STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 00 B. WING	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00412325 and IN00413904. Complaint IN00412325 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00413904 - No deficiencies related to the allegations are cited. Survey dates: July 20, 21, 24, 25, 26, and 27, 2023 Facility number: 000039 Provider number: 155685 AIM number: 100275139 Census Bed Type: SNF/NF: 90 SNF: 5 Total: 95 Census Payor Type: Medicare: 5 Medicaid:68 Other: 22 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 8/4/2023.	F 0000	I submit this Plan of Correction on behalf of Brickyard Healthcare of Elkhart. I formally request a desk review.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as			

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

Chad Knisley 08/21/2023

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	defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation and interview, the facility failed to ensure standards of care of visually observing a resident take their medications was followed for 1 of 1 residents randomly observed. (Resident 75) Finding includes: On 7/20/2023 at 11:14 A.M., a souffle cup with 4 pills was randomly observed on the resident's bedside table. During an interview, on 7/20/2023 at 11:14 A.M., Resident 75 indicated " they brought them in and I have until later to take them." During an interview, on 7/20/2023 at 11:28 A.M., LPN 20 indicated the pills should not have been left at the bedside, and stated after leaving the residents room that she had watched the resident take her medications that morning and did not know where the medications on the bedside table came from. On 7/27/2023 at 1:15 P.M., the Regional Director of Clinical Operations provided the policy titled, "Medication Administration-Preparation and General Guidelines," dated 10/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...18. The resident is always observed after administration to ensure that the dose was completely injested...." 3.1-11	F 0554	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** Licensed nursing staff observed resident 75 finish taking her medications. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** All other residents have the potential to be affected. The DCE/designee educated Licensed Nursing staff on Medication Administration Policy. **3. Measures put into place/ system changes.** The DCE/designee educated Licensed Nursing staff on Medication Administration Policy. The DNS, or designee, will observe 3 medication administrations per day for 7 days; 10 medication administrations per week for 4 weeks and 10 medication administrations per month for 5 months. These observations to be random and include all shifts and both Licensed Nurses and Qualified Medication Aids. **4. How the corrective actions will be monitored.** Results of these audits will be	09/08/2023

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			reviewed at QAPI for the next 6 months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. **5. Date of compliance.** 9/8/2023	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.			

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	(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review, the facility failed to ensure the Physician Orders for Scope of Treatment (POST) forms were accurately completed for 3 of 3 residents whose Advanced Directives were reviewed. (Resident 71, 72, & 4) Findings include: 1. A record review was completed on 7/21/2023 at 2:21 P.M. Resident 71's Physician Orders for Scope of Treatment (POST) form lacked the following documented information: the printed treating physicians name; the date; the office telephone number and the physician's licenses number. 2. A record review was completed on 7/24/2023 at 6:31 A.M. Resident 74's Physician Orders for Scope of Treatment (POST) form lacked the following documented information: the date; the office telephone number and the physician's licenses number. 3. A record review was completed on 7/21/2023 at 1:45 P.M. Resident 84's Physician Orders for Scope of Treatment (POST) form lacked the	F 0578	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The DNS, or designee, ensured that Residents 71, 74 and 84 had complete Physicians Orders for Scope of Treatment (post) forms including the printed treating physicians name; the date; the office telephone number and the physician's license number. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** The DNS, or designee, conducted an audit of all residents Physicians Orders for Scope of Treatment (post) forms to ensure that they contained the printed treating physicians name; the date; the office telephone number	09/08/2023

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	following documented information: the printed treating physicians name; the date; the office telephone number and the physician's licenses number. During an interview, on 7/27/2023 at 11:12 A.M., the Regional Director of Clinical Operations indicated the post forms were not completed and should have been. On 7/27/2023 at 11:13 A.M., a policy was requested regarding advance directives/POST forms, but one was not provided. 3.1-4(I)(7)		and the physician's license number. SSD and Licensed Nurses were educated by DCE/designee on Resident's Rights Regarding Treatment and Advanced Directive Policy to include ensuring that the Physician's Orders for Scope of Treatment (POST) forms had to be completed in their entirety. 3. **Measures put into place/ system changes.** SSD and Licensed Nurses were educated by DCE/designee on Resident's Rights Regarding Treatment and Advanced Directive Policy to include ensuring that the Physicians Orders for Scope of Treatment (POST) forms had to be completed in their entirety. The DNS, or designee, will audit all new admission/readmission charts 5 times weekly x 14 days, then 3 times weekly x 60 weeks, then weekly x 4 months to ensure that all residents have a completed Physicians Orders for Scope of Treatment (POST) form in its entirety. **4. How the corrective actions will be monitored.** Results of these audits will be reviewed at QAPI for the next 6 months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. **5. Date of compliance.** 9/8/2023	

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident			

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	representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify a plysician timely of missed doses of unavailable medication for 2 of 5 residents whose medications were reviewed. (Resident 26 & B) Findings include: 1. A record review was completed on 7/25/2023 at 11:30 A.M. Resident 26's diagnoses included, but were not limited to: Multiple Sclerosis, epilepsy, depression, hypertension and diabetes. Current physician orders included: Vumerity delayed release capsule 231 mg (milligrams) 2 capsules 2 times a day related to MS (Multiple Sclerosis), and Ascorbic acid (vitamin C) 1000 mg daily. The June MAR (Medication Administration Record) indicated on June 1st the Vumerity order was documented as (3) hold/see nurses notes. The Nurses Note, dated 6/1/2023 at 9:17 P.M., indicated the Vumerity medication not given pending pharmacy delivery. The June MAR indicated on June 2nd and 3rd the Vumerity medication was documented as (7)	F 0580	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The DNS, or designee, ensured that Residents 26 and B had all of their medications available and if not, then the physician was notified of inability to obtain medication upon notification or awareness that medication is not available. 2. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** The DNS, or designee, conducted an audit of all resident's medications in order to ensure that they had access to all of their medications and/or if not, then their physician was notified of their inability to obtain medication upon notification or awareness that medication was not available.	09/08/2023

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	other/see nurses notes. A Nurse's Note, dated 6/2/2023 at 10:53 A.M., indicated the Vumerity medication needs reordered. A Nurses' Note, dated 6/2/2023 at 7:37 P.M., indicated Vumerity medication was not available, waiting for pharmacy to deliver. A Nurse's Note, dated 6/3/2023 at 4:48 A.M., indicated the Vumerity medication was not not available, waiting for pharmacy to deliver. A Nurse's Note, dated 6/3/2023 at 11:36 A.M., indicated the Vumerity medication was not not available, waiting on the arrival from pharmacy. The June MAR indicated on June 9th the Ascorbic Acid medication was documented as a (7) other see nurses notes. A Nurse's Note, dated June 9th at 7:27 A.M., indicated the medication was not given due to awaiting pharmacy to deliver, nurse aware. A general note, dated 6/5/2023 at 12:19 P.M., indicated the Physician's Assistant and the MD were notified of the Vumerity Capsule being missed x 5 doses. 2. A Record review was completed on 7/25/2023 at 2:33 P.M. Resident B's diagnoses included, but were not limited to: rheumatoid arthritis, fractured left hip anemia and depression. Current physician orders for July, included the following: Rinvoq 15 mg (milligrams) 1 tablet every day for Rheumatoid Arthritis.		**3. Measures put into place/ system changes.** The DNS, or designee, completed education with Licensed Nursing staff to ensure that they understood the policy regarding Unavailable Medications. The DNS, or designee, will review the medication administration audit report to ensure all medications are available and that the physician was notified of any medication that was not available. These audits to be completed 5 times weekly x 14 days then 3 times weekly x 6 weeks, then weekly x 4 months. **4. How the corrective actions will be monitored.** Results of these audits will be reviewed at QAPI for the next 6 months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. **5. Date of compliance.** 9/8/2023	

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	The June MAR indicated on 6/30/2023 the Rinvoq medication was documented as a (7) other/see nurses notes). A Nurses' Note, dated 6/30/2023 at 8:54 A.M., indicted medication unavailable , awaiting pharmacy to deliver. The July MAR indicated on 7/1, 7/2, 7/3, 7/4, 7/5, and 7/6/2023 the Rinvoq was documented as (7) other/see nurses notes. The Nurse's Notes dated for July 1st and 2nd lacked the documentation of why the medication was not administered. The Nurses Note, dated July 3 at 12:49 P.M., indicated the Rinvoq medication was not available. The Nurses Notes, dated July 4 and 5, lacked the documentation of why the medication was not administered. The Nurses' Note, dated July 6 at 6:49 A.M., indicated the Rinvoq medication was not available. The Nurse's Notes, dated July 7, lacked the documentation of why the medication was not administered. The July MAR indicated on 7/1, 7/2, 7/3, 7/4, 7/5 and 7/6/2023, the Rinvoq was not administered During an interview, on 7/27/2023 at 11:08 A.M., LPN 8 indicated the physician should have been notified of the missed medications. On 7/27/2023 at 4:25 P.M., the Regional Director of			

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	Clinical Operations provided the policy titled," Unavailable Medications", undated and indicated the policy was the one currently used by the facility. The policy indicated"...Notify physician of inability to obtain medication upon notification or awareness that medication is not available...." 3.1-5(a)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)			

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	(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and			

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	Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure pertinent transfer and resident clinical information was completed for 1 of 3 residents reviewed for transfers. (Resident 72) Finding includes: During an interview, on 7/20/2023 at 3:03 P.M., Resident 72 indicated he had gone to the hospital 2 weeks ago.	F 0623	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** Physician notified that pertinent transfer and resident clinical information was not completed and sent with resident 72 when he transferred out to the Emergency	09/08/2023

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	A clinical record review was completed on 7/24/2023 at 2:12 P.M., Resident 72's diagnoses included, but were not limited to chronic kidney disease stage 3, obstructive and Reflux Uropathy, diabetes and depression. A Nurse's Note, dated 7/12/2023 at 8:45 P.M., indicated: QMA on staff contacted this writer to assess resident left Nephro tube, upon assessment this writer found left tube to be leaking urine from insertion site resident entire shirt soiled with urine. No urine noted in left leg bag and blood noted in tubing. On call NP (Nurse Practitioner) called - new orders to send resident to emergency room. A general note, dated 7/13/2023 at 2:32 A.M., indicated the resident returned from the hospital. Left nephrostomy tube was changed without incident and is draining clear, yellow urine. During an interview, on 7/26/2023 at 10:00 A.M., the Regional Director of Clinical Operations indicated they could not provide any transfer form documentation for the resident and there should have been one On 7/26/2023 at 10:55 A.M., the Regional Director of Clinical Operations provided the policy titled," Transfer and Discharge (including AMA), undated, and indicated the policy was the one currently used by the facility. The policy indicated"...For a transfer to another provider, for any reason, the following information must be provided to the receiving provider: Contact information of the practitioner who was responsible for the care of the resident; Resident representative information, including contact information; Advance directive information;		Room on 7/12/2023. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** All residents who transferred out to the hospital in the past 30 days were reviewed to ensure transfer/discharge information was sent with the resident. The physician was notified of any resident who did not have information sent with them. **3. Measures put into place/ system changes.** The DNS, or designee, completed education with Licensed Nursing staff to ensure that they understood the policy regarding Transfer and Discharge (including AMA). The DNS, or designee, will audit all resident's charts who transfer out to the hospital 5 times weekly x 14 days, then, 3 times weekly for 6 weeks, then weekly x 4 months to ensure that all receiving providers received all of the information that they must be provided per the Transfer and Discharge (including AMA) policy. **4. How the corrective actions will be monitored.** Results of these audits will be reviewed at QAPI for the next 6 months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 00 B. WING	07/27/2023

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	Resident status, including baseline and current mental , behavioral, and functional status, reason for transfer, recent vital signs; diagnoses and allergies; Medications (including when last received) ; and Most recent relevant labs, other diagnostic tests, and recent immunizations... Emergency Transfers/Discharges...The original copies of the transfer form and Advance Directive accompany the resident. Copies are retained in the medical record...." 3.1-12(a)(9)		review on a PRN basis. **5. Date of compliance.** 9/8/2023	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for			

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	hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to provide transfer form information for 1 of 3 residents reviewed for hospitalization. (Resident 72) Finding include: During an interview, on 7/20/2023 at 3:03 P.M., Resident 72 indicated he had gone to the hospital 2 weeks ago. A clinical record review was completed on 7/24/2023 at 2:12 P.M., Resident 72's diagnoses included, but were not limited to chronic kidney disease stage 3, obstructive and Reflux Uropathy, diabetes and depression. A Nurse's Note, dated 7/12/2023 at 8:45 P.M., indicated: QMA on staff contacted this writer to assess resident left Nephro tube, upon assessment this writer found left tube to be leaking urine from insertion site resident entire shirt soiled with urine. No urine noted in left leg bag and blood noted in tubing. On call NP (Nurse Practitioner) called - new orders to send resident to emergency room. A general note, dated 7/13/2023 at 2:32 A.M., indicated the resident returned from the hospital. During an interview, on 7/26/2023 at 10:00 A.M., the Regional Director of Clinical Operations indicated they could not provide any transfer form documentation for the resident and there should have been one.	F 0625	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The Physician for Resident 72 was notified that the Bed hold notice upon transfer form was not sent with resident when he transferred out to the hospital on 7/12/023. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** All residents who transferred out to the hospital in the past 30 days were reviewed to ensure that a copy of the Bed hold notice upon transfer form was sent with resident upon transfer. The physician was notified for any resident who did not have copy of bed hold sent with them. **3. Measures put into place/ system changes.** The DNS, or designee, completed education with Licensed Nursing staff to ensure that they understood the policy regarding Transfer and Discharge (including AMA). The DNS, or designee, will audit all resident's charts who	09/08/2023

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	On 7/26/2023 at 10:55 A.M., the Regional Director of Clinical Operations provided the policy titled," Transfer and Discharge (including AMA), undated, and indicated the policy was the one currently used by the facility. The policy indicated"...For a transfer to another provider, for any reason, the following information must be provided to the receiving provider: Contact information of the practitioner who was responsible for the care of the resident; Resident representative information, including contact information; Advance directive information; Resident status, including baseline and current mental , behavioral, and functional status, reason for transfer, recent vital signs; diagnoses and allergies; Medications (including when last received) ; and Most recent relevant labs, other diagnostic tests, and recent immunizations... Emergency Transfers/Discharges...The original copies of the transfer form and Advance Directive accompany the resident. Copies are retained in the medical record...." 3.1-12(25)(A)		transfer out to the hospital 5 times weekly x 14 days, then 3 times weekly for 6 weeks, then weekly x 4 months to ensure that a copy of the Bed hold notice upon transfer form was sent with the resident. 4. **How the corrective actions will be monitored.** Results of these audits will be reviewed at QAPI for the next 6 months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. **5. Date of compliance.** 9/8/2023	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -			

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	(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to provide a care plan for the use of a continuous positive airway pressure (C-Pap) device for 1 of 28 residents	F 0656	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient**	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	reviewed for care plans. (Resident 15) Finding includes: During an observation on 7/20/2023 at 10:19 A.M., Resident 15's continuous positive airway pressure (C-Pap) mask was lying over the top of the machine on the bedside table. A record review was completed on 7/25/2023 at 10:36 A.M. Diagnoses included,but were not limited to: morbid obesity and renal dialysis. A Physician's Order, dated 6/22/2023, indicated a C-Pap at bedtime and as needed. A care plan was not located in the medical record for use of the C-Pap. During an interview on 7/26/2023 at 1:09 P.M., the MDS Coordinator indicated an order was placed for the C-Pap at admission on 6/22/2023. She indicated Resident 15 should have a care plan for the use of the C-Pap. On 7/27/2023 at 1:07 P.M., a policy titled, "Comprehensive Care Plans" was provided by the Regional Director of Clinical Operations. The policy indicated, " ...It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment ...." 3.1-35(b)(1)		**practices.** The DNS, or designee, ensured that Resident 15 had a comprehensive care plan for the use of his continuous positive airway pressure (C-Pap) mask. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** All residents with a C-Pap were reviewed to ensure care plans are in place for these devices. A care plan was put in place for any resident with a C-Pap who did not previously have one. **3. Measures put into place/ system changes.** The DNS, or designee, completed education with all staff to ensure that they understood the policy regarding Comprehensive Care Plans. The DNS, or designee, will review in clinical start up new orders to ensure anyone with a new order for a C-Pap has a care plan in place. These audits to be conducted 5 times weekly x 14 days then 3 times weekly x 6 weeks, then weekly x 4 months. **4. How the corrective actions will be monitored.** Results of these audits will be reviewed at QAPI for the next 6 months to identify any trends or patterns. If any issues identified, will continue audits based on IDT	

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			recommendation, otherwise will review on a PRN basis. **5. Date of compliance.** 9/8/2023	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure showers were provided timely for 1 of 3 residents reviewed for activity of daily living (ADL) care. (Resident 47) Finding includes: During an interview on 7/20/2023 at 11:15 A.M., Resident 47 indicated he was not receiving his showers routinely, and staff would state they were out of hot water or there was not enough staff to complete the shower. A record review was completed on 7/24/2023 at 11:53 A.M. Diagnoses included, but were not limited to: left below the knee amputation, muscle weakness, and chronic obstructive pulmonary disease. A 5-Day Minimum Data Set (MDS) Assessment, dated 6/17/2023, indicated Resident 47 was dependent with the assistance of one staff member for bathing. On a Significant Change MDS Assessment, dated 5/9/2023, Resident 15 indicated it was very important to him to chose between a tub bath,	F 0677	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The DNS, or designee, ensured that Resident 47 received a shower according to his preference. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** All residents have the potential to be affected by the deficient practice. Audit completed to identify residents current bathing preferences. **3. Measures put into place/ system changes.** Nursing staff educated on ensuring residents are offered showers/baths based on their preferences. Nursing staff in-serviced on completing shower	09/08/2023

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	shower, bed bath or sponge bath. The "Tasks" section of the electronic medical record indicated Resident 47's showers were scheduled for Tuesdays and Fridays. A Care Plan, dated 3/23/2022, and revised on 5/31/2023, indicated resident 47 had a physical functioning deficit. An intervention included assistance with staff member for bathing. On 7/26/2023 at 9:59 A.M., a shower binder that had shower documentation sheets from June 2023 to July 2023 was reviewed. Resident 47 had the following shower documentation sheets dated: 6/20/2023, 7/11/2023, 7/14/2023, and 7/18/20023. A review of showers documented in the electronic medical record indicated no showers were provided in June 2023, and showers were provided on 7/6/2023 and 7/12/2023. During an interview on 7/26/2023 at 9:26 A.M., LPN 7 indicated showers are documented on a shower sheet and within the electronic medical record. She indicated residents should get a shower twice a week unless the resident requested for additional shower days. On 7/26/2023 at 10:29 A.M., LPN 6 reviewed the shower binder. She was able to find one additional shower sheet, and indicated no more shower sheets were available. During an interview on 7/26/2023 at 11:28 A.M., Resident 47 indicated he did not receive a shower yesterday. Resident 47's hair was observed to be greasy in the front and sides of his head. On 7/27/2023 at 1:07 P.M., the Regional Director of Clinical Operations provided the policy titled, "resident Showers". The policy indicated, " ...It is		sheets and documenting showers in Point of Care when showers are completed. UM/designee to review the clinical alerts and shower sheets in daily start up to ensure all residents received their shower per preference from the previous day. These reviews to be completed 5 times weekly x 14 days, then 3 times weekly x 6 weeks, then weekly x 5 months. Random interviews with residents will be conducted throughout this monitoring to validate that showers are being given. **4. How the corrective actions will be monitored.** Results of these audits will be reviewed at QAPI for the next 6 months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. **5. Date of compliance.** 9/8/2023	

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	the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per standards of practice ...Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety ...." 3.1-38(b)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to provide sanitation of the continuous positive airway pressure (C-Pap) equipment for 1 of 3 residents reviewed for supportive respiratory usage. (Resident 15) Finding includes: During an observation on 7/20/2023 at 10:19 A.M., Resident 15's continuous positive airway pressure (C-Pap) mask was lying over the top of the machine on the bedside table. A record review for Resident 15 was completed on 7/25/2023 at 10:36 A.M. Diagnoses included, but were not limited to: morbid obesity and renal dialysis.	F 0695	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The DNS, or designee, ensured that Resident 15 had an order for washing the mask, tubing, or canister per the CPAP/BiPAP Cleaning policy for the use of his continuous positive airway pressure (C-Pap) mask. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.**	09/08/2023

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	155685	A. BUILDING 00 B. WING	07/27/2023

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	A Physician's Order, dated 6/22/2023, indicated a C-Pap at bedtime and as needed. During an interview on 7/26/2023 at 1:03 P.M., Resident 15 indicated the C-Pap tubing, mask, and canister had not been cleaned at the facility. On 7/26/2023 at 1:04 P.M., LPN 7 indicated there was not an order for washing the mask, tubing, or canister. The only order related to the C-Pap was to wear the C-Pap at night and as needed. On 7/27/2023 at 1:07 P.M., a policy titled, "CPAP/BiPAP Cleaning" was provided by the Regional Director of Clinical Operations. The policy indicated, " ...It is the policy of this facility to clean CPAP/BiPAP equipment in accordance with current CDC guidelines and manufacturer recommendations in order to prevent the occurrence or spread of infection ...Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use ...Weekly cleaning activities: Wash headgear/straps in warm, soapy water and air dry. Wash tubing with warm, soapy water and air dry ...." 3.1-47(a)(6)		The DNS, or designee, conducted an audit of all residents with orders for C-Pap use to ensure they had an order for washing the mask, tubing, or canister per the CPAP/BiPAP Cleaning policy. **3. Measures put into place/ system changes.** The DNS, or designee, completed education with nursing staff to ensure that they understood the policy regarding CPAP/BiPAP Cleaning. The DNS, or designee, will review in clinical start up new orders to ensure anyone with a new order for a C-Pap has an order in place to clean the C-Pap. These audits to be conducted 5 times weekly x 14 days then 3 times weekly x 6 weeks, then weekly x 4 months. **4. How the corrective actions will be monitored.** Results of these audits will be reviewed at QAPI for the next 6 months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. **5. Date of compliance.** 9/8/2023	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its			

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	residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on observation and interview, the facility failed to ensure medications were available from the pharamacy for 2 of 4 residents reviewed for pain. (Resident 26 & B) Findings include: 1. A record review was completed on 7/25/2023 at 11:30 A.M. Resident 26's diagnoses included, but were not limited to: Multiple Sclerosis, epilepsy,	F 0755	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The DNS, or designee, ensured that Residents 26 and B had all of their medications available and if not, then the physician was notified of inability to obtain	09/08/2023

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	depression, hypertension and diabetes. Current physician orders included: Vumerity delayed release capsule 231 mg (milligrams) 2 capsules 2 times a day related to MS (Multiple Sclerosis), and Ascorbic acid (vitamin C) 1000 mg daily. The June MAR (Medication Administration Record) indicated on June 1st the Vumerity order was documented as (3) hold/see nurses notes. The Nurses Note, dated 6/1/2023 at 9:17 P.M., indicated the Vumerity medication not given pending pharmacy delivery. The June MAR indicated on June 2nd and 3rd the Vumerity medication was documented as (7) other/see nurses notes. A Nurse's Note, dated 6/2/2023 at 10:53 A.M., indicated the Vumerity medication needs reordered. A Nurses' Note, dated 6/2/2023 at 7:37 P.M., indicated Vumerity medication was not available, waiting for pharmacy to deliver. A Nurse's Note, dated 6/3/2023 at 4:48 A.M., indicated the Vumerity medication was not available, waiting for pharmacy to deliver. A Nurse's Note, dated 6/3/2023 at 11:36 A.M., indicated the Vumerity medication was not available,waiting on the arrival from pharmacy. The June MAR indicated on June 9th the Ascorbic Acid medication was documented as a (7) other see nurses notes. A Nurse's Note, dated June 9th at 7:27 A.M.,		medication upon notification or awareness that medication is not available. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** The DNS, or designee, conducted an audit of all resident's medications to ensure that they had access to their medications and/or if not, then their physician was notified of their inability to obtain medication upon notification or awareness that medication was not available. **3. Measures put into place/ system changes.** The DNS, or designee, completed education with all staff to ensure that they understood the policy regarding Unavailable Medications and use of the Emergency Drug Kit. The DNS, or designee, will review the medication administration audit report to ensure all medications are available and that the physician was notified of any medication that was not available. These audits to be completed 5 times weekly x 14 days then 3 times weekly x 6 weeks, then weekly x 4 months. 4. **How the corrective actions will be monitored.** Results of these audits will be reviewed at QAPI for the next 6 months to identify any trends or	

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	155685	A. BUILDING 00 B. WING	07/27/2023

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	indicated the medication was not given due to awaiting pharmacy to deliver, nurse aware. 2. A Record review was completed on 7/25/2023 at 2:33 P.M. Resident B's diagnoses included, but were not limited to: rheumatoid arthritis, fractured left hip anemia and depression. Current physician orders for July, included the following: Rinvoq 15 mg (milligrams) 1 tablet every day for Rheumatoid Arthritis. The June MAR indicated on 6/30/2023 the Rinvoq medication was documented as a (7) other/see nurses notes). A Nurses' Note, dated 6/30/2023 at 8:54 A.M., indicted medication unavailable , awaiting pharmacy to deliver. The July MAR indicated on 7/1, 7/2, 7/3, 7/4, 7/5, and 7/6/2023 the Rinvoq was documented as (7) other/see nurses notes. The Nurse's Notes dated for July 1st and 2nd lacked the documentation of why the medication was not administered. The Nurses Note, dated July 3 at 12:49 P.M., indicated the Rinvoq medication was not available. The Nurses Notes, dated July 4 and 5, lacked the documentation of why the medication was not administered. The Nurses' Note, dated July 6 at 6:49 A.M., indicated the Rinvoq medication was not available.		patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. **5. Date of compliance.** 9/8/2023	

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	The Nurse's Notes, dated July 7, lacked the documentation of why the medication was not administered. The July MAR indicated on 7/1, 7/2, 7/3, 7/4, 7/5 and 7/6/2023, the Rinvoq was not administered A current care plan, dated 6/30/2023, indicated Resident B was at risk for pain and discomfort secondary to diagnoses of status post fractured hip, Rheumatoid arthritis, and left hip surgical wound. Interventions included, but were not limited to: administer medications as ordered. During an interview, on 7/27/2023 at 10:27 A.M., LPN 8 indicated all the medications do not come with the resident when admitted. They have to have the order in the computer/pharmacy before they will send it. The EDK (Emergency Drug Kit) does not have all the medications and indicated the physician should have been notified of the missed med's. On 7/27/2023 at 1:15 P.M., the Regional Director of Clinical Operations provided the policy titled, "Unavailable Medications", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn and emergency drugs... The facility shall follow established procedures for ensuring residents have a sufficient supply of medications...." This Federal tag relates to Complaint IN00412325. 3.1-25(a)			
F 0761 SS=E	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00	§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications were kept in a locked cart when unattended, failed to ensure medication storage areas were free from loose medications; failed to date medications when opened during medication storage reviews for 4 of 4 medication carts observed and 2 of 3 medication rooms observed. (500, 300, 400 and 200 medication carts, 200 and 300 medication rooms) Findings include: 1. During a random observation, on 7/24/2023 at	F 0761	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The DNS, or designee, ensured that the 500 hall medication cart was locked, there were no loose pills in the 300 medication cart, the 300 hall medication refrigerator freezer was defrosted, the 400 middle hall medication cart had no loose pills, the 200 hall medication	09/08/2023

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	5:35 A.M., the 500 Hall medication cart was observed to be unlocked with no staff in site of the cart. During an interview, on 7/24/2023 at 5:38 A.M., LPN 11 indicated the cart should have been locked. 2. During a medication storage observation, on 7/26/2023 at 9:35 A.M., on the 300 Hall medication cart with LPN 19 the following was observed: a loose pill was noted in a drawer. During an interview, on 7/26/2023 at 9:38 A.M., LPN 19 indicated there should be no loose pills in the medication cart. 3. During a medication room observation on the 300 Hall, on 7/26/2023 at 9:37 A.M., the medication refrigerator freezer section was full of ice build up. During an interview, on 7/26/2023 at 9:39 A.M., LPN 19 indicated the freezer should have been defrosted. 4. During a medication storage observation on the 400 Hall, on 7/26/2023 at 9:50 A.M., with QMA 9, the following was observed: the middle hall cart had 1 loose pill in the drawer. During an interview, on 7/26/2023 at 9:51 A.M., QMA 9 indicated there should be no loose pills in the medication cart. 5. During a medication storage observation, on 7/26/2023 at 10:17 A.M., with LPN 10, on the 200 Hall medication cart the following was observed: 2 loose pills and 3 opened and undated Mira lax bottles.		cart had no loose pills or expired medications, and that the 200 hall medication room had no expired medications. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** All residents have the potential to be affected. The DNS, or designee, conducted an audit of all medication carts, medication refrigerators and freezers and medication storage rooms to ensure that there were no loose pills, frost, expired medications and that all of the medication carts were locked. The DNS, or designee, completed education with all staff to ensure that they understood the policy regarding Storage of Medications. **3. Measures put into place/ system changes.** The DNS, or designee, completed education with Licensed Nursing staff to ensure that they understood the policy regarding Storage of Medications. The DNS, or designee, will randomly audit medication carts, medication refrigerators and freezers and medication storage rooms 5 times weekly x 14 days, then 3 times weekly x 6 weeks, then weekly for 4 months to ensure that there are no loose pills, frost, expired medications and that medication	

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	During an interview on 7/26/2023 at 10:19 A.M., LPN 10 indicated there should be no loose pills in the medication cart and the opened containers should have had open dates on them. 6. During a medication storage observation on the 200 Hall medication room with LPN 10 on 7/26/2023 at 10:24 A.M., the following was observed: an expired (4/8/2023) glucose control solution and an expired (7/13/2023) bottle of Liquid Protein. During an interview, on 7/26/2023 at 10:25 A.M., LPN 10 indicated the expired control solution, and the liquid protein should have been thrown away. On 7/27/2023, at 1:15 P.M., the Regional Director of Clinical Operations provided the policy titled,"Medication Storage", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...All drugs and biological's will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms)...." On 7/27/2023, at 1:15 P.M., the Regional Director of Clinical Operations provided the policy titled,"Storage of Medications", dated 11/2018, and indicated the policy was the one currently use by the facility. The policy indicated"...B. Medication rooms, carts,, and medication supplies are locked when not attended by persons with authorized access... H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal... Temperature: F. The facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day...		carts are locked. **4. How the corrective actions will be monitored.** Results of these audits will be reviewed at QAPI for the next 6 months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis. **5. Date of compliance.** 9/8/2023	

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	Expiration Dating (Beyond- use dating)... c. Certain medications, including some multi-dose preparations, may require different dating once opened per regulations/guidelines. d. when the original seal of a manufacture's container or vial is initially broken, it is recommended that a nurse write the date opened on the medication container or vial... F. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining...." 3.1-25(j) 3.1-25(m)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record	F 0812	**1. What corrective actions**	09/08/2023

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	review, the facility failed to ensure the ceiling, oven, counters, and floor were clean and in good condition in the main kitchen; failed to ensure refrigerated foods were held at safe temperatures in the walk-in cooler; failed to dispose of expired foods; failed to ensure a refrigerator was clean; and failed to label and date foods brought in by residents, in 2 of 4 pantries (400 & 500 Halls) and the main kitchen. This deficient practice had the potential to affect 95 of 95 residents who received meals out of the kitchen. Findings include: 1. During an observation of the main kitchen, on 7/20/2023 at 9:45 A.M., with the certified dietary manager (CDM) the following was observed: A hole in the ceiling directly next to the air conditioning/heating vent that had an open bag of insulation hanging down and insulation was on the floor. Two buckets and four towels were under the vent and water was present on the floor. The outside of the oven had grease and food debris. The inside of the oven had a buildup of grease. The stainless-steel counters had food debris. Two containers of potato salad that expired on 7/11/2023. A container of pasta salad with mold made on 6/20/2023 and expired on 6/23/2023. 1 case of rotten lemons with visible mold dated 3/17/2023. 33 individual Jell-O cups with an expiration date of 7/15/2023. The stand alone refrigerator had 6 pitchers of undated apple juice,7 pitchers of undated lemonade, 1 undated plate of salad, and 1 undated plate with a sandwich.		**will be accomplished for those residents found to have been affected by the deficient practices.** The Dietary Manager, or designee, ensured that the ceiling next to the air conditioning/heating vent was sealed and not leaking, that the floor under previous hole was clean and dry, that the outside of the oven was clear of grease and debris, that the inside of the oven was clear of grease, that the stainless steel counters were free of food debris, that the expired potato salad was disposed of, that the rotten lemons were disposed of, that the expired jell-o cups were disposed of, that the pitchers of apple juice and lemonade were poured out and re-made and dated, that the undated salad and sandwich were disposed of, that the out of temperature range milk was disposed of, that the walk in cooler and walk in freezers were repaired and that all temperature logs were documented on per the policy, that the cottage cheese of unknown origin was disposed of, that the 400 hall pantry refrigerator seal was repaired, that the outdated sandwich in the same refrigerator was disposed of, that the undated water and ensure were disposed of, that the 400 hall refrigerator was cleaned, that the 500 hall pantry microwave was disposed of and that the 500 hall refrigerator thermometer was	

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	During an interview, on 7/20/2023 at 10:07 A.M., the CDM indicated that pitchers of juice and lemonade did not contain an expiration date, but the pitchers should have an expiration date. A single serve milk carton was opened, and the temperature of the milk was 48 degrees. The temperature on the inside of the cooler registered 50 degrees, and the temperature on the outside of the walk-in cooler registered 48 degrees. The temperature log on the outside of the door indicated the temperatures of the walk-in cooler were: On 7/17/2023 a morning temperature of 44 degrees with no evening temperature documented. On 7/18/2023 a morning temperature of 46 degrees and an evening temperature of 50 degrees. On 7/19/2023 a morning temperature of 46 degrees with no evening temperature documented. During an interview,conducted at that time, the CDM indicated there was a service order for the leaking vent and the hole was for access to the vents and indicated the hole should be covered, that the oven and counters were dirty and should be clean, the expired food should have been thrown away on or before their expiration date, she indicated the pitchers of juice and lemonade should have an expiration date. The CDM indicated the temperatures of the refrigerator were not within safe storage temperature range and should be within safe storage temperature ranges. The CDM indicated she was notified on 7/20/2023 at 6:00 A.M. that the walk-in cooler was not working, and a service call was placed to have the walk-in cooler repaired. 2. During an observation of the Main Dining Hall, on 7/20/2023 at 11:56 A.M., cottage cheese was		replaced. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** The Dietary Manager, or designee, conducted an audit of all areas of the kitchen and all hall pantries to ensure that there were no deficiencies per the Use and Storage of Food Brought in by Family lor Visitors and Date Marking for Food Safety and Sanitation Inspection policies. The Dietary Manager, or designee, completed education with all staff to ensure that they understood the policies regarding Use and Storage of Food Brought in by Family or Visitors, Date Marking for Food Safety and Sanitation Inspections. **3. Measures put into place/ system changes.** The Dietary Manager, or designee, conducted an audit of all areas of the kitchen and all hall pantries to ensure that there were no deficiencies per the Use and Storage of Food Brought in by Family lor Visitors and Date Marking for Food Safety and Sanitation Inspection policies. The Dietary Manager, or designee, completed education with all staff to ensure that they understood the policies regarding Use and Storage of Food Brought in by	

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	observed being served to a resident. The outside temperature of the walk-in cooler was 52 degrees, and the inside temperature registered 50 degrees. During an interview, on 7/20/2023 at 12:01 P.M., the CDM indicated they were serving the cups of cottage cheese that were sitting in ice at this time. When inquired about where the cottage cheese was taken from, Dietary Aide 3 indicated the cottage cheese was served from the walk-in cooler. The CDM indicated the cottage cheese was only stored in the walk-in cooler and cottage cheese should not have been served. 3. During an observation of the 400 Hall Pantry, on 7/20/2023 at 12:44 P.M., the following was observed: The rubber seal around the refrigerator door was broken. There was a sandwich with the date of 7/16/2023. A bottle of water with no name, and an opened and undated bottle of ensure. The inside of the fridge was dirty and had a red substance on the bottom. During an interview, on 7/20/2023 at 12:49 P.M., Licensed Practical Nurse (LPN) 7 indicated they needed a new refrigerator, the food items should have the resident's name and dates on them, and expired items should have been discarded on the date of expiration. 4. During an observation of the 500 Hall Pantry, on 7/20/2023 at 12:52 P.M., the following was observed: The microwave was dirty with an area that looked as if there were burnt areas. A broken thermometer in the refrigerator.		Family or Visitors, Date Marking for Food Safety and Sanitation Inspections. The Dietary Manager, or designee, will audit all kitchen areas and hall pantries daily for 7 days, weekly for 4 weeks and Monthly for 5 months to ensure that there were no deficiencies per the Use and Storage of Food Brought in by Family or Visitors and Date Marking for Food Safety and Sanitation Inspection policies. **4. How the corrective actions will be monitored.** The Dietary Manager, or designee, will audit all kitchen areas and hall pantries daily for 7 days, weekly for 4 weeks and Monthly for 5 months to ensure that there were no deficiencies per the Use and Storage of Food Brought in by Family or Visitors and Date Marking for Food Safety and Sanitation Inspection policies. The findings of the observations will be recorded and discussed in the facilities QAPI process. **5. Date of compliance.** 9/8/2023	

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	During an interview, on 7/20/2023 at 12:56 P.M., LPN 7 indicated the microwave should be clean, and the refrigerator should have had a working thermometer. On 7/24/2023 at 12:20 P.M., the CDM provided a current policy titled, "Use and Storage of Food Brought in by Family or Visitors", and indicated the policy was the one currently used by the facility. The policy indicated "...Food items that are already prepared by the family or visitor brought in must be labeled with content and dated ...The prepared food must be consumed by the resident within 3 days. If not consumed within 3 days, food will be thrown away by facility staff...." On 7/24/2023 at 1:39 P.M., the CDM provided an undated current policy titled, "Date Marking for Food Safety", and indicated the policy was the one currently used by the facility. The policy indicated "...Refrigerated, ready-to eat, time/temperature control for safety food (i.e., perishable food) shall be held at a temperature of 41 F [Fahrenheit] or less for a maximum of 7 day. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded ...." On 7/24/2023 at 1:39 P.M., the CDM provided an undated current policy titled, "Sanitation Inspection", and indicated the policy was the one currently used by the facility. The policy indicated " ...All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies, and other insects ...The sanitation inspections will be conducted in the following manner: Daily: Food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures, and dishwasher			

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	temperatures daily. Weekly: The dietary manager or designee shall inspect all food service areas 3 times per week to ensure the areas are clean and comply with sanitation and food service regulations. ..." 3.1-21(3)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, clean, and comfortable environment was maintained, related to a broken towel rack, plastic wrapped around the cord of a power strip, stained ceiling tiles, broken heater, dead bugs in the light covers, and black mold on vents. (Room 215, 217, 303, and 200, 400 and 500 Hall) Findings include: During an environmental tour, on 7/27/2023 at 2:30 P.M., with the Maintenance Director, Maintenance Assistant and Account Manager, the following was observed: Room 215 had a broken towel rack. Room 217 had a power strip plugged into the electric outlet but the cord to the power strip was still wrapped in plastic. The resident was using the power strip to power their television. There were ceiling tiles on the 200 hallway with large dark stains.	F 0921	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The Maintenance Director, or designee, ensured that the towel rack in 215 was replaced, the power strip in room 217 was removed, that the stained ceiling tiles in the 200 hallway were replaced, that the baseboard heater in room 303 was repaired, that the bugs in the 5 light covers in the 500 hall were cleaned out, and that the vents on 400 hall were cleaned. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 92 residents. The Maintenance	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 00 B. WING	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

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	Room 303 had a broken baseboard heater. The 500 Hall had dead bugs that could be seen in five light covers. The 400 Hall had black mold that was observed on two of the air vents above the nurse's station. During an interview, on 7/27/2023 at 2:54 P.M., the Maintenance Director indicated that there should not be stains on the ceiling tiles. He indicated he was not aware of the broken towel rack and did not have a work order for the broken towel rack. He indicated he was not aware of the plastic on the power strip and the plastic should not be there. The Maintenance Director indicated the power strip was new and not one of the facilities, and that family had likely brought it in. He indicated the power strip had not been tested before being used. In room 303, the maintenance director didn't have a work order and didn't know the baseboard heater was broken, and it should not be broken and needed fixed. When asked who is responsible for the dead bugs in the light fixtures, the Maintenance Director indicated the maintenance department was responsible, and that the dead bugs should be remove. When asked how work was prioritized, the Maintenance Director indicated work orders were put in and prioritized based on the work order. The Maintenance Director indicated that daily rounds of the facility included the common areas and main hallways. He indicated that the rooms are broken up into blocks and each room is checked by maintenance personnel quarterly. On 7/27/2023 at 3:03 P.M., a policy for the use of outside electrical devices was requested. On 7/27/2023 at 3:04 P.M., a policy for		Director, or designee, conducted an audit of the building in order to ensure that there were no deficiencies per the Electrical Safety and Preventative Maintenance policies. The Maintenance Director, or designee, completed education with all staff to ensure that they understood the policies regarding Electrical Safety and Preventative Maintenance. **3. Measures put into place/ system changes.** The Maintenance Director, or designee, conducted an audit of the building in order to ensure that there were no deficiencies per the Electrical Safety and Preventative Maintenance policies. The Maintenance Director, or designee, completed education with all staff to ensure that they understood the policies regarding Electrical Safety and Preventative Maintenance. The Maintenance Director, or designee, will audit the building daily for 7 days, weekly for 4 weeks and Monthly for 5 months to ensure that there were no deficiencies per the Electrical Safety and Preventative Maintenance policies. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will audit the building daily for 7 days, weekly for 4 weeks and Monthly for 5 months to ensure that there were no	

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BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

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	environmental services was requested, but one was not provided. During an interview, on 7/27/2023 at 3:05 P.M., the Account Manager indicated that the two vents were dirty and should have been cleaned. He indicated floor technicians were responsible for cleaning the vents weekly. On 7/27/23 at 3:06 P.M., a policy for sanitation of the facility was requested, but one was not provided. On 7/27/23 at 3:07 P.M., a floor tech cleaning schedule was provided by the Account Manager, and indicated the vents are to be cleaned every Friday. On 7/27/2023 at 3:22 P.M., the Maintenance Assistant provided an undated policy titled, "Electrical Safety", and indicated it was the policy currently used by the facility. The policy indicated "...Power strips used in a patient care vicinity must be tested by the maintenance department prior to use. Tests shall include the equipment to be powered by the strip ...." On 7/27/2023 at 3:22 P.M., the Maintenance Assistant provided a checklist titled, "Preventative Maintenance", and indicated it was currently being used by the facility. The checklist included checking baseboard heater, inspect hardware, and inspect electrical outlets. 3.1-19(f)		deficiencies per the Electrical Safety and Preventative Maintenance policies. The findings of the observations will be recorded and discussed in the facilities QAPI process. **5. Date of compliance.** 9/8/2023	