

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Petersburg Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 309 W Pike Ave Petersburg, IN 47567	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46882</p> <p>Based on observation, interview, and record review the facility failed to accommodate resident needs for 2 of 13 residents reviewed for call lights within reach. One resident failed to have an available call system in her room and one resident's call light was not within reach. (Resident 26, Resident 38)</p> <p>Findings include:</p> <p>1. On 8/5/24 at 1:45 P.M., Resident 26 was observed sitting up in a recliner with her call light lying on the floor next to the dresser.</p> <p>On 8/8/24 at 9:47 A.M., Resident 26 was observed sitting up in a recliner with her head covered with a blanket and the call light lying on the floor next to the dresser.</p> <p>On 8/8/24 at 2:45 P.M., Resident 26 was observed sitting in her recliner while the call light was lying on the floor next to the dresser.</p> <p>On 8/9/24 at 11:20 A.M., Resident 26's medical records were reviewed. Diagnosis included, but was not limited to non-Alzheimer's dementia, lymphedema, chronic atrial fibrillation, and heart failure.</p> <p>The most recent Annual and State-Optional MDS (Minimum Data Set) Assessment, dated 7/2/24, indicated Resident 26 was severely cognitively impaired, needed supervision of one for bed mobility, transfers, eating and toilet use.</p> <p>The care plan for potential for physical functioning deficit related to: Mobility impairment due to diagnosis of lymphedema, and morbid obesity. Self care impairment r/t (related to) diagnosis of dementia, unsteady gait, muscle weakness, cognitive communication deficit, dated 4/22/2024. Interventions included, but was not limited to call bell within reach.</p> <p>During an interview on 8/9/24 at 9:31 A.M. CNA (Certified Nurse Aide) 14 indicated Resident 26 was able to use the call light and the call lights should be kept within reach of the residents.</p> <p>2. On 8/7/24 at 9:32 A.M Resident 38 was observed lying in bed watching TV with no call light in reach. and unable to see a Wander Guard.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/7/24 at 9:45 A.M., CNA 14 entered Resident 38's room to locate the Wander Guard on her left ankle and was unable to locate it. At that time, CNA 14 indicated they were unable to keep a call light in her room due to her throwing things at the staff and breaking things like the clock, window and dresser. Due to Resident 38 becoming agitated that she was being disturbed while watching TV, CNA 14 left the room and notified LPN (Licensed Practical Nurse) 26 that the Wander Guard was no longer on Resident 38's ankle.</p> <p>On 8/8/24 at 9:38 A.M., Resident 38 was observed lying in bed watching TV (television) with a Wander Guard on left ankle and no call device in her room.</p> <p>On 8/9/24 at 9:26 A.M. Resident 38 was observed lying in bed watching TV with a Wander Guard on left ankle and no call device in her room.</p> <p>On 8/6/24 at 3:12 P.M., Resident 38's Medical Records were reviewed. She was admitted on [DATE]. Diagnosis included, but were not limited to dementia with behavioral disturbance, delusional disorders, anxiety disorder, and major depressive disorder.</p> <p>The most current Significant Change MDS (Minimum Data Set) Assessment, dated 6/27/24, indicated Resident 38 had a moderate cognitive impairment, needed supervision of one for bed mobility, transfer, eating and extensive assistance of one for toilet use. Behaviors indicated Resident 38 had verbal behavioral symptoms directed toward others on 1-3 days. Resident rejected evaluation or care on 4-6 days. Wander/elopement alarm was used daily.</p> <p>The Physician orders included, but were not limited to the following:</p> <p>Check placement and function of device every shift. Record location of device. Replace device if device is not working. Change device one month prior to expiration date. Wander Guard applied to (Location) left ankle, dated 7/15/24</p> <p>A current ADL (Activities of Daily Living) Care Plan dated 4/19/24, included, but was not limited to the following intervention:</p> <p>Call bell within reach, dated 4/19/24.</p> <p>A current Wandering/Elopement Care Plan, dated 6/24/24, included, but was not limited to the following intervention:</p> <p>Test my Wander Guard every shift for placement/function. Left ankle, dated 4/19/24.</p> <p>A current Elopement Risk Care plan related to: Anger at placement in living center, attempts to leave Living Center, hx (history) of breaking window trying to escape/leave, dated 6/13/2024, included, but was not limited to, the following intervention:</p> <p>Remove all items that are a potential for breaking glass/window, dated 6/7/24.</p> <p>The TAR (Treatment Administration Record) for August 2024 was reviewed and indicated the placement and function of the Wander Guard had been checked every shift from 8/1/24 through 8/6/24. the placement and function of the Wander Guard had not been checked for the day shift on 8/7/24.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/7/24 at 1:44 P.M., LPN 26 indicated Resident 38 had calmed down and she had a new Wander Guard on her left ankle. LPN 26 indicated Resident 38 used to have a cowbell in her room since they couldn't keep a call light in her room. She was not sure what happened to the cowbell, but Resident 38 was incontinent so they checked her frequently. The clinical record lacked documentation of times Resident 38 was checked on by staff.</p> <p>During an interview on 8/8/24 at 1:28 P.M., LPN 26 indicated the Wander Guard was checked by the nurse with a box that checks the function. She indicated the Wander Guard was checked first thing of the morning when passing medication. This was done every shift.</p> <p>On 8/9/24 at 2:23 P.M., the Administrator provided a Call Lights: Accessibility and Timely Response Policy, dated 2023, which indicated .5. Staff will ensure the call light is within reach of resident and secured .</p> <p>On 8/9/24 at 2:23 P.M., the Administrator indicated they did not have a policy for the Wander Guard or following orders, but indicated it was their policy to follow provider's orders and care plan interventions.</p> <p>3.1-3(v)(1)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46882</p> <p>Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) Assessments were completed for 2 of 5 residents reviewed for unnecessary medications, 1 of 1 reviewed for hospice, 1 of 1 reviewed for dialysis, and 1 of 1 reviewed for smoking. The MDS Assessment indicated a resident received an anticoagulant but did not, a resident with the diagnosis of PTSD (Post Traumatic Stress Disorder) was marked as not having it, a resident with a diagnosis of schizoaffective disorder was marked as not having it, a resident with the diagnoses of anxiety and depression was marked as not having them, and a resident that did not have a diagnosis of atrial fibrillation was marked that she did have it. (Resident 35, Resident 43, Resident 11, Resident 1, Resident 23)</p> <p>Findings include:</p> <p>1. On 8/6/24 at 1:32 P.M., Resident 35's clinical record was reviewed. Diagnosis included, but was not limited to dementia, atherosclerotic heart disease, and chronic systolic heart failure.</p> <p>The most current Quarterly MDS (Minimum Data Set) Assessment, dated 6/25/24, indicated Resident 35 had severe cognitive impairment and administered an antianxiety, antidepressant, anticoagulant and antiplatelet during the 7 day look back period.</p> <p>Current Physician's Orders included, but were not limited to, the following:</p> <p>Aspirin EC (Enteric Coated) Tablet Delayed Release (antiplatelet medication) 81 mg (milligrams), give 1 tablet by mouth one time a day for STEMI (ST-elevation myocardial infarction) related to atherosclerotic heart disease of native coronary artery without angina pectoris, dated 6/17/24</p> <p>Plavix Oral Tablet (antiplatelet medication) 75 mg, give 1 tablet by mouth one time a day for antiplatelet related to atherosclerotic heart disease of native coronary artery without angina pectoris, dated 6/20/24</p> <p>alprazolam Oral Tablet (antianxiety medication) 0.25 mg, give 1 tablet by mouth two times a day related to anxiety disorder, dated 6/27/2024</p> <p>trazodone HCl (hydrochloride) Oral Tablet (antidepressant medication) 50 mg, give 1 tablet by mouth two times a day related to depression, dated 6/26/2024</p> <p>During an interview on 8/9/24 at 1:46 P.M., the Regional Nurse indicated the MDS Coordinator was out of the building at that time, but would have coded the aspirin as an anticoagulant and Plavix as an antiplatelet medication.</p> <p>46416</p> <p>2. On 8/6/24 at 1:31 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and depression.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The most recent Admission MDS Assessment, dated 6/6/24 indicated Resident 1 was cognitively intact and did not have anxiety or depression.</p> <p>Resident 1's care plans included, but were not limited to, the following:</p> <p>I have a diagnosis of anxiety, initiated 6/3/24</p> <p>I have a diagnosis of depression, initiated 6/3/24</p> <p>During an interview on 8/9/24 at 3:28 P.M., the Regional Nurse indicated anxiety and depression were active diagnoses on Resident 1's list of diagnoses and should have been marked on the MDS Assessment.</p> <p>3. On 8/7/24 at 11:13 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis.</p> <p>The most recent Admission MDS (Minimum Data Set) Assessment, dated 7/25/24, indicated that the resident was cognitively intact and did not have PTSD.</p> <p>Resident 11's care plans included, but were not limited to, the following:</p> <p>I have a history of trauma related to being robbed at gunpoint. I have PTSD from the event and nightmares. I take psychoactive medication, initiated 7/19/24</p> <p>During an interview on 8/9/24 at 3:28 P.M., the Regional Nurse indicated Resident 11 should have had PTSD marked on the MDS Assessment if he had a care plan related to it.</p> <p>4. On 8/9/24 at 9:47 A.M., Resident 23's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, asthma, diabetes mellitus type II, depression, hyperlipidemia, hypertension, and hypothyroidism.</p> <p>The most recent Significant Change MDS Assessment, dated 7/9/24 indicated Resident 23's cognition was severely impaired and had a diagnosis of atrial fibrillation.</p> <p>Resident 23's clinical record lacked documentation of atrial fibrillation as a diagnosis.</p> <p>During an interview on 8/9/24 at 3:28 P.M., the Regional Nurse indicated if the resident didn't have atrial fibrillation as an active diagnosis, then it should not be marked on the MDS Assessment.</p> <p>5. On 8/7/24 at 3:55 P.M., Resident 43's clinical record was reviewed. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease, anxiety, depression, and schizoaffective disorder.</p> <p>The most recent Admission MDS Assessment, dated 6/21/24 indicated Resident 43's cognition was moderately impaired, used tobacco and did not have schizophrenia.</p> <p>Resident 43's care plans included, but were not limited to, the following:</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>I have a level two determination due to diagnosis of Schizoaffective Disorder, Anxiety disorder, Depressive disorder and Polysubstance Abuse . , initiated 6/22/24</p> <p>During an interview on 8/9/24 at 3:28 P.M., the Regional Nurse indicated schizoaffective disorder was on Resident 43's diagnosis list and it should have been marked on the MDS Assessment.</p> <p>The High-Risk Drug Classes: Use and Indication section of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, dated October 2023, was reviewed and indicated . Do not code antiplatelet medications such as aspirin/extended release, dipyridamole [[NAME]], or clopidogrel [Plavix] as N0415E, Anticoagulant</p> <p>During an interview on 8/9/24 at 3:28 P.M., the Regional Nurse indicated she would expect the active diagnoses of residents to be accurate and to be reflected on the MDS Assessment accurately. At that time, she indicated there was no policy for an MDS Assessment, but they used the RAI manual.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416</p> <p>Based on observation, interview, and record review, the facility failed to ensure necessary care and complete assessments were provided for 1 of 1 residents reviewed for dialysis. The medical record lacked post dialysis assessment documentation. The facility also lacked a current dialysis contract at the time of the survey. (Resident 11)</p> <p>Findings include:</p> <p>On 8/7/24 at 11:13 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. Resident 11 was admitted [DATE].</p> <p>The most recent Admission MDS (Minimum Data Set) Assessment, dated 7/25/24, indicated that the resident was cognitively intact and on dialysis.</p> <p>Current Physician's Orders included, but were not limited to, the following:</p> <p>Dialysis treatment on Monday, Wednesday, Friday at 11:45 A.M. (Name, address, and phone number of dialysis facility). Complete pre-dialysis form, ordered 7/23/24</p> <p>Post dialysis assessment. Assess site for signs/symptoms of bleeding, infection, post dialysis complications. Notify MD (Medical Doctor) of any abnormal changes. Every day shift every Monday, Wednesday, Friday for monitoring, ordered 7/19/24</p> <p>A current Dialysis Care Plan, dated 7/22/24, included, but was not limited to, the following interventions:</p> <p>Observe and document post-dialysis: vital signs, mental status, excessive weight gain between treatments, nausea, vomiting, weakness, headache, severe leg cramps. Report abnormalities to MD.</p> <p>Resident 11's progress notes were reviewed from 7/18/24 through 8/6/24 and lacked documentation of the time the resident returned from dialysis, time of post dialysis vital signs including temperature, HR (pulse/heart rate), BP (blood pressure), and pain. The progress notes lacked post dialysis assessment of the access site, mental status, heart, edema (swelling)/redness/skin concerns, and symptoms post dialysis.</p> <p>Resident 11's vitals were reviewed and lacked documentation of post dialysis vitals including temperature, HR, BP, and pain.</p> <p>Resident 11's MAR (Medication Administration Record) was reviewed from 7/19/24 through 8/6/24 and lacked post dialysis assessment documentation.</p> <p>On 8/8/24 at 11:30 A.M., all dialysis/observation communication forms for Resident 11 were provided by the DON (Director of Nursing) and indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7/22 post dialysis assessment section was not completed</p> <p>7/24/24 post dialysis assessment section was not completed</p> <p>7/26 post dialysis assessment section was not completed</p> <p>There was no form provided for 7/31/24</p> <p>7/29/24 post dialysis assessment section was not completed</p> <p>8/2/24 post dialysis assessment included resident's name, time completed, time returned from dialysis, temperature, HR (pulse/heart rate), BP (blood pressure), and pain but lacked assessment of access site, mental status, heart, edema/redness/skin concerns, and symptoms post dialysis.</p> <p>8/5/24 post dialysis assessment included the temperature, HR, and BP, but lacked resident's name, time completed, time returned from dialysis, and assessment of pain, access site, mental status, heart, edema/redness/skin concerns, and symptoms post dialysis.</p> <p>8/6/24 post dialysis assessment section was not completed</p> <p>8/7/24 post dialysis assessment section was not completed</p> <p>On 8/5/24 at 9:50 A.M., during the entrance conference, a current dialysis contract was requested but not provided.</p> <p>During an interview on 8/7/24 at 2:40 P.M., LPN (Licensed Practical Nurse) 44 indicated staff was to fill out the pre assessment section of the dialysis form with the vitals and pre-assessment, then the form was taken to dialysis with the resident where their staff filled out the middle section of form with vitals and assessment during dialysis period, and sent the form back with the resident. When resident returned to the facility, staff should do post dialysis vitals, assess the fistula site, and fill out the post dialysis assessment section of the form. The form should get scanned into the resident's clinical record after it was completed.</p> <p>During an interview on 8/9/24 at 2:18 P.M. the DON indicated Resident 11 was scheduled for dialysis on Monday, Wednesday, and Friday at around noon and returned around 6:00 P.M. to the facility. At that time, she indicated staff should take the resident's vitals and assessments that were asked for on the dialysis form every time resident went to dialysis. She would expect the post dialysis assessment to be completed within 30 minutes after arriving back to the facility. She indicated ideally they would fill out the dialysis form entirely but it would be ok if they put pre and post vitals and assessments under the vitals section or the progress notes in the clinical record as well as scanned the form into the clinical record when completed.</p> <p>During an interview on 8/7/24 at 2:45 P.M., the Administrator indicated the facility did not have a current contract for (Name of dialysis company).</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/7/24 at 3:08 P.M., a current non dated Hemodialysis Policy was provided by the Administrator and indicated . The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility .documentation requirements are met to assure that treatments are provided .monitor for and identify changes in the resident's behavior that may impact the safe administration of dialysis before and after treatment .5. the licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form, that will include, but not limit itself to, a. timely medication administration (initiated, held or discontinued) . b. physician/treatment orders, laboratory values, and vital signs. c. Advanced directives and code status . d. nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions . f. dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring and/or concerns related to the vascular access site. g. Changes and/or declines in condition unrelated to dialysis . 8. the nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding and other complications . 12 . There must be a systematic approach between the facility and the dialysis facility when handling situations where the resident has a condition change and/or becomes ill or unstable during dialysis . 14. The nurse will ensure that the dialysis access site (e.g. Arteriovenous fistula) is checked before and after dialysis treatments and every shift for patency .</p> <p>3.1-37(a)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416</p> <p>Based on observation and interview, the facility failed to ensure a clean and homelike environment for 6 of 13 resident rooms and 1 of 2 shower rooms observed for environment. Bathrooms had holes in the wall, exposed pipes, a baseboard peeling off, uncovered bedpans, and a floor that was badly scuffed. An air condition unit was falling off the wall in a room. Multiple sink water temperatures were higher than 120 degrees. (Rooms 136, 139, 138, 140, 141, 143, East Shower Room)</p> <p>Findings includes:</p> <ol style="list-style-type: none"> 1. During an observation on 8/5/24 at 1:39 P.M., room [ROOM NUMBER]'s bathroom was observed with the baseboard behind the toilet peeling off and the floor had multiple scuffs. The water temperature was 120.8 degrees Fahrenheit. At that time, the resident indicated the water was hot but denied being burned. 2. During an observation on 8/9/24 at 11:06 A.M., the same was observed but the water temperature was not rechecked. 3. During an observation on 8/5/24 at 1:50 P.M., room [ROOM NUMBER]'s water temperature was 123.3 degrees Fahrenheit. 4. During an observation on 8/5/24 at 1:52 P.M., room [ROOM NUMBER]'s wheelchair had food debris covering the seat and on the wheels. The water temperature was 122.9 degrees Fahrenheit. At that time, the resident indicated the water was plenty warm but denied being burned. 5. During an observation on 8/9/24, the same was observed but the water temperature was not rechecked. 6. During an observation on 8/5/24 at 2:05 P.M., room [ROOM NUMBER]'s water temperature was 124.2. At that time, the resident indicated they hardly used it. 7. During an observation on 8/5/24 at 2:07 P.M., room [ROOM NUMBER]'s bathroom had a soap dispenser was not adhered to the stickers by the sink and was sitting on the back of the toilet. An uncovered bed pan was sitting on the floor between the sink and the toilet. In the room, the air conditioner unit was falling off of the wall on the left side. The water temperature was 127.5 degrees Fahrenheit. At that time, the resident indicated they used the sink water sometimes but denied being burned. 8. During an observation on 8/9/24 at 11:05 A.M., the same was observed but the water temperature was not rechecked. 9. During an observation on 8/5/24 at 2:13 P.M., room [ROOM NUMBER]'s bathroom had 2 uncovered graduated cylinders with a syringe in one and multiple cups on the countertop of the sink, a plate and two bowls with silverware were in the sink. There were two holes in the wall behind the toilet with pipes visible and 8 clean uncovered wash cloths on top of the paper towel holder. The water temperature was 123.6 degrees Fahrenheit. At that time, the resident indicated he hardly used the water from the sink, but a visitor with him indicated it gets hot pretty quick. <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Petersburg Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 309 W Pike Ave Petersburg, IN 47567	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 8/9/24 at 10:59 A.M., there were still 2 uncovered graduated cylinders with a syringe in one and multiple cups on the countertop of the sink and two holes in the wall behind the toilet with pipes still visible. The water temperature was not rechecked.</p> <p>7. During an observation on 8/5/24 at 4:00 P.M., the East Hall Shower Room's water temperature was 120.7.</p> <p>During an interview on 8/5/24 at 3:26 P.M., the Maintenance Assistant indicated he checked the water temperatures in the rooms at the end of the halls around 6:30 A.M. every weekday morning. He expected the room water temperatures to be between 110 and 120 degrees Fahrenheit. At that time, he indicated the water lines were in the attic and with the hot temperatures outside, it could cause the water temperatures to elevate some. The East Hall is closest to the water heater. He hasn't been notified of any concerns with the water temperatures recently from staff or residents.</p> <p>During an observation on 8/5/24 from 3:39 P.M. to 4:00 P.M., the Maintenance Assistant checked the water temperatures on the East Hall and indicated the following:</p> <p>room [ROOM NUMBER] - 119-120 degrees Fahrenheit</p> <p>room [ROOM NUMBER] - 119-120 degrees Fahrenheit</p> <p>room [ROOM NUMBER] - 119-120 degrees Fahrenheit</p> <p>room [ROOM NUMBER] - 120 degrees Fahrenheit</p> <p>room [ROOM NUMBER] - 124 degrees Fahrenheit</p> <p>room [ROOM NUMBER] - 119-120 degrees Fahrenheit</p> <p>room [ROOM NUMBER] - 119 degrees Fahrenheit</p> <p>East Hall Shower Room - 120 degrees Fahrenheit</p> <p>During a resident council meeting on 8/7/24 at 2:12 P.M., 3 random residents from the [NAME] Hall indicated their water was usually cold and took almost 15 minutes to warm up enough sometimes. One random resident from the East Hall indicated his water was pretty hot but he had never burned himself with it.</p> <p>On 8/8/24 at 2:05 P.M., CNA (Certified Nurse Aide) 55 was observed saying That's hot referring to the water when she was washing her hands after performing incontinence care in room [ROOM NUMBER] on the East Hall.</p> <p>During an interview on 8/9/24 at 1:50 P.M., the Maintenance Assistant indicated he had that thermometer about a year and didn't know if it's ever been calibrated. He indicated he did turn up the temperature in the [NAME] Hall a smidge but did nothing to East Hall.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/5/24 at 3:35 P.M., the Maintenance Assistant provided the log book documentation from 7/1/24-8/5/24 excluding weekends and in the Steps to Test Water Temperatures, it indicated . the dial thermometer is accurate to 1 to 2 degrees Fahrenheit - however it is not precision instrument and should be calibrated on a regular basis . For burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit, although this temp can still cause burns if exposure reaches five minutes .</p> <p>On 8/8/24 at 11:30 A.M., a current non dated Safe Water Temperatures Policy was provided by the Director of Nursing (DON) and indicated . Staff will report abnormal findings, such as complaints of water too cold or hot, burns or redness, or any problems with water temperature . to the supervisor and/or maintenance staff . water temperatures will be set to a temperature of no more then 120 degrees Fahrenheit .</p> <p>On 8/9/24 at 3:55 P.M., a current non dated Safe and Homelike Environment Policy was provided by the Regional Nurse and indicated . the facility will provide a safe, clean, comfortable and homelike environment .</p> <p>On 8/9/24 at 3:55 P.M., a current non dated Cleaning and disinfection of Resident Care Equipment Policy was provided by the Regional Nurse and indicated . Reusable resident care equipment will be cleaned and disinfected . Direct care staff are responsible for cleaning single-resident equipment when visibly soiled .</p> <p>This citation relates to Complaint IN00437005.</p> <p>3.1-19(e)</p>		