STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155375	A. BUILDING 00 B. WING	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - PETERSBURG CARE CENTER	309 W PIKE AVE PETERSBURG, IN 47567

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 19, 20, 21, 22, 2023 Facility number: 000033 Provider number: 155375 AIM number: 100266280 Census Bed Type: SNF/NF: 43 Total: 43 Census Payor Type: Medicare: 0 Medicaid: 42 Other: 1 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 5, 2023.	F 0000	FACILITY IS REQUESTING PAPER COMPLIANCE FOR RECERTIFICATION	
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			

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

Cathy Eckert | Executive Director | 07/19/2023

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	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 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).			

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	Based on interview and record review, the facility failed to ensure significant changes in the resident's health condition were reported 1 of 1 residents reviewed hospice care and 1 of 1 reviewed for falls the Medical Doctor/Nurse Practitioner and/or family representative or POA (Power of Attorney) were not notified of the resident's change of condition. (Resident 12, Resident 8) Findings include: 1. On 6/20/23 at 11:00 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, emphysema, arteriosclerotic heart disease, peripheral vascular disease, and hemiplegia of right side following stroke. The most recent significant change MDS (Minimum Data Set) Assessment, dated 4/20/23, indicated the resident was severely cognitively impaired and an extensive assist of 2 staff for bed mobility, transfers, and toileting. Current physician's orders included, but were not limited to, the following: "Observe for ... change in usual mental status, lethargy ... Notify MD [Medical Doctor] is [sic] s/s [signs/symptoms are observed ...", dated 1/27/23 A current hemiplegia of right side from a stroke care plan, dated 1/18/23, included, but were not limited to, the following interventions: "Notify MD with any changes prn", initiated 1/18/23 A current dementia care plan, dated 1/13/23, included, but was not limited to, the following interventions: "Update my DPOA [power of attorney] as	F 0580	FACILITY IS REQUESTING PAPER COMPLIANCE. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Hospice was made aware of change in resident #12's health condition and resident #8 physician and family notified of fall. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this alleged practice. Nursing staff is to notify physician and family of any change of condition and document such change in a timely manner. This will be monitored by the IDT team during clinical start up 5 times a week. What measures will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur: Licensed staff been on Change of Condition, Notification of Change in Condition and Falls and Documentation. team will times during clinical start up for any change of conditions and to ensure proper notification to physician and family has occurred in a timely manner. How will this corrective action be monitored to ensure that the deficient practice does not recur: To ensure compliance the DNS/designee will be responsible for the completion	07/20/2023

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	indicated", initiated 1/13/23 A current cardiovascular status care plan, dated 1/18/23, included, but was not limited to, the following interventions: "Observe for changes in condition", initiated 1/18/23 "Observe for abnormal vital signs and report", initiated 1/18/23 A nurse's progress note, dated 3/21/23 at 2:43 P.M., indicated " [Resident has] been quiet today. Requested to stay in bed. Color pale ..." A nurse's progress note, dated 3/21/23 at 10:28 P.M., indicated "Res [resident] spent this shift in bed ... Res [resident] noted to have refused evening meal. Resting in bed at this time with eyes closed ... " A Wound Nurse Practitioner's progress note, dated 3/23/23 at 9:07 P.M. indicated " ... Upon assessment today, patient had slight labored breathing, wet cough, and fatigue. Per nursing, patient has had decreased intake this week. I am recommending a hospice consult at this time ... " A nurse's progress note, dated 3/24/23 at 7:30 P.M. (late entry) Resident noted to be breathing rapidly through mouth and staring ahead with right eye drooping. Vaguely answered yes when asked if he was ok. Vital signs at this time were: temperature 97.4, pulse 64, respirations 24, blood pressure 100/54, oxygen saturation 81% on room air. Noted resident's hands to be cold. Oxygen given as nursing measure but continued to breathe through his mouth. Vital signs recorded in the medical record lacked		of notification to responsibly party/family member and physician or NP. Any trends will be reported to QAPI monthly times 6 months then quarterly thereafter.	

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	documentation of temperature, pulse, blood pressure, respiratory rate and oxygen saturation from 3/14/23 at 3:33 P.M. until 3/24/23 at 7:29 P.M. The medical record lacked documentation of resident's condition being monitored, notification of the physician and POA of the change in his condition until he was sent out to the hospital on 3/24/23. Hospital records were reviewed and included, but were not limited to the following: RN (Registered Nurse) triage assessment, dated 3/24/23 at 10:52 P.M., indicated "RN [at facility] just arrived for her shift a few hours ago ... she reports that during supper time this evening she noticed that patient was not eating his food and was 'breathing out his mouth like a fish' ... She reports that the staff member who took care of the pt [patient] during dayshift [sic] today felt that patient was not acting right but she is unsure why this staff member did not do anything about it ... " A Physician's progress note, dated 4/11/23, indicated " ... The patient had an episode of decreased oxygen saturation to 70% and became poorly responsive with the decreased blood pressure of 70 [sic]. The patient was sent to [name of hospital]. It [sic] was found to have bilateral patchy pneumonia greatest on the right it was admitted to [name of hospital] for treatment [sic] ... The patient received intravenous antibiotics and respiratory therapy, as well as intravenous fluids for hydration. The patient remained somewhat poorly responsive ... the patient returned to [name of facility] for continuation of care, was placed on hospice, and was made comfort measures only by his healthcare power of attorney ..." During an interview on 6/21/23 at 2:30 P.M., the			

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	Nurse Practitioner indicated they had seen him weekly for skin assessment only so they did not do a full resident assessment and had not listened to his lungs. At that time, they did recall seeing the resident on 3/23/23 and that he had "somewhat labored breathing, he seemed a little more confused, and he did not look good ... 'I thought he looked like he was going to die'" During an interview on 6/22/23 at 10:15 A.M., QMA (Qualified Medication Aide) 3 indicated if Resident 12's cognition changed, she would check his O2 (oxygen) saturation, other vitals, and check his color. If he was more lethargic and pale or vitals were different then normal, then those would be reported to the nurse as soon as possible. During an interview on 6/22/23 at 9:48 A.M., RN 5 indicated if the resident had decreased cognition or vitals worsened, they should report the changes to the doctor and POA and it'd be up to the doctor to give orders on what to do. At that time, they indicated when there was a change of shift, concerns that should be discussed with the oncoming nurse would be "anything out of ordinary or a change like accucheck readings, time of last pain medication, confusion, lab results, eating or not eating, refusing care or medications. The staff had been documenting these things on a 24 hour reporting sheet that was kept at the nurse's station and then given to the DON who keeps it for so long. RN 5 indicated at the start of each shift, the nurse is responsible for taking an assessment of the residents on their hall. During their assessment, they will listen to lung sounds and bowel sounds, check pain level, and look for edema (swelling). During an interview on 6/22/23 at 10:45 A.M., the			

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	DON indicated when staff noticed a decline the family and doctor should have been notified even if the resident was on comfort measures only. Notification would not differ from anyone else. At that time, she indicated the symptoms documented on 3/21/23 should have been reported between nurses during shift change and the 24 hour documentation sheet should have been filled out with new orders, strange vitals, and anything abnormal about the resident. When the DON spoke with the day shift nurse, they indicated the resident was just tired and that he did act a little different, but nothing was out of the ordinary enough to notify the doctor or POA at that time. That afternoon the resident started with breathing difficulty and then they called the MD. The DON indicated the staff should do monthly vitals at least or prn if there is a reason to do vital signs and she would have expected vitals to be done and documented in the clinical record when resident's condition changed. After the resident's hospitalization, the DON did an investigation and it came to her attention that staff hadn't used 24 hour report sheets for approximately 6 months, staff wasn't getting vital signs timely, and things that should have been documented were not being documented in the clinical record. 2. On 6/21/23 at 3:09 P.M. Resident 8's clinical record was reviewed. Diagnosis included, but were not limited to, fracture of the right lower leg, diabetes mellitus, stroke, traumatic brain injury and vascular dementia. The most recent quarterly MDS (minimum data set) Assessment, dated 6/8/23, indicated Resident 8 was severely cognitively impaired and required total dependence from 2 staff members to transfer for all ADLs (activities of daily living). The resident had a total of six falls since February			

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	2023, the clinical record lacked documentation about fall six. An incident report, dated 5/9/23, was reviewed and indicated on 5/7/23 Resident 8 was lowered to the floor by a CNA during a transfer. "...On 5/8/23, [resident name] complained of R [right] leg pain from his hip to his ankle. On assessment, edema was noted to the right leg. PRN [as needed] pain medication was administered and [name of doctor] was notified. A new order was received to obtain a portable x-ray of the R [right] hip, knee, and ankle. The x-ray indicated mild degenerative change of the R [right] hip. Moderate degenerative changes of the R [right] knee. Displaced fracture of the R [right] medial malleolus and distal fibula. [Resident name] was transferred to [name of hospital] for evaluation and treatment per order from [name of doctor]...He underwent an external fixation of the fracture..." There was not a new care plan intervention put into place after the fall. Hospital records were reviewed and indicated on 5/9/23 at 6:27 P.M., a CT (computerized tomography) of the right ankle without contrast indicated Resident 8 suffered from a trimalleolar fracture with disruption of the ankle mortis [tibia, fibula, and foot]. During an interview on 6/22/23 at 3:43 P.M., the DON (director of nursing) indicated Resident 8 would use the call light to notify staff if he needed assistance, and when Resident 8 was in the bathroom staff did not need to supervise the resident while he was using the restroom. After the fall on 4/16/23, the DON indicated the new intervention was to place a Dycem in the wheelchair which was included in the care plan with a date of 4/19/23. At that time, the DON further indicated on 5/8/23, she was notified that Resident 8's foot was swollen and an			

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	investigation was started. During the investigation, the DON was told that the resident was lowered to the floor during a transfer in the shower room on 5/7/23, and the nurse did not document the fall because the staff member did not know an assisted fall needed to be documented. The facility failed to notify Resident 8's family, the DON, and the physician after the fall. On 5/8/23, Resident 8 complained of pain from his right hip to right ankle. At that time, an assessment was completed by the DON and Resident 8 had redness to his right lower leg and 2 blood blisters. The doctor was then notified and orders for an x-ray of the right hip, right knee, and right ankle were obtained. When the results were received on May 9, Resident 8 was transferred to [name of hospital] and underwent external fixation due to his foot being broke in 4 places. A current, undated vital signs policy was provided by the DON on 6/21/23 at 3:43 P.M., and indicated " ... 1. Routine vital signs include temperature, pulse, blood pressure, and respiratory rate ... b. Licensed nurses are responsible for knowing the usual range of a resident's vital signs ... and notifying the physician of abnormal findings 2. Oxygen saturation and pain are to be obtained and interpreted by licensed nurses 3. Vital signs shall be obtained at least in the following circumstances: ... c. at least daily for a resident receiving skilled services ...e. when the resident's general condition changes ... g. when a resident reports nonspecific symptoms ... " A current, undated documentation policy was provided by the DON on 6/21/23 at 3:43 P.M., and indicated " ... Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough			

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	information to provide a picture of the resident's progress through complete, accurate and timely documentation ... 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred ... documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care ... " A current, undated 24 hour report policy was provided by the DON on 6/21/23 at 3:43 P.M., and indicated " ... It is the policy of this facility to record relevant information onto a 24 hour report form ... in order to promote continuity of care ... A report form will be completed daily for a 24 hour period and maintained on a clipboard ... The 24 hour period will begin at midnight ... each nurse with responsibility for a resident is also responsible for recording relevant information about each resident onto the shift report form. Examples include, but are not limited to: ...unusual behaviors, change in condition of the resident ... the unit manager or designee will review 24 hour shift report at the beginning of his/her shift to identify and prioritize resident needs ... The paper form 24 hour reports will be kept on the clipboard for at least three days, then forwarded to the Director of Nursing. The reports will be maintained for a specified period of time by the Director of Nursing ... " A current, undated Notification of Changes policy was provided by the DON on 6/21/23 at 3:43 P.M., and indicated " ... The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification ... circumstances requiring notification			

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	include: ... significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status ... " On 6/21/23 at 3:43 P.M., the DON provided an undated Documentation in Medical record policy that indicated "Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation...Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred...." 3.1-5(a)(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, interview and record review, the facility failed to ensure the residents received the necessary respiratory care and services in accordance with the professional standards of practice for 3 of 3 residents reviewed for respiratory care. The facility failed to follow physician oxygenation orders, date oxygen tubing and humidification bottle, and document oxygen	F 0695	FACILITY IS REQUESTING PAPER COMPLIANCE. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #39 oxygen order changed to continuous and placed	07/20/2023

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	use and oxygen saturations. (Resident 39, Resident 12, Resident 21) Findings include: 1. During an observation on 6/19/23 at 11:08 A.M., Resident 21 was observed laying in bed with oxygen on 2 LPM (liters per minute) via nasal cannula. Observation on 6/20/23 at 9:25 A.M., Resident 21 was observed laying in bed with oxygen on 2LPM via nasal cannula. Observation on 6/21/23 at 1:08 P.M., Resident 21 was observed laying in bed with oxygen on 2LPM via nasal cannula. On 6/21/23 at 8:57 A.M., Resident 21's clinical record was reviewed. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease, emphysema, Alzheimer's disease. The most recent significant change MDS (minimum data set) Assessment, dated 6/1/23, indicated Resident 21 had a severe cognitive impairment. The MDS did not indicate that Resident 21 was on oxygen. There was not a current order for oxygen use. A current alteration in respiratory status due to chronic obstructive pulmonary disease and emphysema care plan, revised 6/7/23, indicated to administer oxygen as needed per a doctor's order. Interview on 6/22/23 at 11:23 A.M., the DON (Director of Nursing) indicated Resident 21 was on oxygen, but she was unable to find the oxygen order at that time. She further indicated that a doctor's order was needed when a resident was		on TAR. Oxygen rate on TAR to be checked on each shift. Resident is own responsible party and notified of change. Resident #39's tubing was dated on date of survey. Director took back to room and showed that it was dated, this was not deficient. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: Any and all residents who have oxygen ordered have the potential to be affected by this deficient practice. All oxygen orders have been reviewed by the DNS or . What measures will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur: of licensed staff to follow physician orders, oxygen rate checked each shift and documented on TAR. DNS/designee to review TAR's 5 times week during clinical start up. of oxygen tubing will be audited weekly. How will these corrective actions be monitored to ensure that the deficient practice does not recur: To ensure compliance the DNS/designee will be monitoring of orders/documentation and dating of tubing. Any trends will be reported to QAPI monthly times 6 months then quarterly thereafter.	

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	placed on oxygen. 2. During an observation on 6/19/23 at 8:22 A.M., Resident 12 was observed laying in bed wearing oxygen via nasal cannula. The oxygen concentrator was set between the 3.5 LPM and 4 LPM lines. Observation on 6/20/23 at 9:50 A.M., Resident 12 was laying in bed wearing oxygen via nasal cannula. The oxygen concentration was set between the 3.5 LPM and 4 LPM lines. On 6/21/23 at 10:30 A.M., the same was observed. On 6/20/23 at 11:00 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, emphysema, arteriosclerotic heart disease, peripheral vascular disease, and hemiplegia of right side following stroke. The most recent significant change MDS Assessment, dated 4/20/23, indicated Resident 12 was severely cognitively impaired, on oxygen, and an extensive assist of 2 staff for bed mobility, transfers, and toileting. Current physician's orders included, but were not limited to, the following: Continuous oxygen at 3 LPM via nasal cannula, dated 4/10/23 A current respiratory care plan, initiated on 1/18/23, included, but was not limited to the following intervention: Administer oxygen as needed per Physician order, dated 1/18/23 Interview on 6/22/23 at 9:44 A.M., RN (Registered Nurse) 5 indicated Resident 12's oxygen concentrator should be set at 2 LPM, it is the			

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	nurse's responsibility to check the concentrator setting every shift, and the resident would not change the setting. Interview on 6/22/23 at 3:43 P.M., the DON indicated that there was not a policy for following physician's orders, but it was the facility's policy to do so. 3. On 6/20/23 at 8:59 A.M., Resident 39 was observed sitting in a recliner in her room wearing O2 (oxygen) at 2.5 LPM per nasal cannula with no date on oxygen tubing or humidification bottle. On 6/21/23 at at 8:36 A.M., Resident 39 was observed sitting at a table in the dining room with portable O2 on, no date on oxygen tubing, playing a game with another resident. On 6/22/23 at 10:30 A.M., Resident 39 was observed at the nurse's station in her wheelchair wearing portable O2 at 3 LPM per nasal cannula. There was no date on the oxygen tubing. On 6/20/23 at 10:59 A.M., Resident 39's clinical record was reviewed. She was admitted on 11/2/22. Diagnosis included, but were not limited to, chronic respiratory failure with hypoxia, asthma, and congestive heart failure. The most recent quarterly MDS Assessment, dated 5/13/23, indicated Resident 39 was cognitively intact and required supervision of one for bed mobility, transfers, eating, and toilet use. Oxygen use was marked no. Current physician's orders included, but were not limited to, the following: May have 02, up to 4 LPM per n/c (nasal cannula) if sats (saturations) drop below 90% or c/o (complaint of) shortness of breath; as needed for			

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	chronic respiratory failure with hypoxia (J96.11); acute bronchitis, unspecified (J20.9) 3/5/2023 A current care plan for alteration in respiratory status due to asthma, chronic respiratory failure with hypoxia, congestive heart failure, initiated 11/3/22, included, but was not limited to, the following intervention: Administer oxygen as needed per physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response 11/3/2022 A review of the TAR (treatment administration record) lacked documentation of the prn (as needed) O2 use and oxygen saturations for the months of April, May, and June 2023. A review of the vital signs lacked documentation of oxygen saturations after 4/26/23. Interview on 6/22/23 at 11:30 A.M., the DON indicated it was the facility policy to change O2 tubing every week on Saturday night, tubing should be dated when changed. If the resident was on prn O2, use should be documented on the TAR and O2 saturations should be monitored and recorded. A current non dated Oxygen Administration policy, provided by the DON on 6/22/23 at 11:50 A.M., indicated "Oxygen is administered under the orders of a physician...Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy... Change oxygen tubing and mask/cannula weekly..." 3.1-47(a)(6)			

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F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			

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	Based on observation, interview, and record review, the facility failed to ensure daily posted nurse staffing information was correct for 1 of 4 days during the survey. Findings include: On 6/19/23 at 7:45 A.M., a staffing record was observed posted on the front desk in the lobby of the facility dated 6/15/23, four days prior to the survey. On 6/22/23 at 1:30 P.M., the Director of Nursing(DON) indicated the scheduler places the daily direct staffing sheets for Saturday, Sunday, and Monday behind the posted Friday sheet. She also indicated the day shift nurse will change the staffing sheets each morning. On 6/22/23 at 3:22 P.M., the Administrator indicated the facility has no written policy. The staffing is based on facility assessment of daily resident acuity.	F 0732	FACILITY IS REQUESTING PAPER COMPLIANCE What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Nurse staffing information was corrected and posted for current date. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: The Scheduler/Designee will ensure that the Staff Posting Information is posted on a daily basis. On weekends the day shift nurse will be responsible for changing the posting information. What measure will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur: The Scheduler/Designee will ensure that the Staff Posting Information is posted on a daily basis. On weekends the day shift nurse will be responsible for changing the posting information. How will these corrective actions be monitored to ensure that the deficient practice does not recur: or Designee will monitor Monday-Friday and Manager will monitor on weekends that the Staff Posting Information has been updated for the day. This will be reviewed through facility QAPI monthly times 6 months then quarterly as needed.	07/20/2023

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F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent (%) for 2 of 4 residents (Residents 8, Resident 25) observed during medication pass. Two medication errors were observed during 28 opportunities for error in medication administration. This resulted in a medication error rate of 7.14 %. Findings include: 1. During an observation on 6/21/23 at 10:29 A.M., RN (Registered Nurse) 3 was observed to administer 7 units of Novolog 100 units/ml (milliliter) from the FlexPen subcutaneously in the back of Resident 8's right arm. The open date on the Novolog Flexpen was 5/4/23. During an interview on 6/22/23 at 11:20 A.M., the DON (Director of Nursing) indicated after the insulin pen was opened, it was good for 28 days. It should be discarded and another one opened after the 28th day. She indicated the open date should be checked before administering insulin from the pen. A package insert for the Novolog FlexPen, dated January of 2015, indicated once a NovoLog FlexPen was punctured, it should be kept for up to 28 days. 2. During an observation on 6/21/23 at 7:20 A.M., LPN (Licensed Practical Nurse) 18 was observed	F 0759	FACILITY IS REQUESTING PAPER COMPLIANCE What corrective action will be accomplished for those residents found to have been affected by the deficient practice: All Insulin were reviewed no outdated pens were in use. Resident #25 orders were reviewed by pharmacy and medication was corrected per order. How will you identify residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. DNS/designee reviewed all insulin orders as well as all insulin medication to ensure insulin is within date range. What measures will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur: Nurses on Insulin Pen and Medication Administration policy. DNS or will complete observations on dated Insulin pens and Medication Pass. How will these corrective actions be monitored to ensure that the deficient practice does not recur: DNS or will monitor 5 times	07/20/2023

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	to administer 1 capsule of omeprazole 20 mg (milligram) by mouth to Resident 25. On 6/22/23 at 3:30 P.M., Resident 25's clinical record was reviewed. Current physician's orders included, but were not limited to the following: omeprazole 40 mg capsule by mouth in the morning, dated 9/19/19. During an interview on 6/22/23 at 4:20 P.M., RN 20 indicated Resident 25's physician order was omeprazole 40 mg 1 capsule by mouth daily. The pill packet from the medication cart was labeled "1 x omeprazole 20 mg capsule". They indicated they would contact the physician and pharmacy to double check the order that was given and correct it so the resident would get the correct dosage. During an interview on 6/22/23 at 4:28 P.M., the DON indicated the current order from the physician was sent to (pharmacy name) and the medications were put in the machine. The DON indicated she was not sure how long the incorrect dose of medication had been administered. At that time, she indicated the day shift is responsible for having the machine get the pill packets ready for each resident for the next day, and night shift was responsible for putting the pill packets into the medication cart. The nurse or QMA (Qualified Medication Aide) administering the medication was responsible for checking that the medication matched the physician's orders. A current undated Insulin Pen policy was provided by the DON on 6/21/23 at 3:43 P.M., and indicated " ... 9. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation ... "		weekly. This will be reviewed through facility QAPI monthly times 6 months then quarterly as needed.	

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	A current undated Medication Administration policy was provided by the ADON (Assistant Director of Nursing) on 6/22/23 at 3:38 P.M., and indicated " Medications are administered ... as ordered by the physician and in accordance with professional standards of practice ... 11. Compare medication source (bubble pack, vial, etc.) with MAR (Medication Administration Record) to verify resident name, medication name, form, dose, route, and time ... 12. Identify expiration date. If expired, notify nurse manager ... " 3.1-48(c)(1)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide appetizing and palatable meals on 1 of 1 lunch trays sampled. Residents interviewed during the survey complained of unappetizing food with varying temperatures of food. Findings include: During the survey period 6/19/23-6/22/23, the following confidential resident interviews were conducted:	F 0804	FACILITY IS REQUESTING PAPER COMPLIANCE What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this alleged deficient practice. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be	07/20/2023

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	a. Sometimes cannot tell what the food is. b. The food taste is "not good." c. The temperature varies. On 6/22/23 at 11:40 A.M., a sample lunch tray was provided and included: sloppy joe, tater tots, and carrots. Temperature were as follows: Sloppy joe 116.6 degrees (Fahrenheit) tasted pasty. Carrots 110.1 degrees (Fahrenheit) tasted metallic. Iced tea 42.8 degrees (Fahrenheit) The tater tots were not palatable, cold, and tasted stale. The temperature was unobtainable. During an interview on 6/22/23 at 2:19 P.M., the dietary manager indicated that the internal temp of the meat should be 165 or better based on the meat, and that vegetable has a certain temperature. He provided the temperature log of the serving time: Entree meat 186 degrees (Fahrenheit) Vegetable 191 degrees (Fahrenheit) Starch 178 degrees (Fahrenheit) On 6/22/23 at 4:14 P.M., a current "Food Preparation Guidelines, revised 11/2017 was provided and indicated "... facility to prepare foods in a manner it preserve or enhance a resident's nutrition and hydration status. 3. Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature..." The policy did not include proper serving temperatures. 3.1-21(a)(1) 3.1-21(a)(2)		taken: All residents have the potential to be affected by this alleged deficient practice. Test tray evaluations and Food Committee meetings will be conducted for resident comments on temperatures and palatability. What measures will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur: Dietary staff has been on 7/19/23 palatable, attractive, safe and appetizing temperatures. Test trays will be completed 3 times/week by DSM/ED or for 4 weeks then weekly for an additional . committee will be held weekly 4 weeks and then monthly for at least an additional 8 months or as needed. How will this corrective action be monitored to ensure that the deficient practice does not recur: To ensure compliance the DSM/designee will monitor through facility Food Committee and Resident Council. Any trends will be addressed and reported to QAPI monthly times 6 months then quarterly thereafter.	

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F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			

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	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to ensure infection control practices were in place during 2 of 4 resident medication administrations and 2 of 4 residents observed during incontinence care. Staff failed to sanitize hands and change gloves between dirty to clean tasks. Staff did not sanitize hands between residents during medication administration.	F 0880	FACILITY IS REQUESTING PAPER COMPLIANCE What corrective action will be accomplished for those residents found to have been affected by the deficient practice: CNA #3 and #7 and nurse #18 were on proper hand hygiene. How	07/20/2023

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	(Resident 21, Resident 12, Resident 25, Resident 30) Findings include: 1. During an observation on 6/21/23 at 10:17 A.M., QMA (Qualified Medication Aide) 3 and CNA (Certified Nurse Aide) 7 performed incontinence care on Resident 21. Upon entering the room, both aides put gloves on. QMA 3 stood on the left side of bed and CNA 7 on right side of bed. QMA 3 took blankets off resident and placed them on the chair while CNA 7 raised the bed with the controller. QMA 3 opened the bathroom door and went into the bathroom to get a bedpan. Resident 21 was laying on her back and both aides unfastened her incontinence pad then rolled the resident to her right side and CNA 7 held the resident there while QMA 3 placed the bedpan under the resident. QMA 3 took off her gloves and put on new gloves before she raised the head of the bed to make the resident more comfortable then removed her gloves. CNA 7 lowered the head of the bed. QMA 3 and CNA 7 rolled Resident 21 onto her right side again. CNA 7 held the resident on her right side while QMA 3 took the bedpan out from underneath the resident, took it into the bathroom and dumped the urine into toilet, touched the facet handles, rinsed out the bedpan, flushed the toilet, and put bedpan into a bag and under the sink then closed the bathroom door. QMA 3 took off gloves and put on new gloves without sanitizing hands. Resident 21 was rolled to left side and CNA 7 wiped across Resident 21's buttocks only with a wet cloth, took off gloves and put on new gloves without sanitizing. Resident was rolled on her right side and CNA 7 held her while QMA 3 placed a new incontinence pad and bed pad under the resident and applied barrier cream to her buttocks. QMA 3 removed		will you identify other residents who have the potential to be affected by the deficient practice and what corrective action will be taken: All residents have potential to be affected. What measures will be put in place or what systematic change will you make to ensure the deficient practice does not recur: Nursing staff have been educated on proper hand hygiene and infection control policy. How will these corrective actions be monitored to ensure that the deficient practice does not recur: DNS or will complete 5 audits a week times 4 weeks, 3 audits a week for 4 weeks. Random audits thereafter. Infection Control reviewed any patterns noted with hand hygiene will be address additionally through our QAPI process.	

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	right glove and put on new right glove without sanitizing hands. Resident was rolled to her back. CNA 7 grabbed the new brief out from resident's right side, took off gloves, sanitized hands, and put on new gloves. QMA 3 took a wet cloth, and while CNA 7 held her right leg, QMA 3 wiped across the creases of the legs and lower abdomen. With the same cloth, QMA 3 wiped vaginal area. CNA 7 pulled the incontinence pad up between the resident's legs while QMA 3 applied cream to the left upper leg. Both aides fastened the incontinence brief. Both aides removed their gloves. CNA 7 sanitized her hands. QMA 3 grabbed 2 pillows and blanket from the chair and put the pillows under resident's legs and the blanket back over the resident. CNA 7 lowered the bed. QMA 3 went into the bathroom and washed hands. CNA 7 pulled privacy curtain open and then went into the bathroom to wash her hands with a 15 second lather. 2. During an observation on 6/21/23 at 10:17 A.M., QMA 3 and CNA 30 performed incontinence care on Resident 12. Upon entering the room, both aides put on gloves. QMA 3 closed the door and pulled the privacy curtain. CNA 30 used the controller to raise the bed. The resident was laying on his back in bed. Both aides unfastened the incontinence pad. QMA 3 stood on the right and CNA 30 on the left of the bed. They rolled resident to his left side. The resident had loose BM (bowel movement) in his incontinence pad. QMA 3 wiped backside first with a soapy wet wash cloth folding as she went, put the soiled cloth into trash bag, wiped again in the same manner then took off gloves and put on new gloves without sanitizing hands. QMA 3 placed new bed pad and new incontinence pad under the resident then applied barrier cream to buttocks with right glove, took off that glove put on new			

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	155375	A. BUILDING 00 B. WING	06/22/2023

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	glove without sanitizing. The resident was rolled onto back. QMA 3 grabbed a new wet cloth to wipe down penis and scrotum. The cloth was soiled with BM, folded the cloth, and wiped the penis again with the BM touching the head of the penis. QMA 3 removed her gloves. Both aides fastened the incontinence pad. CNA 30 took off gloves and put new gloves on without sanitizing. QMA 3 put on new gloves without sanitizing. Resident was rolled to his right side. CNA 30 pulled the bed pad and incontinence brief out from under the resident and then rolled him to his back. CNA 30 took shirt off and pulled over left shoulder. QMA 3 grabbed the shirt and pulled it over the resident's head, took off O2 (oxygen) tubing pulled off shirt, and put on O2 nasal cannula tubing back into the resident's nose. They put a gown on the resident and CNA 30 took off her gloves and covered the resident up with blanket. QMA 3 dumped pan of water in the bathroom sink and then took off gloves. QMA 3 moved bedside table back to the side of the resident without sanitizing it and placed the call light in the resident's reach. During an interview on 6/22/23 at 10:15 A.M., QMA 3 indicated when doing incontinence care, she would first set up the room by opening and putting trash bags in the room for soiled linens and the soiled incontinence pad, get supplies ready-incontinence brief, wipes or cloths or dishpan and soap if needed. She would tell the resident what she was going to do. She would clean the front side first, get a different cloth then do backside. She would clean the resident, pull the soiled incontinence pad out, put clean incontinence pad and bed pad under the resident, roll them, and pull clean pads through. QMA 3 indicated hands should be sanitized before new gloves are put on and that gloves should be			

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	changed anytime they are soiled. Hands should be washed before leaving the resident's room for 20-30 seconds. 3. During an observation on 6/21/23 at 7:05 A.M., LPN (Licensed Practical Nurse) 18 was observed passing medications to Resident 25. After administering 12 medications from the medication cup into the resident's mouth, LPN 18 washed her hands in the resident's bathroom with a 4 second lather. Resident 25 asked LPN 18 to adjust her bed and after doing so, LPN 18 went back into the bathroom and washed her hands with a 12 second lather. She did not sanitize her hands before getting the next resident's medications ready. 4. During an observation on 6/21/23 at 7:20 A.M., LPN 18 was observed passing medications to Resident 30. After administering 5 medications from the medication cup and helping the resident drink 1/2 of her Miralax, LPN 18 washed her hands in the resident's bathroom with a 14 second lather. During an interview on 6/22/23 at 3:30 P.M., the ADON (Assistant Director of Nursing) indicated the nurse was supposed to perform hand hygiene before the start of the medication pass and when leaving the resident's room. During an interview on 6/22/23 at 10:45 A.M., the DON indicated staff need to change gloves between dirty to clean tasks, before and after touching a resident, and before and after medication passes. At that time, she indicated during incontinence care, the front of the resident should be cleaned first and then the backside of the resident. A current undated hand hygiene policy was			

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	provided by the DON on 6/22/23 at 11:50 A.M., and indicated " ... All staff will perform proper hand hygiene procedures to prevent the spread of infection ... Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice ... 5. Hand hygiene technique when using soap and water: a. Wet hands with water ... b. Apply to hands the amount of soap recommended by the manufacturer. c. Rub hands together vigorously for 20 seconds, covering all surfaces of the hands and fingers d. Rinse hands with water ... The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning [putting on] and immediately after removing gloves ... " A current undated perineal care policy was provided by the DON on 6/22/23 at 11:50 A.M., and indicated " ... a. Cleanse buttocks and anus, front to back; vagina to anus in females, scrotum to anus in males, using a separate wash cloth or wipes. b. Thoroughly dry 11. Females: ... c. Separate the resident's labia with on hand, and cleanse perineum with the other hand by wiping in direction from front to back (from pubic area toward anus). d. Repeat on opposite side using separate section of washcloth or new disposable wipe. e. Clean urethral meatus and vaginal orifice using clean portion of washcloth or new disposable wipe with each stroke. f. Pat dry with towel. g. Turn the resident on her side. h. Clean and dry the anal area, starting at the posterior (back) vaginal opening and wiping from front to back. 12. Males: assist resident to supine position (unless contraindicated). b. Gently raise penis and place bath towel underneath. c. Wet washcloth and apply perineal cleanser ... e. hold the shaft of the penis with one hand and was with the other [sic]. Begin cleansing tip of penis at urethral			

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	meatus using a circular motion and working outward... g. Cleanse the shaft of the penis, using downward strokes toward the scrotum. Use separate section of wash cloth or new disposable wipe with each stroke. h. Cleanse the scrotum, using a clean portion of the wash cloth, new wash cloth, or new disposable wipe with each stroke. i. Pat dry. j. Turn the resident on his side. k. Clean and dry the bottom of the scrotum and the anal area ... Reposition as desired and cover resident. Remove gloves and discard. Perform hand hygiene ... " A current medication Administration policy was provided by the ADON on 6/22/23 at 3:38 P.M., and indicated " ... 4. Wash hands prior to administering medication per facility protocol and product ... 16. Wash hands after using facility protocol and product ... " 3.1-18(b) 3.1-18(l)			