STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155076	A. BUILDING 00 B. WING	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BROOKVIEW CARE CENTER	7145 E 21ST STREET INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00418192. Complaint IN00418192 - Federal/State deficiencies related to the allegations are cited at F550. Survey dates: November 13, 14, 15, 16, and 17, 2023 Facility number: 000031 Provider number: 155076 AIM number: 100266150 Census bed type: SNF/NF: 69 Total: 69 Census payor type: Medicare: 3 Medicaid: 34 Other: 32 Total: 69 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 28, 2023	F 0000	Preparation, submission and implementation of the Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements. ="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">The facility respectfully requests a desk review of our responses to this survey.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

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

Brandy Coomer | RN-DNS | 12/08/2023

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

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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview and record review, the facility failed to ensure the residents' dignity was maintained by staff not being respectful for 6 of 69 residents reviewed for dignity. (Residents' B, C, D,	F 0550	The facility does ensure that residents' dignity is maintained and the staff sis respectful.	12/20/2023

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	E, G, and H) Findings include: 1. The clinical record for Resident G was reviewed on 11/13/23 at 2:03 p.m. The Resident's diagnosis included, but were not limited to, hypertension and diabetes. An Admission MDS (Minimum Data Set) Assessment, completed 9/9/23, indicated Resident G was cognitively intact. During an interview on 11/13/23 at 2:03 p.m., Resident G indicated that he had overheard the staff of the facility yelling at each other in the hallways. He had heard the staff being disrespectful of each other in the hallways. 2. The clinical record for Resident E was reviewed on 11/13/23 at 2:39 p.m. The diagnosis included, but was not limited to: falls. An interview was conducted with Resident E on 11/13/23 at 2:17 p.m. She indicated the staff are rude in the facility. She had pushed her call light and ask a staff member for a writing pen. After the staff member left the room, the resident had overheard another staff member that was standing in the hallway; state to the staff member that just left her room, "What does that woman want now?" She felt that was disrespectful the the staff member making that comment about her. It made her feel uncomfortable to ask for anything from the staff. 3. The clinical record for Resident B was reviewed on 11/13/23 at 1:39 p.m. The diagnosis included, but was not limited to: anxiety disorder. The resident was admitted to the facility on 10/12/23.		All residents have the potential to be affected. All staff educated related to Residents' dignity and culture. DNS/designee will conduct a random audit of 5 residents each week for 6 weeks for allegation of lack of dignity/respect, then 3 residents each week for 4 weeks. Any negative findings will be reported and investigated appropriately. Results of all audits will be reviewed monthly at QAPI for the next 6 months to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

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A 10/19/23 Admission Minimum Data Set (MDS) Assessment, indicated Resident B's cognition was intact.

An interview was conducted with Resident B on 11/13/23 at 2:21 p.m. He indicated he had reported to the Administrator In Training (AIT) shortly after he was admitted, License Practical Nurse (LPN) 10 was rude to him, and she continues to be rude. During care recently, LPN 10 had stated to him "don't talk to me" while she was providing care. After speaking with other staff about her rudeness, he was told by the staff that was "just how she is."

An interview was conducted with Resident C on 11/13/23 at 2:30 p.m. He indicated he had witnessed LPN 10 stating to Resident B, not to speak to her while she was providing care.

During a resident council meeting on 11/13/23 at 2:34 p.m., the council indicated some staff are respectful and some staff are not.

5. The clinical record for Resident D was reviewed on 11/14/23 at 8:39 a.m. The diagnosis included, but was not limited to: stroke.

An interview was conducted with Resident D on 11/14/23 at 10:44 a.m. She indicated some staff are disrespectful and unpleasant. "You never know what mood they will be in."

6. An interview was conducted with Family Member 12 on 11/14/23 at 11:39 a.m. He indicated some of the staff treated residents with dignity and respect, but some did not. Maybe once a week, he heard staff use vulgar, unprofessional language, including cursing, within earshot of

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	Resident H and other residents. An interview was conducted with the Director of Nursing (DON) and Executive Director (ED) on 11/17/23 at 12:08 p.m. The ED indicated the staff morale has been good in the facility, but they have had to let go a couple of staff members that were not good fit for the facility. The facility was currently working on team building and has started a committee to boost staff morale. The staff have been educated on good customer service and abuse, and it will continue. A "Promoting/Maintaining Resident Dignity" policy was provided by the DON on 11/16/23 at 9:32 a.m. It indicated "Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights...When interacting with a resident, pay attention to the resident as an individual. Respond to requests for assistance in a timely manner. Explain care of procedures to the resident before initiating the activity. Staff members do not talk to each other while performing a task for the resident as if the resident is not there. Conversation should be resident focused and resident centered...Speak respectfully to residents; avoid discussions about residents that may be overheard..." The resident rights policy was provided by the DON on 11/16/23 at 9:23 a.m. It indicated "...Respect and dignity. The resident has a right to be treated with respect and dignity..."			

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	This citation relates to complaint IN00418192. 3.1-3(t)			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file			

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	grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;			

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	(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on interview and record review, the facility failed to ensure a residents' grievances were addressed and timely complete a grievance form for 1 of 1 resident reviewed for missing property and 1 of 3 residents reviewed for dignity. (Residents B and G) Findings include: 1. The clinical record for Resident B was reviewed on 11/13/23 at 1:39 p.m. The diagnosis included, but was not limited to: anxiety disorder. The resident was admitted to the facility on 10/12/23. A 10/19/23 Admission Minimum Data Set (MDS)	F 0585	The facility does ensure that residents' grievances are addressed timely and grievance forms are completed. Resident B has been discharged from the facility. The prayer book for Resident G has been replaced. All residents have the potential to be affected. All staff were educated on the grievance policy, and the new	12/20/2023

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	Assessment, indicated Resident B's cognition was intact. An interview was conducted with Resident B on 11/13/23 at 2:21 p.m. He indicated he had reported to the Administrator In Training (AIT) shortly after he was admitted, License Practical Nurse (LPN) 10 was rude to him, and she continues to be rude. An interview was conducted with the AIT on 11/15/23 at 2:36 p.m. She indicated Resident B had reported to her LPN 10 had been rude to him shortly after he was admitted. She had not filled out a grievance for the concern. She believed, he was just aggravated about being in the facility. 2. The clinical record for Resident G was reviewed on 11/13/23 at 2:03 p.m. The Resident's diagnosis included, but were not limited to, hypertension and diabetes. An Admission MDS (Minimum Data Set) Assessment, completed 9/9/23, indicated Resident G was cognitively intact. During an interview on 11/13/23 at 1:55 p.m., Resident G indicated he was missing a prayer book. He had told a staff member at the nurses' station that it was missing about 2 weeks ago. During an interview on 11/13/23 at 1:55 p.m., Visitor 6 indicated that he had brought the prayer book to Resident G and was surprised it had not been found yet. During an interview on 11/14/23 at 3:25 p.m., the DON (Director of Nursing) indicated there were no grievance forms on file in the last month for Resident G.		grievance form. Social Services educated on maintaining a grievance binder. Social Services/designee will conduct a random audit of 5 residents each week for 6 weeks for any grievances, then 3 residents each week for 4 weeks. Any negative findings will be documented and investigated appropriately. Results of all audits will be reviewed monthly at QAPI for the next 6 months to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

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	During an interview on 11/17/23 at 11:41 a.m., LPN (Licensed Practical Nurse) 2 indicated she had not been made aware that Resident G was missing a prayer book and If Resident G had informed a staff member, a grievance form should have been completed at that time. A grievance policy was provided by the Director of Nursing on 11/16/23 at 9:32 a.m. It indicated "...Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal...Procedure:...The staff member receiving receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form. Take any immediate actions needed to prevent further potential violations of any resident right...Forward the grievance form to the Grievance Official as soon as practicable. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions on the grievance form..." 3.1-7(a)(2)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.			

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	(C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to follow up with a resident's representative regarding their care plan meeting for 1 of 1 resident reviewed for care planning. (Resident H) Findings include: The clinical record for Resident H was reviewed on 11/14/23 at 11:00 a.m. Her diagnoses included, but were not limited to, dementia. She resided on the memory care unit of the facility. The 8/17/23 care plan meeting minutes indicated Resident H's plan of care was reviewed in detail with Family Member 12 by phone. The 11/2/23 care plan meeting minutes indicated the plan of care was reviewed in detail per the IDT (interdisciplinary team.) Resident H's guardian was invited, but did not attend.	F 0657	The facility does follow up with residents/representatives regarding care plan meetings. Representative for Resident H was contacted, and her care plan was reviewed via telephone. All residents have the potential to be affected. RDCO educated IDT on care plan participation and documentation. Social Services/designee will initiate care plan invitations to resident/representative. All care plan meetings will be conducted with resident/representative and documented over the next 3 months to ensure timeliness and	12/20/2023

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	An interview was conducted with Family Member 12 on 11/14/23 at 11:45 a.m. He indicated the facility sent him a care plan invitation informing him of the date of Resident H's most recent care plan and for him to call the facility for a specific time slot. He called the facility, left a message, and they never returned his call. This was a couple of weeks ago, and the care plan had come and gone without his participation. An interview was conducted with the DON (Director of Nursing) on 11/14/23 at 3:24 p.m. She indicated their previous Business Office Assistant sent out care plan invitations, but she stopped working at the facility a couple of months ago, and it had been a group effort since. The MDSC (Minimum Data Set Assessment Coordinator) usually stayed on top of it. An interview was conducted with the MDSC on 11/16/23 at 2:33 p.m. She indicated she did not send out care plan invitations, but she did put the dates on the calendar for the Business Office Manager to review and mail out invitations to family. They wanted the family to call to schedule a care plan meeting. Once they did, they usually spoke with social services, and if social services was unavailable, the call would go to her. She was not made aware Family Member 12 called to schedule. She thought their social services director left around the time of Resident H's care plan meeting, so she was unsure who would have taken Family Member 12's message. On 11/15/23 at 2:40 p.m., the MDSC provided the 10/23/23 care plan invitation mailed to Family Member 12. It indicated the meeting was scheduled for 11/2/23 and to please contact social services at the facility's phone number for Resident H's scheduled time.		invitation and documentation. Any negative findings will be reviewed and corrected immediately. Results of audits will be reviewed at QAPI for the next 6 months to identify any trends or patterns. If any issues are identified, we will continue audits based on IDT recommendation, otherwise we will review on a PRN basis.	

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	The Care Planning-Resident Participation policy was provided by the DON on 11/16/23 at 9:28 a.m. It read, "The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative."			
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			

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	155076	A. BUILDING 00 B. WING	11/17/2023

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	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 ensure a resident's catheter was flushed as ordered; the catheter tubing not touching the ground or kinked and good hygiene practices during catheter care with the removal of a soiled brief for 1 of 1 residents reviewed for catheter. (Resident 56) Findings include: The clinical record for Resident 56 was reviewed on 11/13/23 at 1:39 p.m. The diagnoses included, but were not limited to: urogenital implants and obstructive and reflux uropathy (structural or functional/blockage of urinary tract). A Quarterly 10/11/23 Minimum Data Set (MDS) Assessment, indicated Resident 56's cognition was intact. A bladder care plan dated 12/8/23 indicated the resident had an indwelling catheter. The staff was to provide catheter care every shift. A physician order dated 5/18/23 indicated the resident had 20 french Foley catheter. A physician order dated 5/18/23 indicated the resident was to receive Foley catheter care every shift.	F 0690	The facility does ensure residents' catheters are flushed per order, catheter tubing is not kinked or touching the ground, and briefs are changed during catheter care. Resident 56's catheter bag and tubing were secured off the floor and without kinks. His brief was changed. All residents with catheters have the potential to be affected. Licensed staff educated on catheter care. DNS/designee will conduct a random audit of 3 residents with catheters each week for 6 weeks. The resident will be assessed to ensure the catheter bag and tubing are not touching the floor and free of kinks and the brief (if in place) is free of soilage. DNS/designee will observe catheter care for 2 residents with catheters each week for 6 weeks to ensure care is completed with good hygiene and per policy. Any negative findings will be corrected	12/20/2023

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	A physician order dated 10/20/23 indicated the resident's catheter was to be irrigated with 60 milliliters of acetic acid at night. The November 2023 Medication/Treatment Record (MAR/TAR) indicated the resident's catheter had not been irrigated with 60 milliliters of acetic acid on 11/14/23 and 11/15/23. A random observation was made of Resident 56 on 11/13/23 at 11:50 a.m. The resident was in his wheelchair in the hallway with his catheter tubing observed dragging on the ground. An observation was made of Resident 56 on 11/13/23 at 1:39 p.m. The resident was in his wheelchair with shorts on. The resident's tubing was curled up and strapped to his leg. The tubing was observed with reddish-orange urine puddled and trapped through the looped tubing. An interview was conducted with Resident 56 on 11/13/23 at 1:40 p.m. He indicated he did not like the catheter tubing to be looped on his leg, and he would need to request for someone to flush the catheter. An observation was made of catheter care on Resident 56 with License Practical Nurse (LPN) 7 on 11/15/23 at 10:19 a.m. The resident was in bed at that time. The catheter tubing had yellow urine running through it. LPN 7 was observed removing the tape and pulling the resident's brief down away from the resident's body. The brief was observed with a brown liquid substance on the inside of the brief. LPN 7 had indicated the brown substance was not stool; it was discharge. She then was observed providing catheter care and infection control was maintained through out the care. She then placed the soiled brief back on the		immediately. Results of all audits will be reviewed monthly at QAPI for the next 6 months to identify trends or patters. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

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	resident and retaped it. At that time, LPN 7 had reported to the resident she would have a Certified Nursing Assistant (CNA) come back in and change the resident's soiled brief. An interview was conducted with LPN 7 on 11/15/23 at 10:56 a.m. She indicated the resident's acetic acid irrigation medication to irrigate the catheter was not available on 11/14/23 and 11/15/23 to provide irrigation to Resident 56's catheter. The medical provider had not been made aware, but has been notified that day. The medical provider has placed a hold on the irrigation until the medication arrives. A catheter policy was provided by the Director of Nursing on 11/16/23 at 9:32 a.m. It indicated "...Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintained their dignity and privacy when indwelling catheters are in use. 3.1-41(a)(2)			
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to provide residents on the memory care unit with a consistent activity program that considered their cognitive status; update a resident's dementia care plan to include specific interventions used to address her crying out during group settings; attempt	F 0744	The facility does provide residents on the memory care unit with activities consistent with their cognitive abilities. The facility does update care plans with specific interventions related to behaviors of dementia care residents. The	12/20/2023

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	non-pharmacological interventions prior to increasing a psychotropic medication; and timely update the plan of care for a resident with wandering behaviors for 2 of 3 residents reviewed for dementia care and 24 of 24 residents on the memory care unit. (Residents H, 10, 40, 60, 52, 126) Findings include: 1. The Memory Care Unit activity calendar, posted on the wall of the unit, was provided by the DON (Director of Nursing) on 11/17/23 at 12:47 p.m. It indicated the activity on 11/13/23 at 2:00 p.m. was creative art. An observation was made on 11/13/23 at 2:01 p.m. Resident 10 was walking up the hallway from her room. She passed by 3 people, including 2 residents and one staff member. She asked each of them why it was so boring here. There was no creative art activity occurring on the unit at this time. The Memory Care Unit activity calendar indicated the activities scheduled for 11/14/23 were: chair exercise at 9:00 a.m., coffee & chat at 10:00 a.m., and trivia at 11:00 a.m. An interview with the AIT (Administrator in Training) and observation was made on 11/14/23 at 9:44 a.m. There were 10 residents sitting in the activity room. I Love Lucy was playing on the television. The AIT was sitting with the residents. The AIT indicated they were watching "a little t.v." until the next activity at 10:00 a.m. The AIT indicated she did not normally work on this unit and normally worked at the front of the facility. She made rounds regularly, but did not normally sit on this unit and watch television with the residents. She was unsure who some of the		facility does attempt non-pharmacological interventions prior to increasing medications. Resident 60 has been discharged from the facility. Resident 52's care plan has been updated to show specific interventions to her behavior. All residents on the memory care unit have the potential to be affected. All staff educated on Dementia care including non-pharmacological interventions. All staff completed annual CMS Dementia Care training via Healthcare Academy. MCD educated related to activities consistent with cognitive abilities. Care plans for all memory care residents reviewed and updated with specific behavior interventions. ED/DNS to review activity calendar each month to ensure activities are consistent with cognitive abilities of residents on the memory care unit. Any negative findings will be corrected before the calendar is printed and implemented. ED/DNS to audit activities 3 times a week for 6 weeks to ensure activities are taking place according to the calendar. Any negative findings will be corrected immediately.	

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	residents were in the room with her. Resident 60 was sitting in a black vegan leather chair in the corner, with her head down and eyes closed. On 11/14/23 at 10:00 a.m., the AIT stood up and announced that I Love Lucy was over; that chair exercises were done; and it was now time for the next activity. She walked out of the activity room for about 30 seconds, came back, and sat back down in activity room. Resident H and Resident 10 were present in the room, not watching television. As of 11/14/23 at 10:07 a.m., residents were still in the activity room with the television on, as coffee & chat had not yet began. An interview was conducted with Family Member 14 on 11/14/23 at 10:12 a.m. in Resident 126's room after leaving the activity room. She indicated Resident 126 had only been at the facility for 10 days and she'd visited about 4 times thus far. She never saw any activities on the unit during her 4 visits. He was either sleeping in bed or sitting in the t.v. room. On 11/14/23 at 10:17 a.m., residents were still sitting in the activity/t.v. room, as coffee & chat had not yet begun. An observation of trivia in the dining room was made on 11/14/23 between 10:40 a.m. and 10:55 a.m. The residents who were previously in the activity room were now in the dining room across the hall having coffee. The AIT was sitting at the front of the dining room asking trivia questions aloud. The following trivia questions were asked to the residents with the following responses: What is the smallest unit of memory? None of the residents knew the answer. The AIT informed them the answer was helobite. One resident asked		Results of all audits will be reviewed monthly at QAPI for the next 6 months to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

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	what a helobite was. The AIT answered, "I don't know." What is the hottest planet in the solar system? Two residents answered the sun. The AIT reminded them since the question asked planet, the answer could not be sun, and informed them the answer was Venus. How many Lord of the Rings films are there? None of the residents knew the answer. The AIT informed them the answer was three. Which animal is on the Porsche logo? One of the residents answered two. Another resident answered camel. The AIT informed them the answer was a horse. What does BMW stand for? None of the residents knew the answer. The AIT informed them the answer was Bavarian Motor Works. Which country invented tea? One of the residents knew the answer was China. This was the only trivia questioned answered correctly by a resident during the trivia observation. Which bone are babies born without? None of the residents knew the answer. The AIT informed them the answer was knee cap. Which planet has the most gravity? None of the residents knew the answer. The AIT informed them the answer was Jupiter. Which American state is the largest? One resident answered Texas, and one resident answered California. The AIT informed them the answer was Alaska.			

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	What is the smallest country in the world? None of the residents knew the answer. The AIT informed them the answer was Vatican City. What is the world's longest river? One of the residents answered Amazon. The MCD (Memory Care Director) answered Nile, which was correct. How many Pyramids of Giza were made? The MCD immediately responded 3, which was correct. What is the national dish of Spain? One resident guessed lasagna. None of the residents knew the answer. The AIT informed them the answer was paella. Who wrote Sherlock Holmes? None of the residents knew the answer. The AIT informed them the answer was Arthur Cohen Doyle. When was Nike founded? None of the residents knew the answer. The AIT informed them the answer was 1971. What is the tallest building in the world? None of the residents knew the answer. The AIT informed them the answer was Burj Khalifa. Which mammal has no vocal cords? None of the residents knew the answer. The AIT informed them the answer was a giraffe. An observation of 4 residents, including Resident 10, in the activity room was made on 11/15/23 at 9:24 a.m. The AIT (Administrator in Training) was also present. There was an exercise program playing on the television. Only one resident was participating with the AIT in the exercises. Two of the residents, including Resident 10, were sitting			

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	with their eyes closed. No one was actively encouraging the 3 nonparticpating residents to participate. Resident H and Resident 126 both entered the activity room at 9:26 a.m. Resident 40 was not present during this observation. On 11/15/23 at 9:33 a.m. an interview and observation was conducted with Resident 40 in her room. She was sitting in her wheel chair. She indicated she had a shower earlier this morning, did not know chair exercises were occurring in the activity room, and that no one asked her if she'd like to participate. During an interview with CNA (Certified Nursing Assistant) 13 on 11/15/23 at 9:42 a.m., she indicated she assisted Resident 40 with her shower after coming into work, then took her to breakfast. On 11/15/23 at 9:35 a.m., Resident 40 asked where the exercises were occurring and if she could participate. This information was immediately relayed to QMA (Qualified Medication Aide) 4. QMA 4 assisted Resident 40 into the activity room near the television. Resident 40 began participating by moving her feet up and down to the beat, crossing her arms over her chest, and bopping her head in her wheel chair, mimicking the exercise instructor on the television. An interview was conducted with QMA 4 in the presence of CNA 13 on 11/15/23 at 10:40 a.m. QMA 4 indicated she worked on the memory care unit 3-4 days a week and worked a lot of double shifts. CNA 13 and CNA 3 were the primary CNAs who worked on the unit. It was usually her, 2 CNAs, and the MCD who worked on the unit during the day. As far as activities on the unit, coffee was usually served around this time, the			

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	10:00 a.m. hour, and it was "hit or miss" once that was over. CNA 3 and CNA 13 were good at getting residents bathed, toileted, and dressed. They could do activities with the residents sometimes, but not morning chair exercises, because the CNAs were still busy with ADLs and her with administering medications. A lot of residents went to therapy and didn't want to do chair exercises upon return. They had a variation of residents on the unit, but "most of those activities are too high functioning for these residents, like the trivia game yesterday." Residents needed more sensory type activities. They had maybe a half hour available in the morning to actually sit with residents. Normally, residents were either in their rooms by themselves or in the activity room with the television on. The MCD didn't return to the unit from morning meeting until around 10:00 a.m., when she did the coffee activity with them. The MCD would do another group activity with residents in the afternoon, like puzzles or coloring. There was no structured, ongoing activity program on the unit. The chair exercise activity that occurred earlier today was not a normal thing on the unit. They needed an actual staff member, designated for activities on the unit, if regular, consistent activities were to occur. An interview was conducted with CNA 13 on 11/15/23 at 10:40 a.m. in the presence of QMA 4. She indicated she worked on the memory care unit of the facility 3 to 4 days a week. She and the other CNA tried to help with activities, but they did not have time to do anything regularly. The chair exercise activity that occurred earlier today was not a normal thing on the unit. Normally, after assisting residents with getting up and dressed for the day, after breakfast, they would take them back to their room or into the activity room to			

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	watch television. She didn't think the activities on the unit were "at their level," like bowling. There was no activity aide for the memory care unit. She told the MCD they needed someone to activities on the unit, because she did not have time to do activities and provide care to residents. An observation was made on the way into the MCD's office to conduct an interview with her on 11/15/23 at 1:43 p.m. There were 10 residents sitting in the activity room with the television on. No staff were present in the room with them. An interview was conducted with the MCD on 11/15/23 at 1:43 p.m. She indicated she normally conducted the activity program on the unit. When she began working at the facility in May, 2023, there was an activity assistant on the unit who only did activities, but they hadn't worked at the facility for "a couple of months now." They hadn't had anyone designated for activities since then. They tried to "chip in and do it." The residents enjoyed trivia and she thought the questions being asked during trivia were for seniors, but not necessarily cognitively impaired residents. The hour of 1:00 p.m. to 2:00 p.m. was "down time." They just had Westerns playing on the television, because that was a time to provide toileting to residents after lunch. She stated, "I can't be 10 different places at once. I need a 9:00 a.m. activity person and someone to do room visits." 2. The clinical record for Resident 52 was reviewed on 11/14/23 at 11:00 a.m. Her diagnoses included, but were not limited to: dementia, mood disorder, and major depressive disorder. Her impaired cognition care plan, revised 9/15/23, indicated she had difficulty making herself understood. Interventions were to anticipate her			

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	care needs and help her as needed. There was no intervention to provide soothing touch or to provide one on one attention. Her dementia with incidents of rejecting or resisting care care plan, revised 9/15/23, indicated she may cry out or yell while receiving care such as changing soiled clothing, trying to hit or kick staff. an intervention was to provide soothing touch and reassurance while assisting with care. It did not reference crying or yelling out during group activities/settings. An observation of a group trivia activity was made in the dining room of the memory care unit on 11/14/23 at 10:40 a.m. Resident 52 began yelling out at the table at which she was sitting with other residents. An observation of Resident 52 was made on 11/14/23 at 11:12 a.m. She was no longer in the group trivia activity in the dining room with the other residents. She was sitting by herself in her wheel chair in the hallway outside of the dining room. She was crying and yelling out for her mother. The AIT (Administrator in Training) came out of the dining room, into the hallway and attempted to calm her. After a few minutes of the AIT attempting to calm her, the AIT returned to the dining room, and Resident 52 continued to cry and yell out for her mother. Shortly thereafter, QMA 4 approached Resident 52 in the hallway, began rubbing her back, and attempting to calm her. QMA 4 then assisted Resident 52 down the hall near the nurse's station and provided her more direct attention. Resident 52 began calming down when QMA 4 rubbed her back. An interview was conducted with QMA 4 on 11/15/23 at 10:40 a.m. QMA 4 indicated she			

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	worked on the memory care unit 3-4 days a week and worked a lot of double shifts. She indicated she was unsure how Resident 52 got from the dining room into the hallway during trivia yesterday and left by herself. She stated, "That hurt me." It wasn't right to leave her in the hallway. Someone could have come to her and asked her to watch Resident 52 instead of leaving her alone in the hallway. Some of the other staff would leave Resident 52 in an a group environment that was upsetting to her. When Resident 52 yelled out in group settings, it upset the other residents in the group, and then Resident 52 would just get louder. She tried to deescalate those situations by removing Resident 52 from the upsetting environment and providing her one on one attention, like she did yesterday. An interview was conducted with CNA 13 on 11/15/23 at 10:40 a.m. She indicated she worked on the memory care unit of the facility 3 to 4 days a week. When she removed Resident 52 from a group activity for yelling out, she didn't leave her alone. On Monday, 11/13/23, Resident 52 was "screaming and hollering," during a group setting, so QMA 4 asked her if she'd bring Resident 52 to her near the nurse's station to provide her one on one attention. The MCD stopped CNA 13 from removing her from the room and informed her she was going to redirect her instead. An interview was conducted with the MCD on 11/15/23 at 1:43 p.m. She indicated Resident 52's yelling out was part of her disease process. She didn't want staff to remove her from the group setting right away. She liked to redirect her 3 times before removing her. She knew the other residents "get upset and everything," but she didn't want to isolate her. Yesterday during trivia, the MCD asked one of the CNAs to come and get Resident			

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	155076	A. BUILDING 00 B. WING	11/17/2023

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	52 from the group, but she wasn't sure what they were going to do with her. She assumed they would take her to her room. She didn't know why Resident 52 was left alone in the hallway to cry out. The 11/1/23 psychiatry note read, "Staff Report: Staff report the patient has been speaking with more word salad since she last returned from the hospital, just over a month ago. Over the last couple of weeks she has been getting gradually louder and louder. She begins to yell words that do not make sense. This occurs in all areas of the unit and at anytime. Very unpredictable. Today she got so loud that it began to agitate the residents around her and some felt she was yelling at them. She had to be removed from the dining room as staff was not able to settle her down. Frequently they are able to encourage her to stop yelling and she may take the volume down but most often she does not. They utilize many distraction techniques. Karen does this even when laying in her bed with the lights dimmed. She does it at night as well. Her roommate handles this very well at present." 3. The clinical record for Resident 60 was reviewed on 11/14/23 at 9:44 a.m. The Resident's diagnosis included, but were not limited to, Dementia with agitation. An Admission MDS (Minimum Data Set) Assessment, completed 8/8/23, indicated Resident 60 had severely impaired cognition, wandered without a purpose 4 to 6 days during the 7-day observation period, required supervision with walking 10 feet, and needed set up assist with eating. A physician's order, dated 8/1/23, indicated she was to receive divalproex Sodium (seizure			

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	medication used to stabilize mood) 125 mg each morning and 250 mg each bedtime for dementia and psychotic disturbance. A care plan, initiated 8/4/23, indicated Resident 60 was at risk for elopement related to stating she was leaving and going home and wandering. The goal was for her to remain safe during her placement at the facility. The interventions, initiated 8/4/23, were to access for secure unit, involve her in preferred activities, redirect her from the doors, and take picture of her and update the elopement book. An intervention, initiated 8/7/23, was to place a Roam Alert. A behavior charting progress note, dated 8/10/23 at 7:46 p.m., read "...Describe Behavior/Mood: Resident [60] in another resident room. [Other] Resident stated yelling get out. Writer responded immediately and resident [60] was holding one of [other]resident stuffed animals. Writer attempted to ask resident [60] for animal when resident [60] swung toy at writer knocking off my glasses. Resident [60] then lost balance hitting her upper back on dresser in room. Resident [60] continue to try and swing animal at writer. Writer called for assist and left room. Resident [60] then picked up my glasses and putting them in her pocket and came out into hallway. Staff asked resident [60] for glasses, and she stated no they are mine. Staff walked with resident [60] up and down hallway several times. Staff able to remove glasses from pocket and take resident to her room. Resident was then assisted into bed...." There were no new interventions added to the at risk for elopement/ wandering care plan after the behavior incident on 8/10/23. A care plan, initiated 8/12/23, indicated Resident			

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	60 has a potential for drug related complications due to the use of psychotropic medication, anti-depressant medication, anti-psychotic medication, and mood stabilizer. The goal was for her to be free of psychotropic drug related complications. The intervention, initiated 8/12/23, included but were not limited to, observe for side effects of and report to the physician. provide medications as ordered by physician and evaluate for effectiveness. A care plan, initiated 8/12/23, indicated that Resident 60 had a physical functioning deficit related to her self-care. The goal was for her to improve her level of physical functioning. The interventions included, but were not limited to, eating assistance of set up and supervision. A care plan, initiated 8/12/23, indicated Resident 60 had cognitive loss/ dementia and impaired cognitive function related to dementia. The goal was for her to communicate her basic needs daily. The interventions, initiated 8/12/23, included but were not limited to, administer medications as ordered, assist with ADL (Activities of Daily Living), involve in enjoyable activities which orient to reality and don't depend on orientation, and to offer reminders which assist her in orientation. A Change of Condition note, dated 9/26/2023 at 2:20 p.m., indicated Resident 60 had wandered into another resident's room. The other resident was calling for someone to come and remove Resident 60. Upon entering the room, it was noted that Resident 60 was crying. The staff indicated the other resident had made contact with Resident 60 on her left hand and buttocks. No injuries were noted, and Resident 60 was placed on 15-minute checks.			

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A physician's order, dated 9/26/23, indicated Resident 60 was to receive divalproex sodium oral capsules delayed release sprinkles 250 mg each morning for dementia.

There were no new nonpharmacological interventions added to the elopement/ wandering care plan after the behavior incident on 9/26/23.

A counseling and psychiatric consent, dated 10/2/23, indicated Resident 60 could receive psychiatric consults and counselling.

A Physician's progress note, dated 10/2/23, indicated Resident 60 had increased agitation and restlessness over the last few weeks. Her mood was stable at the time. Depakote (divalproex sodium) dose was recently increased to 250 mg twice daily. Psychiatry services following and assisting with management.

The behavior monitoring documentation for September, October, and November 2023 were reviewed. Behaviors of wandering had been documented on the following days:
behaviors of wandering, crying, repeated movements have been documented on 9/4, 9/5, 9/6, 9/7, 9/11, 9/12, 9/15, 9/20, 9/21, 9/23, 9/24, 9/26, 9/27, 10/2, 10/4, 10/5, 10/10, 10/11, 10/17, 10/18, 10/24, 10/25, 10/26, 10/28, and 10/29/23. The interventions used to assist with managing wandering behavior were to redirect or toilet.

On 11/14/23 at 9:44 a.m., Resident 60 was observed sitting in the activity room with her head down and her eyes closed. She was not watching the television program.

On 11/15/23 at 10:09 a.m., Resident 60 was

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	observed sleeping in her bed. On 11/15/23 at 2:30 p.m., Resident 60 was observed sleeping in her bed. During an interview on 11/15/23 at 2:44 p.m., QMA (Qualified Medication Aide) 4 and CNA (Certified Nursing Assistant) 5 indicated that Resident 60 wandered around the memory care unit often when she was first admitted. The wandering had gotten better recently. They had tried to label her room with bright flowers, but she did not recognize them. Normally, when Resident 60 wandered into another resident's room, the other resident would just call out to have her removed. On 11/16/23 at 10:24 a.m., Resident 60 was laying in her bed with her eyes closed. A staff member was cutting her fingernails and indicated that Resident 60 was "sleepy today". During an interview on 11/16/23 at 10:32 a.m., CNA 3 indicated that Resident 60 had been having a decline in her ability to feed herself for the past couple of weeks and now needed the staff to feed her. Resident 60's wandering had improved recently. When Resident 60 wandered, CNA would redirect her at time by walking with her around the unit to see if Resident 60 needed something. At times CNA 3 would sit and talk with Resident 60 for a while, which seemed to calm her. Resident 60 would also sit and watch the television for a short while. CNA 3 did not recall stop signs or door signs being used to keep Resident 60 from entering rooms. During an interview on 11/16/23 at 2:26 p.m., the Memory Care Coordinator and the DON indicated that Resident 60 had been increasingly lethargic for the last couple of days and the Nurse			

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	Practitioner had been informed. The DON indicated that she was unaware of why new non-pharmacological interventions had not been done prior to the increase of the divalproex sodium. Resident 60 had not been seen by the psychiatry provider since the consent had been signed on 10/2/23. On 11/16/23 at 2:00 p.m., the DON provided the current Dementia Care Policy which read, "It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being...1. The facility will assess, develop, and implement care plans through an interdisciplinary tem (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible...3. The care plan interventions will be related to each resident's individual symptomology and rate of dementia...4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety...5. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being...8. Appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood, or behavioral status..." 3.1-37(a)			