STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 00 B. WING	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER	155 E BURKS DR BLOOMINGTON, IN 47401

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00381488. Complaint IN00381488 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Survey dates: June 6, 7, 8, 9 and 10, 2022 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Census Bed Type: SNF/NF: 126 Total: 126 Census Payor Type: Medicare: 4 Medicaid: 109 Other: 13 Total: 126 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 16, 2022.	F 0000	The submission of this Plan of Correction, for survey event ID NPFE11, does not indicate an admission by Bloomington Care Center that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Bloomington Care Center. The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this Facility. It is thus submitted as a matter of statute only. We are requesting paper compliance for this survey.	
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to			

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

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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	freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			
	Based on observation, interview, and record review, the facility failed to ensure a resident was free from abuse by another resident for 1 of 2 residents reviewed for abuse. This resulted in left hip fracture and fourth and fifth metatarsal (bones in the foot) fracture of the left foot (Resident B). Findings include: On 6/8/22 at 2:42 p.m., Resident B was observed to be lying in her bed with two nonskid strips (strips to prevent falls) on the floor beside her bed. On 6/9/22 at 10:52 a.m., Resident B was observed to be lying in her bed in a low position. On 6/10/22 at 9:49 a.m., Resident B was observed to be lying in her bed in a low position with nonskid strips on the floor beside her bed. On 6/7/22 at 12:17 p.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, left hip fracture, 4th and 5th metatarsal fracture, osteoarthritis, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/29/22, indicated Resident B had moderate cognitive impairment and required limited assistance of one staff member for transfers, walking on the corridor, and locomotion	F 0600	**F 600 SS = G** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B has been moved off the unit after her initial hospitalization until her rehabilitation is completed. Once therapy/recovery is completed staff will assess the residents need to be placed back on the secured unit. Resident B's careplans (Exhibit A) have been reviewed and updated as needed. Resident C's behavior management plan (Exhibit B) will be reviewed and updated as needed. Staff will continue to monitor and document behaviors as they occur. A medication review (Exhibit C) will be completed by the Pharmacy. Psychiatric services will continue as needed. An Indiana Department of Health	07/06/2022

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	on the unit. A care plan, revised on 3/8/22 and current through target date 6/2722, indicated Resident B had behaviors which included other behaviors not directed towards others. The interventions were to attempt interventions before my behaviors begin, help me avoid situations or people that are upsetting me, offer me something I like as a diversion, tell me what you are going to do before you begin, and speak to me in an unhurriedly and in a calm voice. The Progress Notes indicated the following: -On 5/28/22 at 5:10 p.m., Resident B attempted to pull her chair to sit and another resident had "pushed" her. Her injury was a left hip fracture. She had left hip and knee pain. -On 5/28/22 at 5:10 p.m., Resident B tried to sit down in a chair. Resident C did not want her to sit in the chair and moved the chair. Resident B tried to take the chair back. Resident C "pushed" her, and Resident B fell on her left side. Resident B's left lower leg was rotated outward, and she was not able to perform any range of motion to the left lower leg. Resident B complained of hip and knee pain. Resident B was sent to the emergency room. -On 5/28/22 at 5:30 p.m., Resident B attempted to take a seat in the dining room before a meal. She was pushed by another resident. Resident B fell and complained of left hip pain. She was sent to the emergency room and was admitted with a left hip fracture. The History and Physical, dated 5/31/22, indicated Resident B was sent to the emergency room after an "assault" at her extended care facility. She was "pushed off a chair by another resident and fell to		Reportable was completed and submitted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All Residents have the potential to be affected by the alleged deficient practice. All residents will be assessed for the need of a behavior management plan. All current behavior management plans will be reviewed and updated as needed. The Abuse policy and Behavior Management policy were reviewed with no changes. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff will be educated on the Abuse policy (Exhibit E) and the Behavior Management Policy (Exhibit F). Behaviors will be reviewed during morning meetings. All behavior management plans will be reviewed and updated as needed. Staff will be educated to utilize the behavior management plans to minimize the chance for resident conflict. Staff will be educated to report all behavior to charge nurses.	

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	the ground." An extensive x-ray revealed left hip fracture and 4th and 5th metatarsal fracture of the left foot. On 6/10/22 at 3:00 p.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, major depression disorder, anxiety, and dementia. The psychiatric note, dated 9/8/21 at 3:33 p.m., indicated Resident C had been anxious and tearful. The plan was to increase depakote sprinkles (medication for mood stabilization). The Annual Minimum Data Set (MDS) assessment, dated 3/5/22, indicated Resident C had severe cognitive impairment. A care plan, revised on 3/8/22 and current through target date 9/3/22, indicated Resident C had behaviors which included an one time event of agitation with another resident. The interventions were to attempt interventions before my behaviors begin, help me avoid situations or people that are upsetting me, offer me something I like as a diversion, and speak to me in an unhurriedly and in a calm voice. Resident C's progress notes, dated 5/28/22 at 5:31 p.m., indicated a resident was trying to sit down and Resident C moved the chair. Resident C "pushed" the resident. The resident fell on her left side. The May 2022 Behavior Log indicated behavior monitoring of physical aggression towards staff. The log indicated no episodes of the behavior. During an interview on 6/10/22 at 11:34 a.m., the Unit Director indicated Resident C was the "unit		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** The audit tool titled "Behavior Management" (Exhibit G) will be utilized to determine the efficacy of the Behavior Management Plan. The Alzhiemer's Unit Director, Social Services Director, or their designee will complete the audit tool weekly for 2 months, bimonthly for 2 months, and monthly for 2 months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months if 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of**	

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	bully." You never knew when she was going to snap, and it would often be unprovoked. During an interview on 6/10/22 at 3:34 p.m., Registered Nurse (RN) 1 indicated Resident B and C were getting ready to eat dinner in the small dining room across the nurse's station. Resident B went to pull out the chair to sit down, when Resident C moved the chair. Resident B tried to get the chair back, when Resident C "pushed" Resident B down. Resident B left leg was rotated outward. She was sent to the emergency room. On 6/10/22 at 5:11 p.m., the Regional Director of Clinical Operations provided the facility's policy, "Abuse, Neglect and Exploitation," undated, and indicated this was the policy currently being used by the facility. A review of the policy indicated, "..."Abuse" means the willful infliction of injury..." This Federal tag relates to Complaint IN00381488. 3.1-27(a)(1)		**correction date;** **7/6/2022**	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,			

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	(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and			

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	(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.			
	Based on record review and interview, the facility failed to ensure a resident was referred for a Level II Pre-Admission Screening Resident Review (PASRR) mental health assessment for mental illness evaluation and determination as indicated by a Level I PASRR evaluation for 1 of 1 resident reviewed for PASRR. (Resident 117) Finding includes: On 6/8/22 10:09 a.m., Resident 117's clinical record was reviewed. The diagnoses included, but were not limited to, major depressive disorder and schizoaffective disorder The Annual Minimum Data Set (MDS) assessment, dated 5/12/22, indicated Resident 117 was not evaluated by the Level II PASRR and had diagnoses of depression and schizophrenia. The Notice of PASRR Level I Screen Outcome, dated 1/17/19, indicated PASRR Level I Determination: Refer for Level II on site.	F 0645	**F 645 SS = D** - **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** A new level I (Exhibit H) was completed for Resident 117. A level II was triggered and a Mental Health evaluation was initiated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All Residents have the potential to be affected by the alleged deficient practice. All current residents were reviewed for missed level II referrals. Five (5) residents were	07/06/2022

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	During an interview on 6/8/22 at 2:10 p.m., the Director of Nursing (DON) indicated Resident 117's Level I was completed, but they did not have any Level II for Resident 117. On 6/10/22 at 5:11 p.m., the Regional Director of Clinical Operations provided the facility's policy, "Resident Assessment - Coordination with PASARR [sic] Program," undated, and indicated this was the policy currently being used by the facility. A review of the policy indicated, "...PASARR [sic] Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs..." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		identified as having a missed Level II. Those residents all were submitted for level I's for the determination of a Level II referral. The "Resident Assessment-Coordination with PASARR Program" policy (Exhibit J) was reviewed with no changes noted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Social Services or Designee will complete the Level I and monitor for the Level II notification. Social Services or designee will follow up to make sure any level II referral is completed timely. Social Services will be educated on the "Resident Assessment-Coordination with PASARR Program" policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An Audit tool "Level I/Level II" (Exhibit K) will be utilized to monitor for Level II referrals. The audit will be conducted by the BOM or designee weekly for 2 months, bimonthly for 2 months,	

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			and then monthly for 2 months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **7/6/2022**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure residents were provided Activities of Daily Living (ADL) care for 2 of 4 residents reviewed for ADL's. Showers were not given and facial hair was not cut. (Resident 13,	F 0677	**F 677 SS = D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	07/06/2022

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	Resident 48) Findings include: 1. On 6/7/2022 at 10:10 a.m., Resident 13 was observed lying in bed wearing a gown. The gown had a dried orange stain on the front. The resident indicated at that time she had not had a shower or bath for about 2 weeks and she had not refused to get one. On 6/8/2022 at 11:54 a.m., Resident 13 was observed wearing the same gown with a dried orange stain on the front. On 6/8/2022 at 2:45 p.m., Resident 13 was observed wearing the same gown with a dried orange stain on the front. On 6/9/2022 at 10:11 a.m., Resident 13 was observed lying in bed having a test performed wearing the same gown with a dried orange stain on the front. On 6/9/2022 at 12:00 p.m., Resident 13 was observed wearing the same gown with a dried orange stain on the front. The resident indicated at that time she had still not had a bath or a shower in over 2 weeks. On 6/9/2022 at 2:52 p.m., Resident 13 was observed wearing the same gown with a dried orange stain on the front. On 6/10/2022 at 10:58 a.m., Resident 13 was observed wearing the same gown with a dried orange stain on the front. On 6/10/2022 at 3:06 p.m., Resident 13 was observed wearing the same gown with a dried		**practice;** Resident 13 was showered and placed in a clean gown. Resident 13 was interviewed and stated she is now getting her showers as scheduled. Resident 48 was shaven as requested. Resident 48 was interviewed and stated that he is happy with his facial grooming. Preferences of showers and shaves have been discussed with both residents and care plans (Exhibit L and M) updated as needed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. All residents have been reviewed for shower and shave preferences. Care plans have reviewed and updated as needed. The policy “Activities of Daily Living” (Exhibit N) and “Resident Rights” (Exhibit O) policies were reviewed with no changes noted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	

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	orange stain on the front. The resident indicated at that time she had not had a shower or bath in over 2 weeks and her gown had not been changed. On 6/7/2022 at 11:00 a.m., Resident 13's clinical record was reviewed. The diagnoses included, but were not limited to quadriplegia and peripheral vascular disease (PVD). The Quarterly Minimum Data Set (MDS) assessment, dated 5/24/2022, indicated Resident 13 was interviewable, cognitively intact, and required total dependence with bathing. A care plan, initiated on 9/24/2021, and current through target date 8/22/2022, for Resident 13 indicated, "... Focus: I have a physical functioning deficit related to a diagnosis [dx] incomplete quadriplegia related to spinal cord injury, diabetes mellitus [DM] dementia, PVD, spends most of time in bed refuses to get up daily [sic] ... Goal: I will maintain my current level of physical functioning ... I will maintain my current range of motion [ROM] ... Interventions: Bathing: Provide me with extensive assistance with bathing ... dressing ... personal hygiene ..." A review on 6/10/2022 at 3:00 p.m., of Resident 13's "Shower Sheet/Skin Concern Documentation" indicated Resident 13 received a shower or bath on the following dates. -5/10/2022 -5/14/2022 -5/17/2022 -5/27/2022 -6/2/2022 The facility lacked any additional documentation		Staff will be educated on the policy “Activities of Daily Living” and “Resident Rights”. Shower and Shaving preferences will be updated. Care plans will be updated as well. Nursing will monitor showers and shaves daily to ensure they are being and given. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit titled “Showers and Shaves” (Exhibit P) will be utilized to make sure residents preferences are being followed. The DON or designee will complete the audits weekly for 2 months (5 random residents), bimonthly for 2 months (3 random residents), and then monthly for 2 months (3 random residents). This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency**	

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(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
	that Resident 13 had received a shower and/or bath since 6/2/22. During an interview on 6/10/2022 at 10:30 a.m., Certified Nursing Assistant (CNA) 1 indicated Resident 13 was an extensive assistance with showers and bathing, the resident had never refused to get a shower or a bath and when they give a shower or a bath they always change the gown. On 6/10/2022 at 5:10 p.m., the Regional Director of Clinical Operations provided the facility policy, "Activities of Daily Living" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, '... Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care ... 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene ..." 2. On 6/8/22 at 11:05 A.M., Resident 48 was observed lying in bed in his room. the resident had a full beard, approximately 1/2 inch in length. During an interview on 6/8/22 at 11:06 A.M., Resident 48 indicated he would like to have his goatee (a small beard beneath the chin, having the cheeks and sides of the chin shaven), as it was his preferred groomed facial hair style. He has been shaved 3 times in the past 3 months and preferred being shaved often enough to maintain his goatee. He was not capable of adequately shaving himself and needed assistance. During an interview, on 6/10/22 at 10:43 A.M., Certified Nurse's Aide 1 indicated the resident had not been shaved for some time.		**will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date:** **7/6/2022**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 00 B. WING	06/10/2022

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	On 6/10/22 at 11:00 A.M., Resident 48's clinical record was reviewed. The diagnoses included but were not limited to, multiple sclerosis and peripheral vascular disease. The Annual Minimum Data Set assessment, dated 4/4/22, indicated the resident required the extensive assistance of 2 people for hygiene care. The clinical record lacked documentation of when the resident was last shaved. 3.1-38(a)(3) 3.1-38(a)(3)(D)			
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.			

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	(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.			
	Based on observation, interview, and record review, the facility failed to ensure the daily posted nurse staffing reflected the actual hours worked by staff for 6 of 6 days of daily posted nurse staffing reviewed. Findings include: Daily observations from June 6, 2022 through June 10, 2022, indicated the actual hours worked by nursing staff was not posted on the daily staffing sheets. On 6/6/22 at 11:42 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 6/7/22 at 10:26 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 6/8/22 at 9:28 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked.	F 0732	**F 732 SS = C** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** No Residents were affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	07/06/2022

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	On 6/9/22 at 10:49 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 6/10/22 at 10:20 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 6/10/22 at 3:45 p.m., the Regional Nurse Consultant provided the Posted Nurse Staffing sheet for 6/10/22. The Posted Nurse Staffing lacked the actual hours worked. During an interview on 6/10/22 at 4:00 p.m., the Regional Nurse Consultation indicated the facility was not aware the specific working hours needed to be posted on the staffing sheet. They indicated the facility did not have a policy in regard to specific requirements on the nurse staffing sheets, however, the facility followed the Federal Regulations.		The form titled “Brickyard Healthcare Daily Staffing Posting (Exhibit Q) will be utilized to post nursing hours. Nursing Management and the Scheduler were educated on the proper information required on the form. The form will be reviewed daily for correct information. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit tool titled “Daily Staffing Posting” (Exhibit R) will be utilized to determine compliance with the posting. The audit will be completed by the DON or designee daily for 4 weeks, weekly for 1 month, bimonthly for 2 months, and monthly for 2 months. This audit will be reviewed in QAPI for 5 months and at the end of 5 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 5 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan**	

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			of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date; **7/6/2022**	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.			
	Based on observation, interview, and record review, the facility failed ensure a resident who was diagnosed with dementia, received the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being for 1 of 2 resident reviewed for dementia care. (Resident 60) Findings include: On 6/7/22 at 2:00 p.m., Resident 60 was observed sitting in the dining room at the entry way to one hallway of resident rooms. Resident 60 was observed to kick at the wheelchair of another resident. Resident 60 was observed to laugh loudly as the resident wheeled away and then began to scream out about her legs hurting and wanting the bandages removed from her lower	F 0744	**F 744 SS = D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 60's behavioral management plan (Exhibit S) was reviewed and updated as needed. Residents 60's activity preferences were reviewed and updated as needed. Psychiatric services are currently scheduled and will continue to be scheduled as needed. Pharmacy completed a medication review (Exhibit T) and changes will be initiated as	07/06/2022

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	legs. On 6/9/22 at 10:12 a.m., Resident 60 was observed sitting in the dining room at the entry way to one hallway with resident rooms and yelled mumbled words at a Certified Nursing Aide when the resident needed moved out of hallway. On 6/9/22 at 10:18 a.m., Resident 60 was observed sitting in the dining room at the entry way to one hallway of resident rooms. She was observed to be screaming mumbled profanities at other residents. The resident screamed, "GO!" as people walked near her. On 6/9/22 at 10:25 a.m., Resident 60 was observed sitting in the dining room at the entry way to one hallway of resident rooms. She was slightly rocking back and forth, mumbling and saying "Mmmmm...mmmm...mmmm" continued with incoherent garble along with very loud crying noises. On 6/9/22 at 2:51 p.m., Resident 60 was observed sitting in the dining room at the entry way to one hallway with resident rooms. She was observed to loudly screamed "F---!" while in the middle of a group activity which included a guest musician. There were many other residents around and participating in the activity. On 6/9/22 at 10:22 a.m., Resident 60's clinical record was reviewed. The diagnoses included, but were not limited to: insomnia, disorganized schizophrenia, encephalopathy, dementia, generalized anxiety disorder, adjustment disorder with mixed disturbance of emotions and conduct, bipolar disorder, Alzheimer's disease, and paranoid schizophrenia.		needed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. All residents were assessed for the need of a behavior management plan. All current behavior management plans will be reviewed and updated as necessary. All residents with behavior management plans had their activities preferences reviewed and updated as needed. Psychiatric services will be utilized as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be educated on behavior management plan policy (Exhibit F). Behavior problems will be reviewed during morning meetings. Behavior management plans will be reviewed for effective and non-effective pharmacological interventions. Medications will be reviewed for effective and non-effective outcomes **How the corrective action(s)**	

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	Resident 60's June, 2022, current physician's orders indicated the following: Clonzapam (antianxiey medication) 1 mg (milligram), twice daily for generalized anxiety disorder ordered on 1/26/22. Haldol (antipsychotic medication) 50 mg/mL (milligrams/milliliter), to be injected intramuscularly every 28 days for paranoid schizophrenia, ordered on 3/29/22. Risperdal (antipsychotic medication) 0.5 mg, every 8 hours for disorganized schizophrenia, ordered 4/11/22. Seroquel (antipsychotic medication) 100 mg, every 12 hours for paranoid schizophrenia, ordered on 4/11/22. Tramadol (opiate pain medication) 50 mg, every 8 hours for pain, ordered on 5/20/22. Oxcarbazepine (anticonvulsant medication) 300 mg, twice daily for paranoid schizophrenia, ordered on 6/10/22. Resident 60's care plan, "BEHAVIOR: Resident has a history of hallucinations, in relation to her diagnosis of schizophrenia and has experienced both auditory and visual hallucination since admission. Makes false accusations against staff," dated 1/17/22 and current through 7/21/22, indicated a goal, "Resident will cope with hallucinations and will respond positively to interventions." Resident 60's care plan, "BEHAVIOR: Sometimes I show behavior symptoms/risks trying to leave the unit to go home, hallucinations and delusional		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit tool “Behavior Management” (Exhibit U) will be utilized to determine the efficacy of the behavior plans. The Alzheimer’s Unit Director, Social Services Director, or designee will complete the audit weekly for 2 months, bimonthly for 2 months, and monthly for 2 months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;**	

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	thoughts due to dx [diagnosis] of schizophrenia. Resident takes anti psychotic medication for this behavior," dated 1/17/22 and current through 7/21/22, indicated a goal, "Episodes of delusional thinking will not interfere with the safety or well-being of myself or others thru my next review." Resident 60's care plan, "BEHAVIOR: Sometimes I demonstrate sexually inappropriate behaviors aeb [as evidenced by] pulling my pants down and asking for others to spank me," dated 1/17/22 and current through 7/21/22, indicated a goal, "I will interact with others appropriately during social and care situations." Resident 60's care plan, "BEHAVIOR: I sometimes have become physical and have aggression towards staff," dated 1/17/2022 and current through 7/21/22, indicated a goal, "I will calm down with staff intervention. My behavior will stop with staff intervention." Resident 60's care plan, "BEHAVIOR: Potential for resident to resident altercations as this resident has visual and auditory hallucinations she sometimes lashes out at or yells at. Resident does not always seem very aware of surrounding as she is walking or when she seats near others and will close eyes then wake unaware of where she is at or who is around her," dated 1/17/22 and current through 7/21/22, indicated a goal, "Resident will not harm self or others through next review." Resident 60's care plan, "COGNITION: Impaired cognition related to short term memory problems and dx [diagnosis of] dementia," dated 1/17/22 and current through 7/21/22, indicated a goal, "Patient will be able to communicate basic needs."		**7/6/2022**	

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Resident 60's care plan, "MOOD: At times I become anxious aeb [as evidenced by] being socially inappropriate," dated 1/17/22 and current through 7/21/22, indicated a goal, "[Resident's Name] will received medication as ordered for anxiety."

Resident 60's care plan, "MOOD: At times I feel depressed and become tearful," dated 1/17/22 and current through 7/21/22, indicated a goal, "I will have less 2 episodes per week. (sic)"

Resident 60's care plan, "MOOD: Resident has a diagnosis of Anxiety Disorder, Insomnia, Schizoaffective Disorder, and Paranoid Schizophrenia, (sic)" dated 1/17/22 and current through 7/21/22, indicated a goal, "Resident will continue to adjust to facility and daily routine and will not exhibit S/S [signs/symptoms] of these diagnoses."

Resident 60's June, 2022, Behavior Monitoring log indicated the resident did not display any behaviors on 6/7/22 and 6/9/22.

Resident 60's progress notes indicated on 6/7/22 at 2:02 p.m., the resident pulled off her gauze wrapped around her leg and yelled at staff to keep the dressing off.

During an interview on 6/9/22 at 10:30 a.m., Resident 110 indicated Resident 60 often will scream out mean things to others but he tried to stay away from her as much as possible.

During an interview on 6/9/22 at 11:00 a.m., CNA 3 indicated Resident 60 yells out very often and often is talking to someone named "George."

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	During an interview on 6/10/22 at 11:34 a.m., the Alzheimer's Unit Director indicated that Resident 60 often yells out, however, they believed their behaviors to be getting better. The resident's had a family member who did not want the resident to be sent out of the facility so the facility staff managed medication adjustments and behaviors. On 6/10/22 at 5:00 p.m., the Regional Nurse Consultant provided the facility policy, "Dementia Care," undated, and indicated it was the policy currently being used. A review of the policy indicated, "... 5. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being. 6. If needed, the environment will be modified to accommodate individual resident care needs ..." On 6/10/22 at 5:00 p.m., the Regional Nurse Consultant provided the facility policy, "Behavior Management Plan," undated, and indicated it was the policy currently being used. A review of the policy indicated, "... 4. Behaviors should be documented clearly and concisely by facility staff. Documentation should include specific behaviors, time and frequency of behaviors, observation of what may be triggering behaviors, what interventions were utilized, and outcomes of the interventions..." 3.1-37(a)			
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-			

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	§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 food that was palatable for 4 of 32 residents interviewed regarding food quality. (Resident 111, Resident 26, Resident 75, Resident 106). Findings include: During an interview on 6/7/2022 at 10:47 a.m., Resident 111 indicated the food was not very good in the facility. She typically ordered out because the taste and appearance were not appealing. During an interview on 6/7/2022 at 10:49 a.m., Resident 26 indicated the food was always terrible. During an interview on 6/7/2022 at 2:30 p.m., Resident 75 indicated the food was always terrible. It was always overcooked and had no flavor. During an interview on 6/8/2022 at 10:07 a.m., Resident 106 indicated the food was not very good in the facility. On 6/9/2022 at 12:51 p.m., a meal tray was obtained. The meal contained a breaded pork chop, macaroni, green beans, and a cup of peaches with jello sprinkled on top. The breaded pork chop was observed to be hard and unable to be cut, rubbery when chewed and the macaroni	F 0804	**F 804 SS = D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident's 111, 26, 75, and 106 were reinterviewed about food preferences. Residents will be encouraged to voice their concerns at mealtime so staff can correct any issues with their meals. Residents were/will be encouraged to attend food committee meetings to voice any concerns at that time also. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All Residents could be affected by the alleged deficient practice. All residents were interviewed after the food tray assessment (by State Surveyors) to determine if residents wanted a substitution for the current meal. No other concerns were voiced. All residents will be encouraged to	07/06/2022

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	had no flavor. On 6/9/2022 at 12:54 p.m., the Administrator was observed to test the meal tray. He was unable to cut the meat and indicated at the time, "point made." During an interview on 6/9/2022 at 3:47 p.m., Resident 26 indicated she did not eat her food at lunch because the meat was too tough. During an interview on 6/10/2022 at 9:57 a.m., Resident 75 indicated the lunch from the day before was not good because the meat was overcooked, was tough to chew and difficult to cut. A review of the "Food Committee Meeting Minutes" indicated the following: How would you rate the quality of your meals? -On 12/15/2022, Fair -On 1/19/2022, Awful -On 2/16/2022, Poor On 6/10/2022 at 5:10 p.m., the Regional Director of Clinical Operations provided the facility's policy, "Resident Rights" undated, and indicated it was the policy currently being used by the facility. A review of the policy did not mention food being palatable to eat. 3.1-21(a)(2)		come to Food Committee meeting to voice their concerns about food and food service. The resident's rights policy was reviewed with no changes made. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Dietary staff will be educated on the "Food Preparation Guidelines" (Exhibit X) and "Resident Rights" (Exhibit 0). Random interviews will be conducted to determine the palatability of the food served. Food committee meetings calendar (Exhibit Y) will be passed out to all resident's and they will be encouraged to attend meetings and to voice concerns with food service. A test tray will be completed once weekly to determine the palatability served food. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit tool "Food Palatability" (Exhibit Z) will be utilized to determine the food quality by random resident interviews. Food committee will be scheduled	

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(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
			weekly for 9 weeks, bimonthly for 2 months, and monthly for 2 months. Food committee notes (Exhibit 1) will be utilized to determine the changes that will need to be made to the food service. The “Test Tray Evaluation” (Exhibit 1.5) form will be completed once weekly. The audit tool will be completed by the dietary manager or designee weekly for 9 weeks, bimonthly for two months, and monthly for 2 months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **7/6/2022**	

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	155278	A. BUILDING 00 B. WING	06/10/2022

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review, the facility failed to ensure food was stored in a safe and sanitary manner for 1 of 1 kitchen. Findings include: On 6/6/22 at 9:30 a.m., the following was observed during an initial tour in the kitchen with the Dietary Manager (DM): -The walk-in freezer floor, shelves, walls, and ceiling was covered in a thick sheet of ice. Multiple icicles were hanging from the ceiling, shelves, food condenser, and food boxes. The	F 0812	**F 812 SS = E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the alleged deficient practice **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	07/06/2022

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	floor was observed to have large chunks of ice chopped up at the entryway. -The walk-in refrigerator contained a puddle of standing water. -The dry storage racks were not 6 inches off of the ground. During an interview on 6/6/22 at 9:35 a.m., the DM indicated the freezer was ice covered because staff did not push the door closed. She demonstrated how the door would not close completely and needed to be shoved to latch the door. She further indicated the standing water in the refrigerator was likely due to an outside hole in the unit which caused water to enter when it rained. They were recently power-washing the refrigerator from the outside and noticed the standing water. The DM further indicated she was aware the dry storage shelves were not 6 inches above the ground and the facility needed to fix them. On 6/10/22 at 5:10 p.m., the Regional Nurse Consultant provided the facility policies, "Food Storage: Cold Foods," revised September, 2017, and "Food Storage: Dry Goods," revised September, 2017, and indicated they were the policies currently being used by the facility. A review of the policies indicated, "Food Storage: Dry Goods ... 1. All items will be stored on shelves at least 6 inches above the floor..." A review of the "Food Storage: Cold Foods," lacked guidelines for freezers to be free from ice. 3.1-21(i)(2) 3.1-21(i)(3)		**action(s) will be taken;** All residents have the potential to be affected the alleged deficient practice. No residents were identified as being affected. Food stored on shelving within 6” of the floor were immediately removed and raised to higher shelving. The bottom shelves will be raised to be above 6” from the floor. The walk-in refrigerator door hinge was replaced which allows the door to shut properly. The freezer door hinges were lubricated and a new door closure was installed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Dietary staff will be educated on the “Food Safety Requirements” (Exhibit 2) policy. Staff will be educated to report any malfunctioning equipment immediately for repair. Staff will be educated on storage requirements on shelves close to the floor. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and**	

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			An audit tool titled “Focus Checklist” (Exhibit 3) will be utilized to monitor for proper food storage. The audit tool will be completed by the Dietary Manager or designee daily for 4 weeks, weekly for 2 months, bimonthly for 2 months, and monthly for one month. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **7/6/2022**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,			

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	sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and homelike environment for 28 of 45 rooms reviewed and 3 of 4 units observed. Dark brown substances were found around bathroom toilet bases, bedroom and bathroom walls were scuffed, unfinished and dirty, baseboards were damaged, ceiling tiles stained, air vents were dirty, and wheelchair armpad covers were damaged (Room 11, Room 3, Room 21, Room 5, Room 22, Room 14, Room 19, Room 17, Room 18, Room 19, Room 20, Room 21, Room 22, Room 23, Room 24, Room 31, Room 32, Room 33, Room 34, Room 35, Room 26, Room 27, Room 28, Room 44, Room 25, Room 26, Room 47, Room 48, Unit 100, Horizon's Unit, Reminiscence Unit) Findings include: 1. On 6/6/22 at 8:52 a.m., Unit 100 was observed to have a strong odor of urine. On 6/7/22 at 10:11 a.m., Unit 100 was observed to have a strong odor of urine. During an interview on 6/7/22 at 10:13 a.m., Resident 13 indicated the facility always had an odor that smells like defecation. "They need to use some spray." During an interview on 6/7/22 at 10:30 a.m., Resident 111 indicated the facility always had an odor. 2. On 6/7/22 at 10:13 a.m., Room 11 was observed to have paint coming off the wall behind the bed exposing old wallpaper and the bathroom walls were scuffed.	F 0921	**F 921 SS =** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Room 11 was identified as having a roommate who has a colostomy that she takes care of by herself. The roommate and staff were educated on removing the trash after a colostomy change. The wall repair in room 11 was completed. · The urine smell on unit 100 was identified and removed. · Room 3 was assessed and deep cleaned with no identifying causes noted. Dirty towels and face mask were disposed of properly from room 3. Also in room 3, the bathroom walls were fixed · In rooms 17, 18, 19, 20, 21, 22, 23, 24, 31, 32, 33, 34, 35, 36, 37, 38, 44, 45, 46, 47, and 48 all were assessed for brown rings around the bottom of the toilet. All areas were corrected. · In room 21 call cord was cleaned · In room 5 the missing toilet paper dispenser, towel rack and tile under the sink were repaired. · In room 22 the bathroom floor and trim were cleaned and the door handle was tightened. · In room 14 the brown liquid	07/06/2022

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	3. On 6/7/22 at 10:28 a.m., Room 3 was observed to have dirty towels with a brown substance and an old face mask stuffed in the corner of the bathroom and the bathroom walls were scuffed. 4. On 6/7/22 at 2:48 p.m., Room 21 was observed to have a dried, brown substance on the call light pull cord. 5. On 6/8/22 at 10:03 a.m., Room 5 was observed to have the toilet paper dispenser missing from the wall, the towel rack missing from the wall, and the tile was pulling away from the pipes under the sink. 6. On 6/8/22 at 10:15 a.m., Room 22's bathroom floor and trim were observed to be dirty and the door handle was coming loose from the wall. 7. On 6/8/22 at 11:00 a.m., Room 14 was observed to have a brown, liquid substance all over the floor. 8. On 6/8/22 at 2:58 p.m., Room 19 was observed to have a strong odor of urine and a dried, yellow brown substance on the floor. On 6/9/22 at 10:04 a.m., Room 19 was observed to have a strong odor of urine and a dried, yellow brown substance on the floor. On 6/9/22 at 12:00 p.m., Room 19 was observed to have a strong odor of urine and a dried, yellow brown substance on the floor. On 6/9/2022 at 12:10 p.m., Room 19 was observed with the Corporate Nurse. She indicated there was a strong smell of urine and the dried, yellow brown substance must be urine. 9. The following		on the floor was cleaned. · Room 19 was immediately deep cleaned · Resident 53 and 64 had their wheelchair arm rest replaced. · All other areas noted in common areas were repaired as cited. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the deficient practice. All Other rooms were assessed for needed repairs and placed on Building Engines (electronic work orders) for maintenance to prioritize and complete. The policy of Resident Rights (Exhibit 0) was reviewed with no changes made. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff will be educated on the resident rights policy. Resident room rounds will be completed by staff weekly to identify maintenance or cleaning issues. Maintenance issues will be placed in Building Engines (electronic	

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	was observed from 6/6/2022 through 6/10/2022 on the Reminiscence Unit: -Chipped paint on the bedroom doors, door jambs, hallway walls, and fire doors. -In the dining room, the ceiling was dirty with brown splatters above a medicine cart. The floor tile below the refrigerator door was dirty with gray splatter. An overhead light cover near the sink, was cracked in multiple spots. A baseboard was kicked in under the sink. The dry wall had dinner plate size damage below the TV at the table level, revealing drywall underneath. -The tiles in front the the shower room entry and down the hall had multiple large cracks in the tile. -A dead bird was observed in the courtyard with flies on and around the dead carcass. -A strong urine odor was noted throughout the entire unit. 10. The following was observed from 6/6/2022 through 6/10/2022 on the Horizons Unit: -Scuffed entry doors, shower doors, fire doors, walls, and handrails. -Bugs in 4 ceiling lights. -The fire door threshold had multiple cracked tiles. -In the sun room which contained a weight scale and tables, scuffed floors, damaged walls, scuffed paint, a ceiling vent which was rusty and dirty with a black and gray substance around the edge of vent, as well as, on the ceiling tile, old tape residue on the sliding door, multiple cobwebs on		work orders) for Maintenance to prioritize and complete. Room rounds will be discussed in morning meetings for any safety or emergent issues. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit titled “Maintenance Opportunities” (Exhibit 5) will be completed to determine areas of concern. The random audit will be completed by Maintenance or designee weekly for 2 months, bimonthly for 2 months, and monthly for 2 months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The**	

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	the sliding door, and the floor trim was missing to the right of the sliding doors. -In the dining room, walls were were scuffed, a missing door threshold to courtyard, scuffed courtyard doors, dirty ceiling vents, multiple stained ceiling tiles, and multiple scuffed floor tiles. -In sun room which contained a TV and tables, scuffed floors with black marks, damaged dry wall below the TV, scuffed walls, phone numbers written on the far left window sill, the far left window sill was chipped at the corner, unfilled nail holes in the drywall throughout, and a dirty floor observed with dust, sticky substances, and dirt. -A strong urine odor was observed throughout the unit the entire week.11. On 6/8/22 at 10:05 a.m., the wheelchair armpad covers of Resident 53 were observed to be cracked, revealing the padding beneath the covers. 12. On 6/8/22 at 10:10 a.m., the wheelchair armpad covers of Resident 64 were observed to be cracked, revealing the padding beneath the covers. 13. On 6/9/22, from 10:20 a.m. to 11:10 a.m., a brown substance around the base of the toilets was observed in the following resident bathrooms: Rooms 17, 18, 19, 20, 21, 22, 23, 24, 31, 32, 33, 34, 35, 36, 37, 38, 44, 45, 46, 47, and 48. During an interview on 6/10/22 at 4:30 p.m., the Maintenance Specialist indicated the observed environmental concerns were in need of remedying and repair.		**Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **7/6/2022**	

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	On 6/10/22 at 5:10 p.m., the Corporate Nurse Consultant provided the Resident Rights, copyright 2022, and indicated these were the Resident Rights currently used by the facility. A review of the Resident Rights indicated, "...the resident has a right to a safe, clean, comfortable and homelike environment..." 3.1-19(f)			
F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to ensure an effective pest control program in order that the facility was free from pests for 5 of 5 residents reviewed for pests. Cockroaches and gnats were observed in the facility. (Resident 40, Resident 68, Resident 106, Resident 113, and Resident 121). Findings include: 1. During an interview on 6/7/22 at 10:45 A.M., Resident 68 indicated there were frequently cockroaches in her room. On 6/7/22 at 10:48 A.M., 2 live cockroaches were observed crawling on the floor at the head of Resident 68's bed. On 6/9/22 at 11:00 A.M., 3 live cockroaches were observed crawling on the floor at the head of Resident 68's bed. 2. During an interview on 6/8/22 at 10:03 A.M., Resident 106 indicated there were frequently	F 0925	**F 925 SS = E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The pest control company was notified by maintenance immediately with the identification of these issues. The pest control company was in the building treating areas the same day notified. Resident 113 was identified as having issue in his room and the room was deep cleaned immediately. All rooms identified were searched for items that would attract pest and if found removed or stored in sealed containers. **How other residents having the potential to be affected by the**	07/06/2022

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	cockroaches in her room, and they sometimes were in her bed. On 6/10/22 at 10:20 A.M., 2 live cockroaches and 9 dead cockroaches were observed on the floor behind Resident 106's mini-refridgerator. 3. On 6/8/22 at 2:58 P.M., Resident 113's room was observed to have a sandwich on the bedside table. The sandwich had numerous live gnats crawling on it. 4. On 6/9/22 at 10:15 A.M., Resident 121 was observed sitting in a wheelchair in his room. Numerous gnats were observed flying around the resident and landing on the bedside table. 5. On 6/10/22 at 4:15 P.M., Resident 40 was observed sitting, asleep in the dining room with a live gnat on her right hand. During an interview on 6/10/22 at 4:30 P.M., the Maintenance Specialist indicated the facility had a contract with a pest control company, the pests were in need of control, and this was an ongoing challenge in the facility. On 6/10/22 at 5:10 P.M., the Corporate Nurse Consultant provided the Resident Rights, copyright 2022, and indicated these were the Resident Rights currently used by the facility. A review of the Resident Rights indicated, "...the resident has a right to a safe, clean, comfortable and homelike environment..." 3.1-19(f)(4)		**same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this alleged deficient practice. The resident rights (Exhibit 0) policy was reviewed with no changes. All reports of pest sightings will be reported to the Administrator/Maintenance so the areas can be documented and the pest control company can be notified to provide their service. Areas of concern, in between pest company services, will have glue traps placed to address the situation. The Pest Control Program policy (Exhibit 7) was reviewed and no changes were made **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff will be educated on the Pest control policy and the Resident Rights policy. Staff will be educated on reporting pest sightings to the Administrator/Maintenance so the areas can be documented and the pest control company can be notified for service. Areas of concern, in between pest	

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			company services, will have glue traps placed to address the situation. Documented areas of concern will be reported to the pest control company. Staff completing weekly room rounds have been educated to search rooms for pest and to report them accordingly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit tool title “Pest Control” (Exhibit 8) will be utilized to determine areas of concern. The audit tool will be completed by Maintenance or designee weekly for 2 months, Bimonthly for 2 months, and monthly for 2 months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be**	

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			completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date; **7/6/2022**	