DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 00 B. WING	10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - RICHMOND CARE CENTER	1042 OAK DR RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00419162 and IN00419396. Complaint IN00419162 - Federal/State deficiencies related to the allegations are cited at F- 684 & F-695 Complaint IN00419396 - Federal/State deficiencies related to the allegations are cited at F-607, F-684 & F-921. Unrelated deficiencies are cited. Survey dates: October 19, 20, & 23 2023 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 2 Medicaid: 52 Other: 2 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 25, 2023	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth 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. The facility respectfully requests a desk review of our responses to this survey.	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joanne L Denney	Executive Director	11/06/2023

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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	implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.			
	Based on interview and record record review the facility failed report allegations of abuse to the Indiana Department of Health and the Administrator, failed to protect residents after an allegation of abuse for 3 of 13 residents reviewed for abuse (Resident K, Resident Q and Resident R). Findings include:	F 0607	F607 Develop/Implement Abuse/Neglect Policies The facility does report allegations of abuse to the Administrator and the Indiana Department of Health. The facility does protect residents after allegations of abuse. Nursing immediately conducted a head-to-toe assessment on	11/06/2023

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	1.) During an interview with the Administrator on 10/19/23 at 12:40 p.m., indicated on 10/14/23, LPN 19 called and reported that Resident K had a fall. LPN 19 did not report that Resident K reported an allegation of abuse, that CNA 2 had pushed her out of the wheelchair. The Administrator indicated she did not know about the allegation of abuse until 10/16/23 when she came into work and there was a concern form under her door about the allegation. During an interview with CNA 2 on 10/19/23 at 3:15 p.m., indicated on 10/14/23 during the evening time, Resident K was behind the nursing station picking up papers and taking food out of the refrigerator. CNA 2 indicated she asked the resident if she wanted to go to her room and the resident said yes. The resident appeared anxious and talking "gibberish" making no sense. Resident K grabbed the CNA by her throat as she was pushing her down to her room, then put her feet down and fell onto the floor. Resident K started screaming and yelling saying the CNA pushed her out of the wheelchair. CNA 2 indicated LPN 19 came and a couple other staff and got the resident off the floor. CNA 2 continued to work until 10:00 p.m.. and then worked 14 hours on 10/15/23. During an interview with LPN 19 on 10/20/23 at 1:33 p.m., indicated she was the nurse caring for Resident K on 10/14/23 when the resident fell. LPN 19 indicated she did not witness the fall. CNA 2 indicated she was taking the resident to her room in the wheelchair and the resident became combative and fell. Resident K would not let me assess her and kept yelling CNA 2 pushed her out of her wheelchair. LPN 19 indicated she called the Administrator and the Assistant		Residents K and Q. Residents K and Q were assessed by Social Services for any signs of psychosocial distress related to abuse. Resident R discharged from the facility. The physician was notified following assessment. The Executive Director and Director of Nursing conducted a thorough investigation. All residents have the potential to be affected. Direct care staff were educated on allegations including the appropriate actions for reporting such allegations. CNA 20 no longer works at the facility. Social Services Director/designee will conduct a random audit of 5 residents each week for 6 weeks for allegations of abuse, then 3 residents each week for 4 weeks. These residents will be interviewed and assessed related to verbal abuse and any psychosocial distress related to such. Any negative findings will be reported and investigated appropriately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis	

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	Director Of Nursing (ADON) and reported the fall, LPN 19 indicated she could not remember if she reported the allegation of abuse. Review of the record of Resident K on 10/20/23 at 2:55 p.m., indicated the resident's diagnoses included, but were not limited to, congestive heart failure, lack of coordination, weakness, hypertension, weakness, diabetes, depression, osteoarthritis, muscle wasting, cardiomegaly, dementia and mood disturbance. The Quarterly Minimum Data (MDS) assessment for Resident K, dated 7/25/23, was moderately impaired for daily decision making. The resident required extensive assistance of one. The resident required extensive assistance of one person for locomotion on and off the unit. The progress note for Resident K, dated 10/14/23 at 8:30 p.m., indicated the resident was found on the floor in the sitting position after a fall from her wheelchair. The resident claimed the CNA pushed her out of the wheelchair. The resident refused an assessment. The grievance form for Resident K, dated 10/16/23, indicated the resident reported CNA 2 pulled her out of her wheelchair and she landed on the floor. The resident indicated CNA 2 lied about what happened and she no one was around she stuck her tongue out at the resident. The resident did not want CNA 2 to care for her any longer. 2.) During an interview with the Administrator on 10/20/23 at 1:20 p.m., indicated she did not report the allegations of abuse by CNA 20 to the Indiana Department Of Health related to Resident Q and Resident R's allegations filed on grievances			

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because CNA 20 was terminated.

Review of the record of Resident Q on 10/23/23 at 11:28 a.m., cerebral infarction, hemiplegia, chronic obstructive pulmonary disease, cardiomegaly, respiratory failure, osteoarthritis, chronic kidney disease, depression, obesity, muscle weakness, epilepsy, muscle weakness, hypertension, insomnia and anxiety.

The Quarterly MDS assessment for Resident Q, dated 8/7/23, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident required extensive assistance of one person for dressing.

The grievance filed by Resident Q, dated 10/4/23, indicated CNA 20 was "very rude, mean and hateful to her". The resident requested to have her pajama bottoms on and CNA 20 put a nightgown on her and said she was not going to change the resident into pajamas. While CNA 20 was assisting the resident to bed she pointed and shook her finger at Resident Q and said "you better have everything you want because I am not coming back." CNA 20 told Resident Q that another resident was a nasty B---- because she did not like to be cleaned up.

3.) Review of the record of Resident R on 10/23/23 at 12:00 p.m., indicated the resident's diagnoses included, but were not limited to, atrial fibrillation, diabetes, schizophrenia, hypertension, chronic pain syndrome, cerebral infarction, insomnia, muscle weakness and chronic respiratory failure.

The Quarterly MDS for Resident R, dated 9/3/23, indicated the resident was cognitively intact for daily decision making. The resident was

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	consistent and reasonable. The grievance filed by Resident R, dated 10/3/23, indicated the resident was attempting to move from the wheelchair to the bed and CNA 20 for help. CNA 20 told the resident "Get you A-- out of wheelchair and do it yourself". The employee memorandum for CNA 20, dated 10/5/23, indicated the staff was terminated from employment. The abuse policy provided by the Administrator on 10/19/23 at 11:00 a.m., indicated abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. An immediate investigation is warranted when suspicion of abuse, the facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. The facility would report all alleged violations to the Administrator, state agency, adult protective services and law enforcement (when applicable) immediately, but not later than 2 hours after the allegation was made. This citation related to Complaint IN00419396. 3.1-28(a) 3.1-28(c) 3.1-28(d)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review the facility failed to treat and assess a resident experiencing emesis and failed to transport a resident with a change in condition to the hospital timely for 1 of 3 residents reviewed for quality of care (Resident C). Finding include: During an interview with LPN 23 on 10/19/23 at 2:00 p.m., indicated on 10/6/23, she was not assigned to care for Resident C, but she had went to check on him and got RN 22 to evaluate him also. RN 21 was his assigned nurse on 10/6/23 and told her she knew something was "off" with the resident during morning medication pass and was waiting to see what the physician on call wanted to do. During an interview with RN 22 on 10/19/23 at 2:30 p.m., indicated on 10/6/23 she was in morning meeting and someone came down and got her to check on Resident C. RN 2 indicated his oxygen saturation was in the 40's, his eyes were fixed and pinpoint. The resident was having problems breathing and oxygen was placed on the resident and his oxygen saturation came up into the 80's. RN 22 sent the resident to the hospital. During an interview with RN 21 on 10/19/23 at 4:30 p.m.., indicated she was caring for Resident C on 10/6/23 day shift. RN 21 indicated it was reported in shift report to her that the resident had episodes of emesis on 10/5/23 and nothing else was reported about the resident. RN 21 first saw	F 0684	F684 Quality of Care The facility does assess and treat residents with changes of conditions. Resident C discharged from the facility. A 5-day look back was completed for all residents to identify any changes of condition. All residents have the potential to be affected. Licensed staff educated proper action to assess and treat a change of condition. DNS/designee will review progress notes and vital signs daily to identify any potential change of condition. Any negative findings will be addressed immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	11/06/2023

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	Resident C around 7:30 a.m., during medication pass. RN 21 indicated the resident was not his normal self, the resident was gazing off, his mouth was drooping and his arm was flaccid, normally the resident would give me a fist bump when approached but he did not. RN 21 indicated after breakfast the residents CNA's reported to her that he did not seem like his normal self and she checked his blood sugar and it was within normal limits at 135. RN 21 reported the Director Of Nursing (DON) around 9:00 a.m., Resident C's change in condition and the DON told her not to send him to the hospital that he may have been having Transient Ischemic Attack (TIA) (stroke that last a few minutes). RN 21 indicated she felt like the resident should have been sent to the hospital and she continued to monitor him. RN 21 indicated when she came back from break the nurse covering her was sending Resident C to the hospital. During an interview with CNA 2 ON 10/19/23 AT 4:07 p.m., indicated she was caring for Resident C on 10/5/23 on evening shift. CNA 2 indicated Resident C "threw up" continuously between 8:00 p.m. until 10:00 p.m. when she got off work. CNA 2 indicated she reported the resident vomiting continuously to RN 18 and the third shift CNA coming on duty. During an interview with RN 18 on 10/19/23 at 6:02 p.m., indicated he cared for Resident C on 10/5/23 and the resident had two episodes of emesis. RN 18 called the on call physician and received an order for zofran (antiemetic). RN 18 did not conduct lung assessment on Resident C. During an interview with the DON on 10/20/23 at 2:25 p.m., indicated she was notified of Resident C's change of condition during morning meeting.			

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	The DON indicated nothing had been reported to her about Resident C by RN 21. The DON indicated she did not tell the staff not to send Resident C to the hospital. The DON indicated the expectation was the nurse on duty should have completed an assessment on Resident C on 10/5/23 after he had episodes of emesis to include abdominal and lung assessment. During an interview with the DON on 10/23/23 at 9:45 a.m., indicated she checked the automated drug unit disposition and there was no zofran signed out for Resident C on 10/5/23. During an interview with the DON on 10/23/23 at 1:22 p.m., indicated Resident C did not receive zofran or cough syrup on 10/5/23 as ordered. Review of the record of Resident C on 10/20/23 at 2:04 p.m., indicated the resident's diagnoses included, but were not limited to, Cerebral Vascular Accident (CVA), hemiplegia, hemiparesis, diabetes, right hand contracture, aphasia (difficulty with communication) neuromuscular dysfunction, muscle weakness, hypertension and seizures. The Annual Minimum Data Set (MDS) assessment for Resident C, dated 10/4/23, indicated the resident was severely cognitively impaired for daily decision making. The resident required total calories through tube feedings. The State Optional MDS assessment for Resident C, dated 10/4/23, indicated cognitively impaired for daily decision making. The resident required extensive assistance of two people for bed mobility, totally dependent of two people to transfer.			

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	The plan of care for Resident C, dated 9/1/16, indicated the resident had impaired communication and inability to speak due to aphasia/CVA. The intervention included, but were not limited to, "fist bump for yes". The progress note for Resident C, dated 10/5/23, indicated the Nurse Practitioner (NP) was notified that the resident had emesis one time of tube feeding, this may have been triggered by a cough. The NP ordered a Covid test, cough syrup as needed and zofran. There was no documentation that Resident C was provided with zofran, cough syrup or that a Covid test was complete. The progress note for Resident C, dated 10/6/23 at 10:20 a.m., indicated the resident appeared to be less responsive than normal. The resident was not responding to his name and unable to hold his arm up. Looks and wiggles toes with stimuli. Eyes fixated, and left side of mouth drooping. Vitals were blood pressure- 106/61 , temperature- 98.9, pulse 101, oxygen saturation 90% on room air, blood sugar 135. The physician was notified and an order was received to send to the emergency room. The progress note was electronically signed by RN 21. The progress note for Resident C, dated 10/6/23 at 10:48 a.m., indicated this nurse was called to Resident C's room. The resident was not responding, tongue protruding, cold/clammy, pupils fixed and pinpoint. Oxygen saturation was 64% on room air, pulse 42. Oxygen placed on resident and Emergency Medical Services (EMS) called and transported to the local hospital. The progress note was electronically signed by RN 22. The progress note for Resident C, dated 10/9/23 at 6:12 a.m., (late entry for 10/6/23), indicated CNA's			

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	concerned about the resident. This nurse went to evaluate the resident, the resident was not responding to his name and request made for RN 22 to come assess the resident. The resident was not holding his arm up off the bed, pupils were not reactive, his face was drooping. The resident had bit his lip and left a hole in his lip. The resident was unable to move eyes to look at staff. Oxygen saturation were 67% and oxygen was applied. The resident was sent to the Emergency Room (ER) by RN 22 and LPN 23. The resident's last known wellness was before shift start at 6:00 a.m. The resident's nurse stated she knew something was off, but wanted to see what the on call NP wanted to do first. This citation relates to Complaint IN00419162 and Complaint IN00419396. 3.1-37(a)			
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 interview and record review, the facility failed to ensure oxygen therapy was provided according to physician orders and available for use for 1 of 3 residents reviewed for oxygen therapy. (Resident D)	F 0695	F695 Respiratory/Tracheostomy Care and Suctioning The facility does ensure oxygen is provided per physician orders. Resident D discharged from the facility.	11/06/2023

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	Findings include: The clinical record for Resident D was reviewed on 10/23/23 at 1:58 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen, congestive heart failure, and muscle weakness. A grievance form, dated 10/5/23, indicated the Payroll Coordinator was made aware of a concern from Resident D. The grievance form stated "Resident was sent to dialysis w/o [without] oxygen on. Staff asked resident where oxygen was at, resident stated that she went to dialysis w/o [without] it & another staff member rolled her down to room & located concentrator & placed her on that & it was @ [at] 61% - staff member placed oxygen on resident...GRIEVANCE OFFICIAL FOLLOW-UP...DNS [Director of Nursing Services] reminded staff to check...." A respiratory care plan, revised 10/10/23, indicated Resident D had altered respiratory status and at risk for decreased oxygen saturation related to COPD and sleep apnea. The care plan indicated Resident D wore oxygen and was non-compliant at times. The interventions included, but were not limited to, administer oxygen as needed per the physician orders and monitor oxygen saturation on room air and/or oxygen. A progress note, dated 10/4/23 at 6:55 a.m., noted the documentation of Resident D's pre dialysis evaluation. It was documented that oxygen was in use per nasal cannula. A dialysis form, dated 10/4/23, indicated Resident		All residents with oxygen orders have the potential to be affected. Nursing staff educated related to oxygen administration per physician order. DNS or designee will conduct resident audits to ensure oxygen is administered per physician order. The audit will include 5 residents daily x 2 weeks, then 3 residents daily x 2 weeks, then 2 residents a week for 6 weeks. Any negative findings will be addressed immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

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BRICKYARD HEALTHCARE - RICHMOND CARE CENTER	1042 OAK DR RICHMOND, IN 47374

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	D started dialysis at 7:05 a.m. and 2 liters of oxygen was in place. The notes indicated the following, "...Lungs dim/wheezes [diminished/wheezes]...SOB [shortness of breath] exertion, 02 [oxygen] 2L [2 liters] NC [nasal cannula]...." An interview conducted with Payroll Coordinator on 10/23/23 at 1:49 p.m., indicated Resident D was at the nurses' station and seemed really out of breath. Resident D indicated that they returned from dialysis without oxygen. The oxygen concentrator was on the back of her wheelchair, but it was empty and did not have any oxygen tubing located on the concentrator or on Resident D. The resident stated they didn't have oxygen on all morning and the "girls" didn't refill the oxygen tank. An interview conducted with the Director of Nursing (DON), on 10/23/23 at 1:47 p.m., indicated on 10/4/23, Resident D was sent to dialysis without her oxygen. The DON believed when the staff rounded with Resident D on 10/5/23, they voiced the concern then. A policy titled "Oxygen Administration", undated, was provided by the Payroll Coordinator on 10/23/23 at 2:08 p.m. The policy indicated the following, "...Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences...." This citation relates to Complaint IN00419162. 3.1-47(a)(6)			

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F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based on observation, interview and record review, the facility failed to ensure adequate staffing was available to provide showers, to toilet and/or change residents, transfer residents who utilized a mechanical lift, and conduct dining services in the main dining room. This had the potential to affect 38 of 55 residents that reside in the facility on the Extended Care Unit (ECU).	F 0725	F725 Sufficient Nursing Staff The facility does ensure adequate staffing to provide ADL care for all residents. All residents have the potentional to be affected. ED, DNS, and leadership team educated related to minimum staffing requirements. ED, DNS or designee will monitor	11/06/2023

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	Findings include: 1. Anonymous interview 1 conducted during the survey from 10/19/23 through 10/23/23, indicated on 10/6/23 there were only 2 Certified Nursing Assistants (CNAs) in the entire facility from 6:00 a.m. until 8:30 a.m. They indicated "you cannot expect these aides to take care of 60 people by themselves". Anonymous interview 2 conducted during the survey from 10/19/23 through 10/23/23, indicated there was typically only 1 CNA working on the Transitional Care Unit (TCU) on day and evening shift. It would be helpful to have 2 CNAs. There are times we have found residents inside the nurses' station and there "could have been things she [Resident K] got into" due to the lack of supervision one was able to provide on the TCU unit. Anonymous interview 4 conducted during the survey from 10/19/23 through 10/23/23, indicated on 10/6/23 there were only 2 CNAs for the entire facility until other CNAs showed up around 8:30 a.m. There were usually 3 CNAs that work on ECU. On 10/14/23, there were 2 CNAs on ECU until 11:00 a.m. That was when another staff member was sent home for being ill. That left only 2 CNAs for the entire facility until around 4:00 p.m. To only have 1 CNA on ECU was "not feasible". The staff were not able to get everybody up and there were a lot of resident complaints that day. The staff attempted to ensure the residents were "dry" and "turned" but no showers could be given. It was not uncommon to have only 2 CNAs on ECU until someone else can show up later, around 8:00 to 10:00 a.m. Anonymous Interview 5 conducted during the		facility staffing each shift 7 days a week for 4 weeks to ensure minimum staffing requirements are met, then 5 days a week for 2 weeks, then 3 days a week for 2 weeks. Any negative findings will be addressed immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

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	survey from 10/19/23 through 10/23/23, indicated they have noticed more of a "struggle" with the staff. The lack of care was "unbelievable". The ability to bathe residents, provide incontinence care, toileting, "everything" had declined. The staff will just walk past a resident's room that needed incontinence care and comment "I just changed you" instead of providing such care. It's the "neglect" of the residents not being properly cared for. Anonymous interview 6 conducted during the survey from 10/19/23 to 10/23/23, indicated the quality of care had declined. They are running the units with less staff, and they feel like it's "neglect". Anonymous interview 3 conducted during the survey from 10/19/23 through 10/23/23, indicated there were only 2 CNAs on 10/14/23 for day shift on the ECU until one went home around 11:00 a.m. due to being sick. After 11:00 a.m., that just left one CNA on each unit (TCU and ECU). The ECU unit was usually staffed with 3 CNAs and TCU will staff with 1-2 CNAs. The care would get delayed due to only having 1-2 CNAs on ECU. Sometimes it can be difficult because "we have a lot of lifts", and they must find another staff member to assist with such task. 2a. An interview conducted with Resident L, on 10/20/23 at 12:31 p.m., indicated she doesn't get showers and would like to have 3 a week but was "lucky" to get one a week. The staff tried to run the floor with one person. Last weekend, 10/14/23 to 10/15/23, the facility only had one person on ECU. The staff member was able to provide toileting needs but call lights did not get answered timely. This last Saturday, 10/14/23, the call light was on for over 2 hours. There was an			

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observation of Resident L's room to where a clock was present with the correct time. Resident L indicated her preference was to get up at 11:00 a.m., and on 10/14/23, she did not get up until after 3:00 p.m., due to only having one staff member working on the floor. She had not been changed since 5:00 a.m. Resident L commented on how her bed was "soaked" with urine. She indicated a grievance was filed regarding what happened on 10/14/23.

A Quarterly MDS (Minimum Data Set) assessment, dated 9/16/23, indicated Resident L was cognitively intact and needed extensive assistance with 2 staff for bed mobility, transfers, dressing, and toilet use.

A grievance form, dated 10/14/23, indicated the following, "...Family member called 1:32 p.m. [sic] saying [name of CNA] refused to get her up as she was only aide in building...FOLLOW-UP...Texted [name of CNA]...Both expressed that they are 'short'. I told both to do best as family is bringing in food...Called family back at 1:59 apologizing for [name of CNA] saying that but we do have some call-ins & she should be up shortly...."

Another grievance form, dated 10/16/23, indicated the following, ""...Staff worked 6AM-2PM shift on Saturday. Resident [name of Resident L] was in need of assistance getting up. CNA could not lift resident by herself because resident is a two-person lift. Other staff was available at 4pm & CNA & other staff was able to get resident up. CNA had a conversation with the ED [Executive Director] about needing assistance on the floor, and was told, "FYI [for your information] sent the mass text about an hour ago. Worry about yourself and finish your schedule", via text....""

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Another grievance form, dated 10/16/23, indicated the following, ""...Resident needed help getting up and states that "there was nobody here to help me". Resident states that there was only [Name of CNA] here to take care of the floor", and that "there is never enough help here on the weekends, and that I wasn't the only resident that couldn't get up that day"....""

Another grievance form, dated 10/16/23, indicated the following, "...wasn't enough help on the floor- spoke w/ [with] ED @ [at] 2pm & was told that's when mother would be getting up. Resident was not up until 4 p.m. & very saturated with urine...."

2b. An interview conducted with Resident M, on 10/20/23 at 11:18 a.m., indicated he would like to receive showers twice a week but only received them weekly. His bed doesn't seem to be made. An observation of Resident M's bed unmade was noted during the interview. Resident M commented on how "last weekend", 10/14/23 to 10/15/23, the dining room was "closed" for breakfast and lunch on Saturday and breakfast on Sunday due to not having enough staff. He always eats in the dining room and prefers to eat meals in the dining room. He liked to sit with friends during mealtimes and be there to socialize, instead of eating by himself in his room. Resident M commented on how he had "begged and pleaded" for the facility to get more staff.

A Quarterly MDS assessment, dated 9/8/23, indicated Resident M was cognitively intact and needed physical help with one staff for bathing.

2c. An interview conducted with Resident O, on 10/20/23 at 11:05 a.m., indicated that care can be delayed regarding putting her to bed and

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	changing her. She would "sit wet" for extended periods of time. She utilizes a mechanical lift. An observation was conducted of Resident O's room to where there was a clock and phone with the correct time on it. She waited over an hour to "be changed" when she was wet and "burns" while sitting in urine. The past weekend, 10/14/23 to 10/15/23, was bad regarding the concerns with staffing. A Quarterly MDS assessment, dated 8/3/23, indicated Resident O was cognitively intact and needed extensive assistance with 2 staff for bed mobility, transfers, and toileting. 2d. An interview conducted with Resident P, on 10/20/23 at 11:52 a.m., indicated nail care and shaving are not consistent with being provided. Observed Resident P to have long nails with a black substance underneath along with a moderate amount of black facial hair above and below her lips. Her hair was not always washed, and it appeared to be greasy and dirty. A Quarterly MDS assessment, dated 9/23/23, indicated Resident P was cognitively intact and needed extensive assistance with 2 staff for bed mobility, dressing, toileting, personal hygiene along with total assistance with 2 staff for transfers and bathing. The time sheets were reviewed for the staff working on 10/14/23. It consisted of the following: CNA 11 working from 6:00 a.m. to 2:18 p.m. on ECU and clocked back in from 3:57 p.m. to 6:32 p.m., CNA 10 working from 6:01 a.m. until 11:03 a.m. on ECU, CNA 12 working from 10:00 a.m. until 2:20 p.m.,			

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CNA 14 clocking in at 3:02 p.m.,
CNA 15 clocking in at 3:37 p.m.,
CNA 16 clocking in at 3:49 p.m., &
CNA 17 clocking in at 3:49 p.m.

It appeared that there were no CNAs working on ECU from 2:20 p.m. until 3:02 p.m.

An interview conducted with the Scheduling Coordinator, on 10/19/23 at 3:31 p.m., indicated The Director of Nursing (DON) was on call on 10/6/23. The Executive Director (ED) was on call for 10/14/23. They have a Weekend Supervisor that works from 6:00 a.m. to 6:00 p.m., on Saturday and Sundays. On 10/14/23, it appeared to start out with 3 CNAs on ECU, but she was told that there were only 2 and then one of the CNAs had to leave due to being sick. She was made aware of needing staff at 2:19 p.m., on 10/14/23. There was a mass text sent out for assistance with staffing, but she, the Scheduling Coordinator, was not included on that mass text. So, she contacted a couple of staff and was able to get people to agree with coming into work "within minutes". She was able to get 3 staff members to come in at 4:00 p.m. on 10/14/23. The staffing goals consist of the following:

- 2 CNAs on TCU and 3 CNAs on ECU for day shift,
- 1.5 CNAs on TCU and 3 CNAs on ECU for evening shift, &
- 1 CNA on TCU and 2 CNAs on ECU for night shift.

A Census and Condition report, dated 10/23/23, indicated there was a facility census of 55. Out of the 55 residents there are 13 residents' dependent with transferring, 37 residents' dependent with bathing, 6 residents' dependent for toilet use, and

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	4 residents' dependent with eating. A Facility Assessment Tool, dated 6/1/23, was provided by the Executive Director (ED) on 10/23/23 at 1:23 p.m. The document indicated the staffing plan, that consisted of nurse aides, was 11 for the total number needed or an average number. The direct care staff was listed as a ratio of 1:10 on day shift, 1:12 ratio on evening shift, and 1:20 ratio on night shift. A document provided by the Director of Nursing (DON), on 10/23/23, listed 28 residents that usually come down to the main dining room. There were 3 residents listed as needing to be fed and another 3 residents listed as needing "assist". A document provided by the DON, on 10/23/23 at 11:05 a.m., listed 18 residents who utilized a mechanical lift for transfers. An interview conducted with the ED, on 10/23/23 at 10:32 a.m., indicated there was no facility policy regarding staffing. The expectations are for the facility to staff with the staff needed for the residents' level of care needs. 3.1-17(a)			
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			

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

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	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 interview and record review, the facility failed to ensure a staff member did not work while experiencing signs and symptoms of a gastrointestinal illness before and during their shift. This had the potential to affect 38 out of 55 residents that reside in the facility. Findings include: An interview conducted with Certified Nursing Assistant (CNA) 10, on 10/19/23 at 4:00 p.m., indicated she had vomited prior to coming to work on 10/14/23. She had thrown up but since she felt better after throwing up, she felt it was okay to come into work. She worked until 11:00 a.m., on 10/14/23, and proceeded to throw up, again. She also had a fever along with the vomiting.	F 0880	F880 Infection Prevention & Control The facility does ensure that staff do not work while experiencing signs and symptoms of gastrointestinal illness. CNA 10 was sent home after management was notified of her condition. All residents have the potential to be affected. All staff educated on gastrointestinal illness and not reporting to work when showing symptoms of gastrointestinal illness. ED, DNS or designee will monitor facility staffing each shift 5 days a week for 4 weeks to ensure no	11/06/2023

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	An interview conducted with CNA 11, ono 10/19/23 at 4:07 p.m., indicated she was working with CNA 10 on 10/14/23. CNA 10 was vomiting and had a fever while working and ended up leaving around 10:30 a.m. on 10/14/23. The timesheet for CNA 10, dated 10/14/23, indicated they worked day shift (6:00 a.m. to 2:00 p.m.) until 11:03 a.m. on 10/14/23 when they clocked out of work. An interview conducted with the Executive Director (ED), on 10/20/23 at 2:55 p.m., indicated there was no facility policy for staff working while experiencing illness. The facility follows the Indiana Department of Health standards for this. A Centers for Disease Control and Prevention (CDC) document, titled "Norovirus", reviewed 5/10/23, indicated the following, " ...Prevention ...Do not prepare and handle food or care for others when you are sick ...You should not prepare food for others or provide healthcare while you are sick and for at least 2 days (48 hours) after symptoms stop. This also applies to sick workers in restaurants, schools, daycares, long-term care facilities, and other places where they may expose people to norovirus ...." 3.1-18(b)(6)		staff members are showing symptoms of gastrointestinal illness, then 3 days a week for 2 weeks, then 2 days a week for 2 weeks. Any negative findings will be addressed immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			
	Based on interview and record review the facility failed to maintain a sanitary environment for a resident when a supper tray was stored in the	F 0921	F921 Safe/Functional/Sanitary/Comfortable Environment	11/06/2023

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	resident's dresser and acquired maggots for 1 of 5 residents reviewed for sanitary conditions (Resident E). Finding include: During an interview with Restorative Aide 5 on 10/20/23 at 11:32 a.m., indicated she found a whole meal tray of maggots in Resident E's dresser drawer, the entire plate was covered in maggots. The tray card was dated for 9/22/23 and she found it on 9/26/23. Restorative Aide 5 reported this to everyone in morning meeting including the Administrator and Director Of Nursing (DON). During an interview with the DON on 10/23/23 at 12:02 p.m., indicated there were maggots found on a meal tray in Resident E's dresser. The facility did an investigation and the staff member who had delivered the tray had already been terminated for other reasons. There was no documentation of the incident. Review of the record of Resident E on 10/23/23 at 12:09 p.m., indicated the resident's diagnoses included, but were not limited to, cerebral palsy, hemiplegia, neuromuscular dysfunction of the bladder, dysphagia, diabetes, aphasia, speech disturbance and profound intellectual disabilities. The Significant Change Minimum Data Set (MDS) assessment, dated 9/22/23, indicated the resident was severely impaired for daily decision making. The resident was rarely/never understood. The resident was totally dependent on staff for eating. The resident rights policy provided by the DON on 10/23/23 at 12:14 p.m., indicated the residents had the right to a home-like environment.		The facility does maintain a sanitary environment. The meal tray was immediately removed from Resident E's room. All residents have the potential to be affected. Staff educated on timely removal of meal trays and ensuring all room trays are accounted for and returned to dietary. ED or designee to audit resident rooms following all three meals to ensure no meal tray remains in any resident room. The audit will include 8 resident rooms daily x 2 weeks, then 5 resident rooms daily x 2 weeks, then 3 resident rooms a week for 6 weeks. Any negative findings will be addressed immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT recommendation, otherwise will review on a PRN basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 00 B. WING	10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	This citation is related to Complaint IN00419396. 3.1-19(f)			