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	10/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00409817, IN00415222, IN00417608, IN00418127, IN00418156 and IN00418208. Complaint IN00409817. Federal/state deficiencies related to the allegations are cited at F686 and F842. Complaint IN00415222. Federal/state deficiencies related to the allegations are cited at F686 and F842. Complaint IN00417608. No deficiencies related to the allegations are cited. Complaint IN00418127. Federal/state deficiency related to the allegations is cited at F677. Complaint IN00418156. Federal/state deficiency related to the allegations is cited at F677. Complaint IN00418208. Federal/state deficiencies related to the allegations are cited at F686 and F842. Survey dates: October 3 and 4, 2023 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 58 Total: 58	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joanne L Denney	Executive Director	10/26/2023

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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	Census Payor Type: Medicare: 4 Medicaid: 52 Other: 2 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 10, 2023			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to ensure a dependent resident received assistance and supervision with toileting to where they were later found on the floor of the bathroom, for an unknown period, for 1 of 3 residents reviewed for activities of daily living (ADLs). (Resident D) Findings include: The clinical record for Resident D was reviewed on 10/3/23 at 12:30 p.m. The diagnoses included, but were not limited to, end stage renal disease, malnutrition, dependence on renal dialysis, cognitive communication deficit, peripheral vascular disease, and fluid overload. Resident D was admitted to the facility on 7/21/23. An admission minimum data set (MDS) assessment, dated 7/28/23, indicated Resident D was cognitively intact and limited assistance with	F 0677	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 does ensure that residents receive assistance and supervision with toileting. Resident D was discharged. All residents that require assistance and supervision with toileting have the potential to be affected. Nursing staff educated related to toileting and ensuring that	10/26/2023

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	one staff for toilet use, personal hygiene, dressing, and transfers. An ADL care plan, initiated on 8/2/23, indicated Resident D had an ADL self-care deficit related to impaired mobility. The interventions included, but not limited to, extensive assistance with bathing, bed mobility, dressing, personal hygiene, and toileting along with incontinence care as needed. Resident D was assistance with walking while with therapy. A 5-day MDS assessment, dated 8/16/23, indicated Resident D had moderate cognitive impairment and extensive assistance with one staff for transfers, toileting, dressing, and personal hygiene. Resident D had unwitnessed fall events to where she was attempting to ambulate without assistance on 8/15/23, 9/4/23, 9/6/23 at the dialysis center, and 9/15/23. Resident D was marked as being confused on 9/4/23 and 9/15/23 after the fall incidents. A significant change MDS assessment, dated 9/13/23, indicated severe cognitive impairment and extensive assistance with 2 staff for transfers and toileting along with extensive assistance with one staff for dressing and personal hygiene. A fall incident report, dated 9/15/23, indicated the following, "CNA [certified nursing assistant] found res. [resident] on the floor of her bathroom, without her 02 [oxygen], not responsive to CNA. SATS [oxygen saturation] in the 50s when nurse arrived and required sternal rub to respond to nurse...EMS [emergency medical services] called. Resident taken to hospital...."		residents receive care based on their plan of care. An audit of residents who require toileting assistance and supervision was conducted to ensure the plan of care and Kardex reflect the appropriate needs. For a period of 30 days, MDS or designee to audit care plans of all new admissions and residents with a change in condition to ensure the care plan and Kardex reflect the appropriate needs. MDS or designee will then audit 2 admissions and residents with a change in condition for 4 weeks. Any negative findings will be corrected 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 are identified, we will continue audits based on IDT recommendation, otherwise we will review on a PRN basis.	

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A post fall evaluation, dated 9/15/23, indicated the following, "...unknown if she was already on the toilet, or going to use the bathroom...."

A statement, undated, was typed up and signed by Therapy Staff 6 in regards to the incident involving Resident D on 9/15/23. The statement indicated ""On Friday 9/15/23 I don't remember what time it was I was walking by patient room and she was wheeling wc [wheelchair] into bathroom and asked pt [patient] what she was doing she stated I have to go to the bathroom. I told patient I would help her transfer to toilet. I assisted patient with transfer and her brief was soiled so I removed it and put it in the trash...She stated she needed more time. I took trash to soiled utility and threw it away. I then stopped at nurses station where aide was sitting and I stated "I put [name of Resident D] on her toilet and gave her call light and told her to pull it when finished but I wanted you to know I put [name of Resident D] on her toilet." The aide shook her head yes and said "ok thank you I will get her"...."

An interview conducted with the Executive Director (ED), on 10/4/23 at 9:40 a.m., indicated Therapy Staff 6 brought this situation to her attention with Resident D. Therapy staff had told CNA 8 about Resident D being on the toilet. CNA 8 doesn't recall being told this. We gave CNA 8 a final written warning due to not responding to care requests. The CNA that found Resident D was CNA 10. The ED was unsure of a timeline to when Resident D was placed on the toilet and when Resident D was found by CNA 10.

An interview conducted with CNA 10, on 10/4/23 at 11:30 a.m., indicated she worked 6:00 a.m. to 6:00 p.m. on 9/15/23. She was assigned to

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	Resident D on 9/15/23. She last checked on Resident D around 12:30 p.m. to 12:40 p.m. Resident D's son was in the room at that time. She found Resident D on the floor in her bathroom around 2:00 p.m. because it was during shift change. Resident D was laying on the bathroom floor and breathing very shallow. This was her first time caring for Resident D. When asked when the last time Resident D was toileted CNA 10 indicated Resident D's son was in her room the whole time and she didn't end up toileting Resident D prior to her being placed on the toilet because she believed that Resident D would press her call light if she needed assistance. A policy titled "Activities of Daily Living", undated, was provided by the Director of Nursing on 10/4/23 at 1:45 p.m. The policy indicated the following, "...The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless is unavoidable...Care and services will be provided for the following activities of daily living...3. Toileting... ." This Federal tag relates to Complaints IN00418127 and IN00418156. 3.1-38(a)(2)(C) 3.1-38(a)(3)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure skin impairments were assessed on a weekly basis, ensure appropriate treatments were initiated timely for a skin impairment, and ensure continued treatment for a skin impairment for 3 of 4 residents reviewed for skin integrity. (Residents B, D and E) Findings include: 1. The clinical record of Resident B was reviewed on 10-3-23 at 10:42 a.m. Her diagnoses included but were not limited to, type 2 diabetes with a history of skin ulcers, morbid obesity, a history of skin infections, high blood pressure, general weakness and a history of bilateral lower extremity cellulitits. Her most recent Minimum Data Set (MDS) assessment, dated 9-1-23, indicated she is cognitively intact, is non-ambulatory, requires extensive assistance of or more persons for bed mobility and personal hygiene care, is dependent of 2 or more persons for transfers, toileting and bathing. This MDS assessment identified Resident B as being at risk for pressure ulcer development, but currently was without any pressure ulcers or other skin-related issues. A review of Resident B's "weekly skin reviews,"indicated the reviews were conducted as	F 0686	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 does ensure that skin impairments are assessed on a weekly basis, does ensure that appropriate treatments are initiated timely, and does ensure continued treatment for skin impairments. Resident D was discharged. Clinical records for Residents B and E were reviewed. Weekly assessments, treatment orders and care plans were updated. All residents with skin impairments have the potential to be affected. Licensed staff educated related to	10/26/2023

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	follows: -8-17-23: skin intact without any issues identified. -8-24-23: "residents skin dry. nurse will continue to moisturize as needed." No issues were identified. -8-31-23: skin intact without any issues identified. -9-7-23: No skin assessment conducted/documented. 9-14-23: skin intact without any issues identified. -9-20-23 at 9:04 a.m.: "Alert Note. Note Text: Open area coccyx area. Nurse notified, barrier cream was applied. Stop and watch given to wound nurse. Wound nurse notified." -9-21-23: skin intact without any issues identified. 9-28-23: No skin assessment conducted/documented. No other skin notes in the progress notes or in the treatment administration record (TAR) addressed an open area to the coccyx through the chart review on 10-3-23. A review of the progress notes indicated the above documented open area on 9-20-23. A review of the progress notes reflected Resident B had an unwitnessed fall on 9-21-23. Multiple resident assessments were conducted on 9-21-23 by medical providers and nursing staff for the post-fall assessments, including two medical provider notes on 9-21-23 which did not allude to any new skin issues. A routine weekly skin review was due on/around 9-28-23, but a review of the progress notes and treatment administration record (TAR) did not reflect this was performed or documented. In an interview on 10-3-23 at 1:35 p.m., with CNA 4, she indicated she was familiar with Resident B and worked with her on a regular basis. CNA 4 recalled Resident B recently had an open area to her coccyx, but it is healed now. She added she		assessment and treatment of skin impairments. An audit of residents who have skin impairments was completed to ensure weekly assessments are complete and appropriate treatment orders are in place. Skin sweep was conducted to identify any new skin impairments. DNS or designee will audit each new admission to ensure all skin impairments are identified, assessed and appropriate treatment orders and plan of care are in place. DNS or designee will audit clinical documentation daily to ensure appropriate treatment orders and plan of care are in place when any new skin impairments are identified. Any negative findings will be corrected 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 are identified, we will continue audits based on IDT recommendation, otherwise we will review on a PRN basis.	

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	could not recall the date, but thought it was within the last month. She recalled it was a very small slit, located at or immediately above her coccyx. In an interview with LPN 3 on 10-4-23 at 11:56 a.m., she shared she had spoken with the Director of Nursing (DON) recently about Resident B's open area documented on 9-20-23. "I did give the 'stop and watch' form to the Wound Nurse on the day I charted it. The DON said there was a skin assessment done a few days later and it was cleared up by then." In an interview with the Wound Nurse on 10-3-23 at 2:52 p.m., she indicated the last open area she could recall for Resident B was approximately 3 months ago of moisture-associated skin damage (MASD). She indicated she did not recall receiving a stop & watch notification for this resident's skin in the last few weeks. In an interview with the DON on 10-4-23 at 1:07 p.m., she indicated from her review of the progress notes, it appeared Resident B's open area "was healed pretty quickly." She shared around the same time, the Wound Nurse was off work for a few days and she may not have seen the 'stop & observe.' She continued, "But the area was looked at. I'm thinking they used the butt cream on the area. But, it should have been charted on [as to size, appearance, etc], as well as when it healed. It looks like the nurse on duty didn't chart the weekly skin assessment that was due around 9-27-23; I think she may have put it on the TAR. That nurse is new to us and an experienced nurse, but she does not have strong computer skills." A review of the medication administration record (MAR) and the TAR for September, 2023 failed to indicate the 9-28-23 skin assessment was			

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	conducted. The TAR reflected vital signs were conducted on 9-7-23, 9-14-23, 9-21-23 and 9-28-23, as a part of the weekly skin review, but did not reflect the outcome of the skin review on the grid. The documented skin reviews in the progress notes were reflected as completed on 9-14-23 and 9-21-23, but not present for 9-7-23 or 9-28-23. A care plan for Resident B for being at risk for skin integrity was documented as initiated on 9-26-22, and revised on 9-8-23. It indicated she is to have weekly skin inspections conducted. 2. The clinical record for Resident E was reviewed on 10/3/23 at 1:15 p.m. The diagnoses included, but were not limited to, lymphedema, anxiety, chronic pain, absence of left leg below knee, absence of right leg below knee, and disruption of wound. Resident E was admitted to the facility on 9/19/23. A "Skin Only Evaluation", dated 9/19/23, indicated an amputation to the left and right knee. No other skin concerns were documented. A physician order, dated 9/18/23, indicated the utilization of house barrier cream three times daily to buttocks. Another "Skin Only Evaluation", dated 9/20/23, indicated "resident admitted with unstageable pressure ulcer to sacrum/bilateral buttocks". The evaluation indicated daily treatment with slough tissue present. A physician order, dated 9/24/23, indicated the utilization of Medihoney gel (wound dressing gel); apply to sacrum/bilateral buttocks daily for wound care. Another "Skin Only Evaluation", dated 9/27/23,			

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	indicated "sacrum/bilateral buttocks pressure wound remains stable". An interview conducted with Wound Nurse, on 10/3/23 at 2:55 p.m., indicated "I might have been late putting the order in". This was in regards to the Medihoney gel to Resident E's pressure ulcer. 3. The clinical record for Resident D was reviewed on 10/3/23 at 12:30 p.m. The diagnoses included, but were not limited to, end stage renal disease, malnutrition, dependence on renal dialysis, cognitive communication deficit, peripheral vascular disease, and fluid overload. Resident D was admitted to the facility on 7/21/23. An admission assessment, dated 7/21/23, did not indicate any open areas. A "skin only evaluation", dated 7/23/23, indicated "open lesion to coccyx". There was no further assessment or description of the skin impairment. A "skin only evaluation", dated 8/9/23, indicated "redness on coccyx". There was no further assessment or description of the skin impairment. Weekly skin assessments were documented from 8/11/23 to 9/12/23 with no skin concerns listed. A "skin only evaluation", dated 9/13/23, indicated "MASD [moisture associated skin dermatitis] to bilateral buttocks". A care plan, dated 9/13/23, indicated Resident D had MASD to bilateral buttocks. The interventions were listed to apply treatment per physician order, assessment conducted weekly, and weekly wound documentation.			

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	A document from the wound management company, dated 9/13/23, indicated MASD to bilateral buttocks. The treatment was with Medihoney and bordered foam daily. The date the wound was acquired was listed as 8/9/23. A physician order, dated 9/12/23, indicated the use of Medihoney gel to bilateral buttocks daily for wound care. There were no previous orders for treatment of Resident D's buttocks from 9/1/23 until 9/12/23. A skin assessment, dated 9/20/23, indicated moisture associated skin dermatitis (MASD) to bilateral buttocks. An interview conducted with Wound Nurse, on 10/3/23 at 3:00 p.m., indicated Resident D was being followed for MASD to bilateral buttocks. She was not aware of any previous skin concerns for Resident D. Weekly wound and skin assessments were supposed to be conducted weekly. A policy titled "Wound Treatment Management", undated, was provided by Corporate Nurse on 10/4/23 at 12:07 p.m. The policy indicated the following, "...To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders...8. The effectiveness of treatments will be monitored through ongoing assessment of the wound...." This Federal tag relates to Complaints IN00409817, IN00415222 and IN00418208. 3.1-40(a)(2)			

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F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral			

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

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	directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure complete documentation of the electronic medication administration records (MAR) and treatment administration records (TAR or ETAR) for 2 of 4 residents reviewed for skin impairment. (Residents B and D) Findings include: 1. The clinical record of Resident B was reviewed	F 0842	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	10/26/2023

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	on 10-3-23 at 10:42 a.m. Her diagnoses included but were not limited to, type 2 diabetes with a history of skin ulcers, morbid obesity, a history of skin infections, high blood pressure, general weakness and a history of bilateral lower extremity cellulitits. Her most recent Minimum Data Set (MDS) assessment, dated 9-1-23, indicated she is cognitively intact, is non-ambulatory, requires extensive assistance of or more persons for bed mobility and personal hygiene care, is dependent of 2 or more persons for transfers, toileting and bathing. This MDS assessment identified Resident B as being at risk for pressure ulcer development, but currently was without any pressure ulcers or other skin-related issues. A review of the MAR and TAR for September 2023, reflected the following undocumented medications and/or treatments, as represented by empty cells or "holes" on the MAR/TAR grids as follows: -ammonium lactate 12%, apply 1 application every day shift for day skin topically to bilateral feet and legs. Blank cells on 9-6, 9-7, 9-11, 9-16, 9-17, 9-21 and 9-22. -Aquaphor External (emollient) Ointment, apply to left elbow every shift for dry skin. Blank cells on 9-6, 9-7, 9-11, 9-17, 9-21 and 9-22. -Nystop Powder 100,000 units per gram, apply to groin area topically every day and evening shift for rush under breasts and left underarm. Blank cells on 9-6, 9-7, 9-11, 9-17, 9-21 and 9-22 for the day shift and blank cells on 9-3, 9-4, 9-11, 9-17, 9-22 9-23 and 9-30 for the evening shift. -clotrimazole-betamethasone 1-0.05% cream, apply to groin and abdominal folds topically every shift for excoriation. Blank cells on 9-6, 9-7, 9-11, 9-16, 9-17, 9-19, 9-21 and 9-22 for the day shift; blank cells on 9-3, 9-4, 9-11, 9-17, 9-23, 9-24 and 9-30 for the evening shift and blank cells for 9-2, 9-4, 9-8,		applicable federal and state requirements The facility does ensure complete documentation of the electronic medical administration records and treatment administration records. Resident D was discharged. Clinical records reviewed for Resident B and treatment orders updated on the TAR. All residents with treatment orders for skin impairments have the potential to be affected. Licensed staff educated on treatment documentation and completion of the MAR/TAR prior to the end of every shift. DNS or designee will audit MAR/TAR daily to ensure complete and accurate documentation. Any negative findings will be corrected 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 are identified, we will continue audits based on IDT recommendation, otherwise we will review on a PRN basis.	

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	9-15, 9-18, 9-19, 9-20, 9-21, 9-22, 9-23, 9-24 and 9-26 for the night shift. -Monitor for redness to bilateral lower extremities every and shift and report any abnormal findings to the MD/NP (medical doctor or nurse practitioner) every shift for Nurse measure. Blank cells on 9-6, 9-7, 9-11, 9-17, 9-19, 9-21, 9-22 and 9-30 for the day shift; blank cells on 9-3, 9-4, 9-11, 9-17, 9-23, 9-24 and 9-30 for the evening shift and blank cells for 9-2, 9-4, 9-8, 9-15, 9-18, 9-19, 9-20, 9-21, 9-22, 9-23, 9-24 and 9-26 for the night shift. A review of the medication administration record (MAR) and the TAR for September, 2023 failed to indicate the 9-28-23 skin assessment was conducted. The TAR reflected vital signs were conducted on 9-7-23, 9-14-23, 9-21-23 and 9-28-23, as a part of the weekly skin review, but did not reflect the skin review had been documented. The documented skin reviews in the progress notes were reflected as completed on 9-14-23 and 9-21-23, but not present for 9-7-23 or 9-28-23. In an interview with the DON on 10-4-23 at 1:07 p.m., she indicated from her review of the progress notes, it appeared Resident B's open area "was healed pretty quickly." She shared around the same time, the Wound Nurse was off work for a few days and she may not have seen the 'stop & observe.' She contained, "But the area was looked at. I'm thinking they used the butt cream on the area. But, it should have been charted on [as to size, appearance, etc], as well as when it healed. It looks like the nurse on duty didn't chart the weekly skin assessment that was due around 9-27-23; I think she may have put it on the TAR. That nurse is new to us and an experienced nurse, but she does not have strong computer skills." The September, 2023 MAR nor TAR reflected any specific physician orders for the use of "butt			

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	cream."2. The clinical record for Resident D was reviewed on 10/3/23 at 12:30 p.m. The diagnoses included, but were not limited to, end stage renal disease, malnutrition, dependence on renal dialysis, cognitive communication deficit, peripheral vascular disease, and fluid overload. Resident D was admitted to the facility on 7/21/23. A "skin only evaluation", dated 9/13/23, indicated "MASD [moisture associated skin dermatitis] to bilateral buttocks". A care plan, dated 9/13/23, indicated Resident D had MASD to bilateral buttocks. The interventions were listed to apply treatment per physician order, assessment conducted weekly, and weekly wound documentation. A physician order, dated 9/12/23, indicated the use of Medihoney gel to bilateral buttocks daily for wound care. The ETAR for September of 2023 was reviewed and indicated hole(s) for the Medihoney wound treatment on 9/23/23, 9/24/23, and 9/26/23. An interview conducted with Wound Nurse, on 10/3/23 at 3:00 p.m., indicated Resident D was being followed for MASD to bilateral buttocks. She was not aware of any previous skin concerns for Resident D. Weekly wound and skin assessments were supposed to be conducted weekly. A policy titled "Wound Treatment Management", undated, was provided by Corporate Nurse on 10/4/23 at 12:07 p.m. The policy indicated treatments would be documented on the TAR or in the electronic health record.			

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	This Federal tag relates to Complaints IN00409817, IN00415222 and IN00418208. 3.1-50(a)(1)			