STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, IN 47304

(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 Complaints IN00436377, IN00436684, and IN00437298. Complaint IN00436377 - No deficiencies related to the allegations are cited. Complaint IN00436684 - Federal/state deficiencies related to the allegations are cited at F690. Complaint IN00437298 - No deficiencies related to the allegations are cited. Survey dates: July 8, 9, 10, 11 & 12, 2024 Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census Bed Type: SNF/NF: 98 Total: 98 Census Payor Type: Medicare: 3 Medicaid: 70 Other: 25 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 23, 2024.	F 0000	Preparation, submission and implementation of this plan of correction does not constitute an admission or agreement with the facts and conclusions set forth the survey report. Our plan of correction was prepared and executed as a means to continously improve the quality of care and comply with all applicable federal and state requirements. The facililty respectfully requests a desk review of our response to this survey.	
F 0637 SS=D	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant			

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

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

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Bldg. 00	Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on record review and interview, the facility failed to ensure completion of a Significant Change Minimum Set (MDS) assessment within 14 days of a determined status change for 2 of 5 residents reviewed for timely Significant Change assessments. (Residents 18 and 203) Findings include: 1. Resident 8's clinical record was reviewed on 7/10/24 at 3:12 p.m. Diagnosis included Chronic Obstructive Pulmonary Disorder (COPD), morbid obesity due to excess calories, and dependence on supplemental oxygen. A current physician order, dated 12/8/23, indicated admission to hospice services related to COPD. The annual MDS assessment, dated 12/11/23, indicated the resident utilized oxygen daily and received hospice services. A significant change MDS assessment was not completed.	F 0637	-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 18 MDS was updated to reflect the Significant change of Hospice. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Current Residents of Muncie are at risk having missed Significant Change in Status Assessments. A baseline audit of admissions to hospice was completed for the last to ensure completed on Significant Change MDS. -what measures will be put into place and what systemic changes will be made to ensure that the	08/12/2024

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	During an interview, on 7/11/24 at 10:58 a.m., the MDS Coordinator indicated she started her current position in April of 2024. She utilized the Resident Assessment Instrument (RAI) manual for overseeing the MDS department. Resident 18 required a Significant Change assessment with the new order for hospice services. The annual assessment completed was not the correct assessment for this status change. 2. Resident 203's clinical record was reviewed on 7/11/24 at 4:00 p.m. Diagnosis included Alzheimer's Disease, protein-calorie malnutrition, and diastolic heart failure. A physicians order, dated 5/31/24, indicated admission to hospice services related to Alzheimer's Disease. The clinical record lacked a Significant Change assessment for new hospice services. During an interview, on 7/11/24 at 10:58 a.m., the MDS Coordinator indicated she utilized the Resident Assessment Instrument (RAI) manual for overseeing the MDS department. Upon reviewing the MDS for resident 203, a Significant Change assessment was needed for the new order for hospice services. Resident 203 had been removed from one hospice provider on 5/8/24 and the appropriate assessment was completed. She was not sure why the appropriate assessment for the additional status change on 5/31/24 was not completed. Review of the current RAI manual, retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf, on 7/15/24 at 9:05 a.m., indicated the following: "...A Significant		deficient practice does not recur Education provided to MDS regarding importance of completing the MDS when a resident admits or discharges from hospice services and if help is needed, to request it from supervisor. On- going audit to be completed by ED or designee to ensure timely completion of Significant Change for hospice admission. Audit to be completed Bi-weekly X 2 months then monthly thereafter to complete 6 months. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place	

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	Change in Status Assessment (SCSA) must be within 14 days from the effective date of the hospice election... and must be performed regardless of whether an assessment was recently conducted on the resident..." 3.1-31(d)(1)			
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to ensure timely completion of Quarterly Minimum Data Set (MDS) assessments every three months for 1 of 5 reviewed for timely assessment. (Residents 65) Findings include: Resident 65's clinical record was reviewed on 7/10/24 at 3:37 p.m. Current diagnosis included heart failure, paranoid schizophrenia, bipolar disorder, and anxiety disorder. The resident had a Quarterly MDS assessment, with the Assessment Reference Date (ARD) of 12/13/23 completed on 1/11/24. The assessment was completed 15 days late. The resident had a Quarterly MDS assessment, with the ARD of 9/12/23 which was completed on 9/27/23. The assessment was completed one day late. During an interview, on 7/11/24 at 10:58 a.m., the MDS Coordinator indicated she started her	F 0638	-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 65's quarterly MDS with ARD 12/13/2023 was completed on 1/11/2024. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Current residents of Muncie with are at risk of having late MDS. A baseline audit of past due Quarterly MDS's was completed on 8/6/2024. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur	08/12/2024

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	current role in April 2024 and utilized the Resident Assessment Instrument (RAI) manual for organizing the MDS position. She indicated the above listed assessments were completed late. Review of the current RAI manual, retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf, on 7/15/24 at 9:05 a.m., indicated the following: "... The Quarterly MDS completion date must be no later than 14 days after the assessment reference date (ARD)..." 3.1-31(d)(3)		Education provided to the MDS nurse on the importance of completing the MDS on time. On-going audit to be completed by ED or to ensure completion of MDS timely. Audit to be completed Bi- weekly X 2 months and monthly thereafter to complete 6 months. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place	
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.			

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	§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on record review and interview, the facility failed to ensure timely submission of Minimum Data Set (MDS) assessments for 1 of 5 resident	F 0640	what corrective action(s) will be accomplished for those residents found to have been affected by the	08/12/2024

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	reviewed for assessment submission. (Resident 65) Findings include: Resident 65's clinical record was reviewed on 7/10/24 at 3:37 p.m. Current diagnoses included heart failure, paranoid schizophrenia, bipolar disorder and anxiety disorder. The resident had a Quarterly MDS assessment with the Assessment Reference Date (ARD) of 5/6/24, completed on 5/13/24. The assessment was completed on time. The record lacked a transmission date. During an interview, on 7/11/24 at 10:58 a.m., the MDS Coordinator indicated she was not aware this assessment had not been transmitted. Upon reviewing the above assessment, she thought this could be an error in the program, as she could see the document was marked as not required for transmission. She would need to reach out to her consultant for direction. Review of the current the RAI manual, retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf, on 7/15/24 at 9:16 a.m., indicated the following: "..."... The Quarterly MDS submission date must be no later than the completion date plus 14 calendar days..."		deficient practice Resident 65's MDS was transmitted on 7.11.2024 -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Current of Muncie with MDS's due are at risk of MDS transmitted late. A baseline audit of MDS's transmitted late was completed on 8.6.2024. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education was completed with MDS on importance of transmitting the MDS on time. On-going audit to be completed by ED or designee to ensure timely completion and transmission of MDS. Audit to be completed Biweekly X 2 months then monthly thereafter to complete 6 months. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place	

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to provide consistent interventions to maintain urinary drainage devices	F 0690	what corrective action(s) will be accomplished for those residents found to have been affected by the	08/12/2024

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	for 2 of 3 residents reviewed for urinary catheters. (Residents B and C). Findings include: 1. Resident B's clinical record was reviewed on 7/9/24 at 3:04 p.m. Diagnoses included, paraplegia, obstructive and reflux uropathy, malignant neoplasm of the bladder, and Methicillin-resistant Staphylococcus aureus (MRSA - bacteria resistant to treatment) infection. A current physician order, dated 7/3/24, included Bactrim (antibiotic) Double Strength (DS) - give 1 tablet by mouth twice daily related to a MRSA infection for 10 days. A current physician order, dated 3/9/23, included monitor urostomy site for signs/symptoms of infection every shift for urostomy monitoring. A current physician order, dated 3/9/23, included record urostomy output every shift for output monitoring. A current physician order, dated 3/9/23, included observe for signs/symptoms of urinary tract infection such as leaking or abdominal cramps every shift and notify the physician. A current physician order, dated 4/8/24, included gown and gloves for all interactions with the resident every shift. A quarterly Minimum Data Set (MDS) assessment, dated 6/5/24, indicated the resident was cognitively intact. He was dependent on staff assistance for toileting and transfers and used a wheelchair for mobility. He required a urostomy and had frequent bowel incontinence.		deficient practice Maintenance of catheter completed during survey for Resident B and C. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed of all current residents with catheter/ the last to ensure documentation of output monitoring completed. MD updated resident documented outputs. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with all nursing staff on catheter care to include Maintenace of catheter drainage bag and monitoring output. On-going monitoring to be completed by DNS or to monitor TAR of those with a catheter for lack of documentation and monitoring drainage bag. On- going audit to be completed by DNS or to randomly check resident with catheter on random shift to ensure catheter bag drainage. Resident interview to be	

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	A current care plan, dated 3/9/23, indicated the resident had a urostomy related to obstructive uropathy. Interventions included the following: observe for complications and the document findings if noted (3/9/23), monitor output from the urostomy (5/19/23), and document output as per facility policy (1/24/23). Review of the residents Treatment Administration Record, from 6/1/24 to 6/11/24, indicated the resident lacked urostomy output monitoring on the following dates and shifts: a. 6/2/24 - second shift b. 6/14/24 - second shift c. 6/19/24 - second shift d. 6/28/24 - second shift e. 7/2/24 - third shift f. 7/3/24 - third shift The resident failed to have his urostomy urinary drainage bag emptied until it was completely full on the following dates, shifts, and output amounts: a. 6/7/24 - third shift - 2000 milliliters (ml) b. 6/16/24 - third shift - 2000 ml c. 6/21/24 - second shift - 2000 ml d. 7/2/24 - first shift - 2600 ml e. 7/10/24 - first shift - 3050 ml During an observation on 7/10/24 at 10:00 a.m., LPN 8 delivered medication to Resident B's roommate. Resident B's urinary drainage bag was hung on the right side of his bed and excessively expanded, much like a balloon, and the tubing was full of clear yellow urine. LPN 8 exited the resident's room. The resident's catheter was not emptied at this time.		completed to ensure no concerns with catheter care. Monitoring to be X weekly for weeks, weekly X 4 weeks, then monthly to complete 6 months. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place	

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	During an observation on 7/10/24 at 11:32 a.m., LPN 8 used a graduated measuring container to empty the resident's over-full and expanded urinary drainage bag. The nurse had to make three separate trips with the graduated measuring container to empty the urinary drainage bag entirely. During an interview on 7/10/24 at 11:35 a.m., LPN 8 indicated the aides were not supposed to allow the urinary drainage bags get full and were responsible for emptying the urinary drainage bags every shift. She indicated a total of 3050 milliliters (ml) was in the resident's urinary collection bag when she emptied it during the observation. She thought the resident's urinary drainage bag was severely over-full and she was afraid it might burst when she touched it to empty it. During an interview on 7/10/24 at 3:57 p.m., Resident B indicated, approximately two or three times a week, staff had failed to empty his urinary drainage bag for an entire shift in the last month. He was dependent on staff to empty his urinary collection bag as he was unable to do it himself. 2. During an interview on 7/09/24 at 11:33 a.m., Resident C was in his bed with his urinary drainage bag hung on the resident's left side of the bed frame. The urinary drainage bag contained 900 ml of clear yellow urine. Wet, yellow residue was observed on the floor tiles below the urinary drainage bag the span of 1.5 large tiles in length and 1 large floor tile in width, towards the center of the bed. The yellow residue was wet underneath the urinary drainage bag and dried as it went towards the center of the bed. Resident C indicated the facility staff had been			

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	letting the urinary drainage bag get very full before they emptied it. He knew it was very full because they had to use two of the graduated measuring containers to get it emptied. Resident C's clinical record was reviewed on 7/9/24 at 3:14 p.m. Diagnoses included obstructive and reflux uropathy and urine retention. A current physician's order, dated 4/28/24, included monitoring of the suprapubic urinary catheter site for sign or symptoms of infections and document output every shift. A current physician order, dated 4/29/24, included gown and gloves for all interactions with the resident every shift for enhanced precautions. A quarterly MDS assessment, dated 5/3/24, indicated the resident was cognitively intact. The resident was dependent on staff assistance for toileting, lower body dressing, bathing, and transfers. He had an indwelling catheter and was always incontinent of bowel. A current care plan, dated 10/31/22, indicated the resident had a suprapubic urinary catheter. Interventions included the following: change catheter bag as ordered/needed (9/14/22), check catheter tubing for proper drainage and positioning (9/14/22), catheter care every shift and as needed (11/1/22), and observe for signs/symptoms of leaking, burning with urination, increased frequency of urination, cloudy urine, flank pain, fever or abdominal cramps every shift (5/20/23). Review of the resident's Treatment Administration Record from 6/1/24 to 6/11/24 indicated the			

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	resident lacked suprapubic catheter output monitoring on the following dates and shifts: a. 6/2/24 - first and second shift b. 6/8/24 - first shift c. 6/14/24 - second shift d. 6/19/24 - second shift e. 6/28/24 - second and third shift f. 7/2/24 - third shift g. 7/3/24- third shift h. 7/10/24 - first shift During an observation on 7/10/24 at 11:23 a.m., LPN 8 indicated Resident C's urinary drainage bag must have had a hole in it because it had leaked on the floor. During an interview on 7/11/24 at 12:20 p.m., Resident C was in his bed with the urinary catheter hung on the left side of the bed frame. He indicated he had some trouble with night shift emptying his urinary drainage bag for his suprapubic catheter. He was uncertain how long this had been a problem, but he knew they had not emptied it on 7/9/24 and 7/10/24 for night shift because he started writing it down this week. He had requested night shift not to wake him from midnight until 6:00 a.m. unless he pressed his call light, but not the whole shift. During an interview on 7/12/24 at 10:37 a.m., CNA 9 indicated she was familiar with the residents' care and never had any problems with Residents B or C refusing to have their urinary drainage bags emptied. Aides were required to empty the urinary collection bags every shift and report the output and any concerns to the nurse for output documentation in the resident's clinical record. The urinary drainage bags were full when the bag contained 2000 ml.			

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	During an interview on 7/12/24 at 12:10 p.m., the DON indicated the urinary drainage bags should have been emptied, at minimum, every shift. A urinary drainage bag should not be entirely full where the urine is backing up the drainage tube. CNAs typically emptied the urinary drainage bags, but all nursing staff were responsible to recognize if a urinary drainage bag was leaking. This information must be reported to the nurse immediately. A current facility policy, undated, titled "Catheter Care," provided by the DON on 7/12/24 at 2:15 p.m., indicated the following: "...Policy: It is the policy of this facility to ensure that resident with indwelling catheters receive appropriate catheter care... when indwelling catheters are in use. Policy Explanation: Empty drainage bags when bag is half-full or every 3 to 6 hours... 24. Document care and report any concerns noted to the nurse on duty...." This citation relates to complaint IN00436684. 3.1-41(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to monitor the amount of fluids consumed by 1 or 2 residents on fluid restrictions reviewed for dialysis. (Residents 30)	F 0698	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	08/12/2024

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	Findings include: The clinical record for Resident 30 was reviewed on 7/10/24 at 10:23 a.m. Diagnoses included end stage renal disease (ESRD), heart failure, and dependence on renal dialysis. A quarterly MDS (Minimum Data Set) assessment, dated 3/4/24, indicated the resident had moderate cognitive impairment, and made themselves understood and understood others. A current, 10/23/24 physician's order indicated a 1500 milliliter (ml) fluid restriction, with 960 ml to be provided by dietary and 540 ml provided by nursing. During an observation on 7/11/24 at 9:44 a.m., Resident 30 was asleep in bed. Several Styrofoam cups containing fluid and two cans of soda were observed on the overbed table and bedside table. A current care plan, initiated 1/20/23, indicated the resident was at risk for alteration in hydration related to fluid restriction due to ESRD. Interventions included to maintain fluid restriction per physician order, provide diet and fluids per physician orders, to record intakes, and to see the nurse prior to providing resident fluids related to a fluid restriction order. A current care plan, initiated 12/5/22, indicated the resident had a potential for alteration in kidney function due to ESRD and was dependent on renal dialysis. Interventions included to follow diet and fluid restrictions per physicians order and to encourage resident to follow hydration program interventions		MD was updated on monitoring of fluid restriction and orders were updated to reflect of fluid consumed. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed of all residents with fluid restriction to ensure proper amount monitoring orders are in place. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with all staff on fluid restriction to include documenting amount of intake. On-going monitoring to be completed by DNS or to ensure appropriate documentation of of fluids consumed for with fluid restriction. Monitoring to be completed 3X weekly X 4 weeks, weekly X 4 weeks and monthly thereafter to complete 6 months. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place	

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	A current care plan, initiated 12/8/22, indicated the resident received a therapeutic diet and fluid restriction. Interventions included diet as ordered and monitor meal consumption daily. The eMAR (electronic medical record) for July 2024, contained checkmarks and nursing initials, but lacked measurement amounts of fluids consumed. A resident bedside report, provided by the DON on 7/11/24 at 10:40 a.m., lacked indication the resident had a fluid restriction. The point of care charting for the staff lacked entry of fluid intake amounts. During an interview on 7/11/24 at 9:16 a.m., LPN 5 indicated she was not aware of any documentation or monitoring needed regarding Resident 30's fluid intakes. During an interview on 7/12/24 at 9:03 a.m., the DON indicated the staff were not monitoring Resident 30's fluid intakes. The fluid intakes should have been recorded and monitored per physician's order. A current facility policy, dated 2022, titled, "Fluid Restriction," provided by the DON on 7/12/24 at 9:21 a.m., included the following: "...Policy: It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders....Compliance Guidelines: 1. ...and will be recorded on the medication record of other format as per facility protocol....4. Water will not be provided at the bedside unless calculated into the daily total fluid restriction...."			
F 0880 SS=E	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	§483.80 Infection Control The facility must establish and maintain 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			

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	(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to implement and utilize infection prevention and control practices related to contact isolation, enhanced barrier precautions (EBP), and diagnostic testing for 3 of 5 residents reviewed for infection control. (Resident's B, C, and 99) 1.During an observation on 7/10/24 at 11:04 a.m., Resident B's door had an EBP sign on the left side	F 0880	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice All residents monitored for s/s of infection. -how other residents having the potential to be affected by the same deficient practice will be	08/12/2024

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	of the door and a contact isolation sign was on the right side of the resident's door. The personal protective equipment canister was just inside the resident's room beside the bathroom door. The contact isolation sign indicated everyone must clean their hands, put on a gown, and put on gloves before entering the room. During an observation on 7/10/24 at 11:32 a.m., LPN 8 performed hand hygiene and put on gloves as she entered the resident's contact isolation room. She walked to the resident's left side of the bed and her clothing brushed up against the bed linens with her unprotected clothing. Then she went around the foot of the bed and used a graduated measuring container to empty the resident's over full expanded urinary drainage bag. An isolation gown was not worn by LPN 8 throughout the observation. During an interview on 7/10/24 at 11:35 a.m., LPN 8 indicated the resident was in contact isolation and she had not worn a gown when she was in his room emptying the urinary drainage bag. During an interview on 7/12/24 at 10:37 a.m., CNA 9 indicated contact isolation was posted on a sign outside the residents' doors when it was required. A gown and gloves should have been worn for care in contact isolation rooms. Resident B's clinical record was reviewed on 7/9/24 at 3:04 p.m. Diagnoses included, paraplegia, obstructive and reflux uropathy, malignant neoplasm of the bladder, and Methicillin-resistant Staphylococcus aureus (MRSA - bacteria resistant to treatment) infection. A current physician order, dated 7/3/24, included Bactrim (antibiotic) Double Strength (DS) - give 1		identified and what corrective actions will be taken All have the potential to be by the alleged deficient practice. No current residents noted with signs or symptoms of infection. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education was completed with all staff on infection control to include precautions, Enhanced Barrier Management of c-diff. On-going monitoring to be completed by DNS or to ensure staff appropriate precautions. Monitoring to be completed on random shifts, random resident with orders for TBP, and to be completed 5X weekly X 4 weeks, 3X weekly X 4 weeks, weekly X 4 weeks, then monthly thereafter to complete 6 months. On-going monitoring to be completed to monitor residents with loose stools. Documentation to be monitored documentation of loose stools 5X X 4 weeks, 3X weekly X 4 weeks, weekly X 4 weeks, then monthly thereafter to complete 6 months. -how the corrective action will be monitored to ensure that deficient	

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	tablet by mouth twice daily related to a MRSA infection for 10 days. A current physician order, dated 4/8/24, included gown and gloves for all interactions with the resident every shift. A quarterly Minimum Data Set (MDS) assessment, dated 6/5/24, indicated the resident was cognitively intact. He was dependent on staff assistance for toileting and transfers and used a wheelchair for mobility. He required a urostomy and had frequent bowel incontinence. 2. During an interview at the time of observation on 7/10/24 from 11:18 a.m. to 11:23 a.m., LPN 8 was in the Resident C's EBP room at bedside with gloves on and no gown during the observation. She leaned in towards and against the resident's bed mattress with her scrubs directly against the resident's linens as she disconnected the old urinary drainage bag in her right hand and held the new drainage bag tubing in her left hand. LPN 8 reconnected the new urinary drainage bag to the suprapubic catheter. During an interview on 7/10/24 at 11:35 a.m., LPN 8 indicated the resident was in EBP and she had not worn a gown when she was in his room emptying the urinary drainage bag. Resident C's clinical record was reviewed on 7/9/24 at 3:14 p.m. Diagnoses included obstructive and reflux uropathy and urine retention. A current physician order, dated 4/29/24, included gown and gloves for all interactions with the resident every shift for enhanced precautions.		practice will not recur; I.e., what quality assurance program will be put into place	

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	A quarterly MDS assessment, dated 5/3/24, indicated the resident was cognitively intact. The resident was dependent on staff assistance for toileting, lower body dressing, bathing, and transfers. He had an indwelling catheter and was always incontinent of bowel. 3. During an interview on 7/9/24 at 12:15 p.m., Resident 99 was in her room and indicated she was currently suffering from very loose stools, perhaps from antibiotic use. The loose stools impacted her ability to participate in therapy. Resident 99's clinical record was reviewed on 7/9/24 at 4:00 p.m. Diagnoses included the following: unspecified open wound of right foot, subsequent encounter, constipation, and need for assistance with personalized care. A current physician order, dated 7/3/24, included vancomycin hydrochloride (antibiotic used to treat serious infections) administer 10 milliliters (ml) intravenously every 12 hours. A current physician order, dated 7/8/24, included check stool for Clostridium difficile (C. diff- a bacteria that causes an infection of the colon) one time for loose stools. The clinical record lacked any current, completed, or discontinued contact isolation orders from the date loose stools were reported through 7/11/24. An admission Minimum Data Set assessment, dated 6/12/24, indicated the resident was cognitively intact. She required moderate to maximal assistance for toileting, dressing, personal hygiene, and mobility. The resident had occasional urinary incontinence and frequent bowel incontinence. She had a surgical wound			

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	and received antibiotic during the assessment period. The clinical record lacked care plans for contact isolation or potential for C. diff. A Nurse's Note, dated 7/7/24 at 1:36 p.m., indicated a bowel movement had not been documented for 3 days, but the resident had experienced loose stools. A Nurse's Note, dated 7/8/24 at 7:20 p.m., indicated the resident voiced concerns related to diarrhea the past few days. Physician orders were received for a stool sample for C. diff and an order for anti-diarrhea medication. Review of the lab results report, dated 7/9/24, indicated the specimen was not collected for C. diff. The nurse was notified. The clinical record lacked indication another specimen was collected, nor the provider notified, that the order was not completed. During an observation on 7/9/24 at 4:15 p.m., the resident's door was closed and had an enhanced barrier precaution (EBP) sign noted on the left side of the door. During an observation on 7/10/24 at 9:44 a.m., the resident's door was closed and had an enhanced barrier precaution sign noted on the left side of the door. During an interview at the time of observation on 7/10/24 at 11:02 a.m., an EBP sign remained on the left of the resident's door. The resident exited her room in her wheelchair and indicated she was headed down to therapy. She was wearing her			

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	normal clothing. During an interview, QMA 6 indicated Resident 99 was not in her room. The door was labeled as EBP and lacked indication of any other type of isolation. The clinical record lacked any other isolation orders, active or discontinued, since the resident's ordered stool sample for C. diff testing. A resident with loose stools should have been placed immediately in contact isolation while awaiting the results of the C. diff stool specimen. He was unable to find or provide stool sample laboratory results. During an interview on 7/10/24 at 11:35 a.m., LPN 8 indicated a gown and gloves were required in contact isolation and EBPs. Failure to use a gown in contact isolation and EBPs put other residents at risk for infection because bacteria could have been carried from her clothing into other residents' rooms. During an interview on 7/11/24 at 3:58 p.m., the ADON indicated any resident suspicious for C. diff with loose stools and awaiting results from a C. diff stool sample should have been placed on contact isolation. The contact isolation should not have been removed unless the test result came back negative. Staff should have been educated on the contact isolation and the importance of washing their hands. They did not have any residents in contact isolation for C. diff precautions in the facility. During an interview on 7/11/24 at 5:07 p.m., LPN 7 indicated the resident's clinical record lacked C. diff stool sample results because the specimen was not collected. It should have been collected as ordered. The clinical record lacked indication why the specimen was not obtained. There was			

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	no indication of physician notification of the inability to obtain the ordered stool specimen. The resident was not restricted to her room because EBPs were ordered, rather than contact isolation. The resident was at an increased risk for C. diff due to her intravenous antibiotics. Services should have been provided in her room to prevent the potential spread of an infection to other residents. During an interview on 7/11/24 at 5:12 p.m., the ADON indicated the resident should have been placed in contact isolation when she was symptomatic with loose stools and the stool specimen was ordered. The ADON was the Infection Preventionist and should have caught the error, but she had not recognized the the resident was not in contact isolation, nor the stool specimen not collected, due to additional responsibilities. During an interview on 7/12/24 at 10:37 a.m., CNA 9 indicated she was responsible for the care of the residents on C- 3 Unit on this date. She had not received information/education regarding any residents on contact isolation for C. diff on her unit. It was posted outside the residents' doors when contact isolation was required. Resident 99's door remained with an EBP sign to the left of the door. The resident was not in contact isolation. During an interview on 7/12/24 at 12:10 p.m., the DON indicated staff were required to wear a gown and gloves upon entering the contact isolation rooms. Staff were required to wear a gown and gloves in EBPs for manipulation of a urinary catheter drainage bag. Three or more loose stools in a day, foul odors, and abdominal cramping were signs of potential C. diff. Residents on			

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	intravenous vancomycin were at higher risk for C. diff. She had to look at the entire clinical picture to determine if a resident should have been placed in contact isolation with the above mentioned symptoms of C. diff. During an interview on 7/12/24 at 2:25 p.m., the Administrator indicated the facility followed the Center for Disease Control (CDC) and Indiana Department of Health guidelines regarding infection control practices. During an observation on 7/12/24 at 2:30 p.m., the resident was not in her room. A contact isolation sign was hung to the left of the door, along with the EBP sign. An unknown staff member indicated the resident had gone to the activity room. During an observation on 7/12/24 at 2:33 p.m., Resident 99 was in the activity room in a group activity. Resident 99 had cards in her hand and was in the process of playing a card game where cards were exchanged with the other players. During an interview on 7/12/24 at 2:35 p.m., Resident 99 indicated she last had several loose watery stools on 7/11/24. She had not been educated or encouraged to remain in her room. She was unaware the facility had not received the C. diff stool specimen results. A current facility policy, undated, titled "Provision of Physician Ordered Services," provided by the DON on 7/12/24 at 2:43 p.m., indicated the following: "...Policy: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality... Policy Explanation and			

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BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, IN 47304

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	Compliance Guidelines: 1. Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders... 2. Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to the appropriate entity... 4. Documentation of consultations, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record..." A current facility policy, undated, titled "Enhanced Barrier Precautions," provided by the DON on 7/12/24 at 1:50 p.m., indicated the following: "Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms... Policy Explanation and Compliance Guidelines: ...3. Implementation of Enhanced Barrier Precautions: ...b. PPE [personal protective equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities... 4. High-contact resident care activities include: ...g. Device care or use: central lines, urinary catheters... 10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk...." A current facility policy, undated, titled "Isolation Precautions," provided by the DON on 7/12/24 at 1:50 p.m., indicated the following: "Policy: It is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents. This policy specifies the different types of precautions, including when and how isolation should be used for a resident... Policy Explanation and Compliance Guidelines:			

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	...2. Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission... 10. The Infection Preventionist will serve as a consultant to facility staff on infectious diseases and the implementation of isolation precautions...." 3.1-18(a)(2) 3.1-18(b)(2)			
F 0881 SS=E Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to implement an antibiotic stewardship program per facility policy. This had the potential to affect 98 or 98 residents residing in the facility. Findings include: A review of the facilities Infection Control Surveillance Binder was completed on 7/12/24 at 10:43 a.m., for the months of May and June 2024, and included the following: For June 2024, the binder contained an Infection Control Report completed by the ADON. It indicated the facility had 19 infections and 19	F 0881	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Antibiotic Stewardship program initiated. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed of all with infection noted for last . ATB	08/12/2024

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	residents received antibiotics. The binder lacked documentation of resident names and infection types, or supporting documentation of treatment's provided or criteria for determining treatment. For May 2024, the binder contained an Infection Control Report completed by the ADON. It indicated the facility had 18 infections and 18 residents received antibiotics. The binder included 14 Revised McGeer Criteria for Infection Surveillance Checklist forms and three lab or xray results. The checklists lacked documentation regarding symptoms, criteria, or type of infection, or if the criteria for antibiotic treatment was "met" or "not met." During an interview on 7/12/24 at 11:45 a.m., the ADON indicated she was the facility's infection preventionist. The surveillance binder was her record for infection surveillance. The facility's unit managers were to complete the Revised McGeer Criteria for Infection Surveillance Checklist forms when an infection was suspected. These were to be forwarded to her for the monthly report generation. She had not completed the forms herself or reviewed them. She had not received any forms during the month of June. She had not followed up with the unit managers and had not confirmed appropriateness for antibiotic usage. Her responsibility was solely to complete the monthly report. A current, undated facility policy titled "Antibiotic Stewardship Program," provided by the DON on 7/12/24 at 12:10 p.m., indicated the following: "Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while		program and list of infections reviewed with MD. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with Infection prevention nurse on Antibiotic Stewardship to include completed of Mcgreers. On- going monitoring to be completed by DNS or to ensure antibiotic stewardship is being completed per policy. Monitoring to be completed weekly X and monthly thereafter to completed 6 months. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place	

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	reducing the adverse events associated with antibiotic use....Policy Explanation and Compliance Guidelines:...2. a. Infection Preventionist - utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms....4. The program includes antibiotic use protocols and a system to monitor antibiotic use...."			
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. Based on interview and record review, the facility failed to designate one or more individual(s) as the Infection Preventionist with qualifying training or certification. The facility did not have a currently certified Infection Preventionist for 2 of	F 0882	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Infection Preventionist class	08/12/2024

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	the 5 days of the survey, or prior since 2/5/24. This deficient practice had potential to affect 98 of 98 residents in the facility. Findings include: During an interview on 7/8/24 at 10:35 a.m., the Administrator indicated RN 12 was the Infection Preventionist. A review of the facility's Infection Control Surveillance Binder was completed on 7/12/24 at 10:43 a.m., and documentation indicated the information was completed by the ADON. During an interview on 7/12/24 at 11:45 a.m., the ADON indicated she was the infection preventionist and had been in that roll since January 2024. During an interview 7/12/24 at 12:46 p.m., the Administrator indicated the ADON had been acting Infection Preventionist for the facility. RN 12 had been promoted about two months ago and had not completed her certification as yet. RN 13, who had Infection Preventionist certification, worked at the facility part-time and was to train and consult for the Infection Control Program. A review of a Centers for Disease Control and Prevention Completion for Nursing Home Infection Preventionist Training Course certificate for the ADON, provided by the Administrator on 7/12/24 at 12:42 p.m., indicated the course was completed on 7/10/24. During a telephone interview on 7/12/24 at 1:57 p.m., RN 13 indicated she had not worked as the Infection Preventionist or consulted for the ADON since 2/5/24. She had trained the ADON		completed during survey and certificate obtained. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken All residents have potential to be by 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 Education completed with ED and DNS on Infection Preventionist Qualifications and ensuring completion of class. On- going monitoring to be completed by Regional Director of Clinical Operations to ensure Infection Prevention Nurse in place with proof of completion of certification. Monitoring to be completed monthly to complete 6 months. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.	

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	regarding surveillance issues and how to map infections, how to identify clusters of infections and how to respond, as well as antibiotic stewardship and how to identify and document criteria. She currently worked part-time at the facility and had no involvement with the infection control program. A current facility policy, dated 3/21/23 and titled, "Infection Prevention RN Job Description," provided by the DON on 7/12/24 at 1:50 p.m., included the following: "...Qualifications...Must also meet state requirements for relevant licensure or certifications....Completed specialized training in infection prevention and control through accredited continuing education...." Cross reference F880. Cross reference F881.			