ensure the practice will not recur:** Executive Director or designee will audit doors to ensure biohazard room doors remain locked. This audit will be conducted 5 times weekly on various shifts for 4 weeks, then 3 times weekly for 4 weeks, then monthly thereafter to complete 6 months. Results of all audits will be reviewed monthly at QAPI to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	