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	04/05/2023

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 IN00404542, IN00404629, and IN00405188. Complaint IN00404542 - Federal/State deficiencies related to the allegations are cited at F558 and F684. Complaint IN00404629 - Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00405188 - Federal/State deficiencies related to the allegations are cited at F755 and F842. Survey dates: April 3, 4, and 5, 2023 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 7 Medicaid: 43 Other: 9 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 11, 2023	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on 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
Amber Hestand RN	Regional Director of Clinical Operations	04/27/2023

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F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure residents were provided fluids throughout the day for 5 residents interviewed. (Resident G, H, K, L, and M) Findings include: 1. A facility tour was conducted on 4/3/23 at 2:00 p.m. The following interviews were conducted: 1a. An interview conducted with Resident M, on 4/3/23 at 2:02 p.m., indicated in the morning the staff pass out fresh ice water and then she will request water afterwards. The staff only pass ice water out daily. There was a Styrofoam cut on her bedside table with no date noted. 1b. An interview conducted with Resident L, on 4/3/23 at 2:10 p.m. indicated the staff come in once in the morning to pass fresh ice water and throughout the day he has to ask for it. Resident L indicated the staff utilize the same Styrofoam cup. The cup was noted on the bedside table without a date present. 1c. An interview conducted with Resident K, on 4/3/23 at 2:12 p.m., indicated the staff pass ice water daily and if she asks for more, they give it to her. A Styrofoam cup was on her bedside table with no date present.	F 0558	**F 558 E Reasonable Accommodations Needs/Preferences** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident G facility is not able to identify Resident H facility is not able to identify Resident K facility is not able to identify Resident L facility is not able to identify Resident M facility is not able to identify **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit and interview of all residents that receive oral hydration and availability of hydration between meals was completed. Any concerns or discrepancies identified were	05/05/2023

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	1d. An interview conducted with Resident H, on 4/3/23 at 2:19 p.m., indicated the staff pass ice water in the morning and if he wants anymore throughout the day, he has to ask for it. The staff do give him a different cup but not daily. 1e. An interview conducted with Resident G, on 4/3/23 at 2:24 p.m., indicated she was not sure of what routine the facility had in regard to passing ice water. She will get ice water when she asked for it, and they utilize the same cup. A Styrofoam cup was noted on her bedside table without a date present. A policy titled "Hydration", was provided by the Resource Nurse on 4/5/23 at 10:05 a.m. The policy indicated the following, "...4. Care plan implementation...b. Interventions will be individualized to address the specific needs of the resident. Examples included, but are not limited to...i. Offer the resident a variety of fluids during and between meals...ii. Provide assistance with drinking...iii. Ensure beverages are available and within reach...." This Federal deficiency relates to Complaint IN00404542 3.1-3(v)(1)		corrected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Clinical staff (Nurse/QMA/CNA) were educated on the guidelines for Hydration to include but not limited to offering the residents a variety of fluids during and between meals, provide assistance with drinking and ensure beverages are available and within reach. On-going monitoring DNS or Designee will round twice a day to observe and/or interview residents (at least 5/day) to ensure hydration is provided. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on	

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			QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure weekly skin assessments were conducted on a resident who was later identified as having a deep tissue injury at the hospital and not ensuring a urinary catheter was replaced and flushed per recommendations and physician orders to where a resident was later sent out with a clogged urinary catheter for 2 of 4 residents reviewed for change in condition. (Resident B and Resident E) Findings include: 1. The clinical record for Resident B was reviewed on 4/3/23 at 3:20 p.m. The diagnoses included, but were not limited to, spastic hemiplegia affecting right dominant side, neuromuscular dysfunction of bladder, profound intellectual disabilities, hypertension, diabetes mellitus, pain, spastic diplegic cerebral palsy, and aphasia. A progress note by the Nurse Practitioner (NP), dated 1/17/23, indicated Resident B tested	F 0684	F 684 D Quality of Care **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B : Clinical record was reviewed for orders to ensure all orders were initiated timely. Resident E : Clinical record was reviewed for timely completion of assigned assessments. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit weekly skin assessments: A 7 day look back was completed to ensure all residents have assigned weekly	05/05/2023

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	positive for influenza. A progress note by the NP, dated 1/18/23, indicated a follow up was conducted and Resident B's urinary catheter had sediments in it. This was a chronic issue for Resident B and a routine order to flush the urinary catheter was in place. The NP indicated she advised the nursing staff to change the urinary catheter for now and will re-evaluate urine output after the urinary catheter had been changed. The electronic treatment administration record (ETAR) for January of 2023 indicated the irrigation order for Resident B's urinary catheter, dated 12/15/22, was not signed off, as administered, on 1/1/23 (day), 1/3/23 (day), and 1/18/23 (day). The order to change Resident B's urinary catheter as needed, dated 1/8/23, did not have any administrations signed off for 1/18/23. There were no progress notes to indicated the nursing staff changed Resident B's urinary catheter. A progress note, dated 1/19/23 at 9:58 p.m., indicated Resident B was having leaking from the urinary catheter. An order was obtained to send Resident B to the emergency room. A progress note, dated 1/20/23 at 9:11 a.m., indicated Resident was admitted to the hospital for treatment of a possible urinary tract infection and was receiving intravenous antibiotics. An interview conducted with Resource Nurse, on 4/5/23 at 3:17 p.m., indicated it doesn't appear the staff changed the urinary catheter for Resident B. A policy titled "Medication Administration",		skin assessment completed. Any found not in compliance were corrected immediately with documentation present in their clinical record. Initial audit catheter care, changes, flushes per MD orders: An audit of all residents with indwelling foley catheters was completed to ensure all physician orders pertaining to catheter and catheter care are completed and documented in the residents' clinical record. Any found not in compliance were corrected immediately with documentation present in the clinical record. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Licensed Nurses were educated on the guidelines for Skin Assessment to include but not limited to ensuring weekly skin assessment are conducted as assigned and documented in the clinical record. Education: Licensed Nurses were educated on the guideline for follow physician order to include but not limited to ensuring Catheter flushes and changes are completed per physician order and documented in the clinical record.	

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	revised November 2017, was provided by the Resource Nurse on 4/5/23 at 10:05 a.m. The policy indicated the following, "...Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice...." 2. The clinical record for Resident E was reviewed on 4/5/23 at 12:15 p.m. The diagnoses included, but were not limited to, chronic viral hepatitis C, venous insufficiency, aphasia, presence of cardiac pacemaker, diabetes mellitus, and cerebral infarction. An Annual Minimum Data Set (MDS) assessment, dated 1/10/23, indicated Resident E needed extensive assistance with two staff for bed mobility, dressing, toilet use, and personal hygiene. A care plan for skin, revised 1/20/23, indicated Resident E was at risk for skin impairment related to muscle weakness, needed assistance with skin care and positioning, and increased moisture. The interventions listed were to encourage and assist with turning and repositioning and skin assessment to be completed per policy. A skin assessment, dated 2/7/23, indicated no skin concerns. A progress note, dated 2/16/23, indicated a full skin assessment was conducted for Resident E with no open areas noted. Resident E was hospitalized from 3/5/23 to 3/6/23 in regard to vomiting for multiple days and diagnosed with acute kidney injury along with hyperglycemia.		On-going monitoring: DNS or designee will observe orders daily during clinical meeting to ensure all orders pertaining to catheters are followed with documentation present in the clinical record. DNS or designee will audit assigned weekly skin assessments daily to ensure assessments are completed as assigned. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	The hospital discharge summary, dated 3/6/23, indicated a discharge diagnosis of "deep tissue pressure injury to coccyx, present on admission". There were no further skin assessments regarding Resident E since 2/16/23 leading up to hospitalization. An interview conducted with Resource Nurse, on 4/5/23 at 3:17 p.m., indicated she was not able to locate any further skin assessments since 2/16/23. This Federal deficiency relates to Complaint IN00404542 and IN00404629. 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-			

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	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure intravenous (IV) antibiotics were administered timely and for the full course and ensure administration of medications, available in the emergency drug kit (EDK), for a new admission for 1 of 7 residents reviewed for skin integrity and 1 of 3 residents reviewed for medication administration. (Resident C and Resident F) Findings include: 1. The clinical record for Resident C was reviewed on 4/3/23 at 4:06 p.m. The diagnoses included, but were not limited to, hypertension, congestive heart failure, malnutrition, and muscle weakness. Hospital records, dated 12/29/22, indicated Resident C was discharged from the hospital with a primary diagnosis of sepsis and a secondary diagnosis of sacral wound. The discharge medication list included piperacillin-tazobactam (intravenous antibiotic) 3.375 grams and to infuse such every 8 hours for 14 days.	F 0755	F 755 D Pharmacy Services/Procedures/Pharmacist/ Records **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident C No longer resides at the facility Resident F No longer resides at the facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: the facility completed a 7 day look back of all new orders to ensure they were initiated timely and for the duration as ordered. Any discrepancies identified were corrected and documented in the clinical record.	05/05/2023

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	A physician order, dated 12/29/22, indicated the use for Piperacillin Sodium - Tazobactam solution and to utilize 3.375 grams IV every 8 hours for a wound infection for 14 days. The electronic medication administration record (EMAR) for December of 2022 indicated the IV antibiotic was not administered per the following: 12/30/22 6:00 a.m. was blank, 12/30/22 at 2:00 p.m. indicated it wasn't available, 12/30/22 at 10:00 p.m. indicated it wasn't available, 12/31/22 at 6:00 a.m., 2:00 p.m., and 10:00 p.m. indicated it wasn't available, 1/1/23 at 6:00 a.m. and 2:00 p.m. indicated it wasn't available, 1/1/23 at 10:00 p.m. was blank, and 1/2/23 at 6:00 a.m. indicated it wasn't available. The initial dose of the IV antibiotic was signed off, as administered, on 1/2/23 at 2:00 p.m. The last dose of the IV antibiotic was signed off on 1/12/23 at 10:00 p.m. Resident C only received 27 doses out of 42 doses scheduled to be administered. An interview conducted with Resource Nurse, on 4/4/23 at 1:15 p.m., indicated the staff should have extended the IV antibiotic after notifying the physician to ensure the resident received the full course. 2. The clinical record for Resident F was reviewed on 4/4/23 at 1:42 p.m. The diagnoses included, but were not limited to, chronic atrial fibrillation, depression, hypertension, hyperlipidemia, insomnia, anxiety disorder, and muscle weakness. Resident F was admitted to the facility on 3/11/23 at 11:50 a.m.		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Licensed Nursing staff were educated on the guidelines for Medication Administration and Unavailable Medications to include but not limited to ensuring intravenous antibiotics are administered timely and for the full course and ensuring administration of medications that are available in the EDK (ADU) for new admissions. On-going monitoring: DNS or Designee will review new medication orders during daily clinical meeting to ensure meds are initiated timely, available, and administered for the full assigned course of treatment. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to	

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	A physician order, dated 3/11/23, was noted for Ramelteon (medication for sleep) 8 milligrams at bedtime for insomnia. A physician order, dated 3/11/23, was noted for buspirone 10 milligrams twice a day for anxiety disorder and due at 8:00 p.m. A physician order, dated 3/11/23, was noted for Eliquis (blood thinning medication) 5 milligrams twice daily for anticoagulant and due at 8:00 p.m. The electronic medication administration record (EMAR) for March of 2023 indicated the Ramelteon, buspirone, and Eliquis were not administered due to not available. A list of medications available in the EDK was provided by the Resource Nurse on 4/4/23 at 2:57 p.m. The document indicated Ramelteon 8 milligrams, buspirone 10 milligrams, and Eliquis 5 milligrams were available in the EDK. An interview conducted with the Resource Nurse, on 4/4/23 at 2:09 p.m., indicated there have been education on administration of medications timely. The staff are to check the EDK to see if the medication is available. The staff should have "STAT out" (immediately, without delay) Resident F's medications. A policy titled "Medication Administration", revised November 2017, was provided by the Resource Nurse on 4/5/23 at 10:05 a.m. The policy indicated the following, "...Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice...."		make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	This Federal deficiency relates to Complaint IN00405188 3.1-25(a) 3.1-25(b)(1) 3.1-25(b)(3)			
F 0842 SS=E 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			

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	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 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	F 0842	F 842 E Resident Records-Identifiable Information	05/05/2023

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	04/05/2023

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

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	failed to ensure complete documentation in the electronic medication administration record (EMAR), electronic treatment administration record (ETAR), and conduct a readmission assessment upon return from the hospital for 5 of 5 residents clinical records reviewed. (Resident B, C, D, E and F) Findings include: 1. The clinical record for Resident B was reviewed on 4/3/23 at 3:20 p.m. The diagnoses included, but were not limited to, spastic hemiplegia affecting right dominant side, neuromuscular dysfunction of bladder, profound intellectual disabilities, hypertension, diabetes mellitus, pain, spastic diplegic cerebral palsy, and aphasia. The EMAR and ETAR for March of 2023 were reviewed for Resident B and consisted of 31 pages. Out of the 31 pages there were 80 holes for medications and/or treatments. 2a. The clinical record for Resident C was reviewed on 4/3/23 at 4:06 p.m. The diagnoses included, but were not limited to, asthma, hypertension, congestive heart failure, muscle weakness, dysphagia, neuromuscular dysfunction of bladder, malnutrition, and chronic obstructive pulmonary disease. The EMAR and ETAR for March of 2023 were reviewed for Resident C and consisted of 37 pages. Out of the 37 pages there were 35 holes for medications and/or treatments. 2b. Resident C was hospitalized from 12/26/22 to 12/29/22. Upon readmission to the facility there were no readmission assessments found in the clinical record.		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B : Clinical record was reviewed for orders to ensure all orders were initiated timely Resident C No longer resides at the facility Resident D No longer resides at the facility Resident E : Clinical record was reviewed for timely completion of assigned assessments. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: a 24 hour look back of medication administration has been completed to identify residents with missing entries. Any discrepancies have been reviewed and follow up documentation in the clinical record. A 7 day look back of all admissions and readmissions for completion and documentation of assessments in the clinical record. Any discrepancies have been reviewed and follow up documentation in the clinical	

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	An interview conducted with the Resource Nurse, on 4/4/23 at 1:57 p.m., indicated she did not see the readmission assessment for Resident C. 3. The clinical record for Resident D was reviewed on 4/4/23 at 11:35 a.m. The diagnoses included, but were not limited to, cerebral infarction, diabetes mellitus, hypertension, chronic kidney disease, and obstructive and reflux uropathy. The EMAR and ETAR for March of 2023 were reviewed for Resident D and consisted of 40 pages. Out of the 40 pages there were 95 holes for medications and/or treatments. 4. The clinical record for Resident E was reviewed on 4/5/23 at 12:15 p.m. The diagnoses included, but were not limited to, chronic viral hepatitis C, venous insufficiency, aphasia, presence of cardiac pacemaker, diabetes mellitus, and cerebral infarction. The EMAR and ETAR for March of 2023 were reviewed for Resident E and consisted of 36 pages. Out of the 36 pages there were 47 holes for medications and/or treatments. 5. The clinical record for Resident F was reviewed on 4/4/23 at 1:42 p.m. The diagnoses included, but were not limited to, chronic atrial fibrillation, depression, hypertension, hyperlipidemia, insomnia, anxiety disorder, and muscle weakness. The EMAR and ETAR for March of 2023 were reviewed for Resident E and consisted of 49 pages. Out of the 49 pages there were 57 holes for medications and/or treatments. An interview conducted with Resource Nurse, on		record. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Nurses and QMAs have been educated on the guidelines for Medication Administration to include but not limited to ensuring complete documentation in the electronic medication administration record and treatment administration record. Nurses were educated on the guideline for completion and documentation in the clinical record of Assessments upon admission or readmission to the facility. On-going monitoring: The DNS or designee will review EMAR/ETAR documentation daily during clinical meeting for any discrepancies in documentation and ensure corrections are made timely. DNS or designee will audit assigned weekly skin assessments daily to ensure assessments are completed as assigned. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.	

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	4/4/23 at 1:15 p.m., indicated she had noticed holes in the EMARs and ETARs. A policy titled "Documentation in Medical Record", dated October of 2022, was provided by the Resource Nurse on 4/5/23 at 10:05 a.m. The policy indicated the following, "...Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation...1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy...3. Principles of documentation include, but are not limited to...b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care...." This Federal deficiency relates to Complaint IN00405188. 3.1-50(a)(1) 3.1-50(a)(2)		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	