STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155390	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Woodbridge Care Center	816 N First Ave Evansville, IN 47710

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations of needs by transporting a resident in an improperly fitted wheelchair for 1 of 1 residents reviewed for mobility. (Resident 8) Findings include: During an observation on 7/9/24 at 9:46 A.M., Resident 8 was observed sitting in a manual wheelchair in the hallway. Resident 8 indicated he was ready to get out of the wheelchair and go to bed. During an interview on 7/10/24 at 9:47 A.M., RN (Registered Nurse) 3 indicated the manual wheelchair was not Resident 8's personal wheelchair and was the one staff used for transportation due to Resident 8's personal electric wheelchair not being able to fit in the facility's mobility van. On 7/10/24 at 10:39 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on [DATE]. Current diagnoses included, but were not limited to, quadriplegia, post traumatic seizures, COPD (chronic obstructive pulmonary disease), stage four (4) pressure ulcers, and contracture of muscle/joint. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/22/24, indicated Resident 8 was cognitively intact, and was fully dependent on staff for eating, toileting, bathing, and transfers. Current orders included, but were not limited to:OT (Occupational Therapy) screen attempted due to reports of poor positioning in wheelchair however pt (patient) LOA (leave of absence/out of building) at this time Order date 7/10/24 During an interview on 7/12/24 at 9:29 A.M. Occupational Therapist 10 indicated she was not aware until this week Resident 8's trunk was not being supported in the manual wheelchair nursing staff had been using to transport Resident 8 in the mobility van. (continued on next page)

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

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	155390	A. Building B. Wing	07/15/2024

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/24 at 3:04 P.M., the Regional Support Consultant provided a document titled Functional Mobility and Wheelchair Assessment, dated 4/24/24, that indicated manual wheelchair use was contraindicated for Resident 8 by diagnoses, the only mobility device that met the needs for safety independent functional ambulation/mobility was a power wheelchair due to quadriplegia and impairment in arms, legs, and trunk, and stage 4 pressure wounds on the sacral region, and inability to achieve repositioning for pressure relief in a standard wheelchair. On 7/15/24 at 12:10 P.M. the Administrator provided a policy titled Therapy Evaluation, dated 2023, that indicated The Licensed Therapist will perform an initial evaluation upon physician referral and any re-evaluation where indicated. 3.1-3(v)(1)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on observation, interview, and record review, the facility failed to notify a resident's physician of treatments not provided for 1 of 2 residents reviewed for pressure ulcers. (Resident 8) Finding includes: On 7/10/24 at 10:39 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on [DATE]. Current diagnoses included, but were not limited to, quadriplegia, post traumatic seizures, COPD (chronic obstructive pulmonary disease), stage four (4) pressure ulcers, and contracture of muscle/joint. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/22/24, indicated Resident 8 was cognitively intact, and was fully dependent on staff for eating, toileting, bathing, and transfers. Current physician orders included, but were not limited to: Dakins external solution (sodium hypochlorite) Apply to coccyx topically every day and night shift for wounds, start date 7/3/24. Cleanse with Dakins Solution, apply silver alginate to the wound bed and cover with superabsorbent dressing every day and night shift for Stage three pressure area to right dorsal foot. Wound #1 left gluteal pressure treatment recommendations: Cleanse with 0.25% Dakins solution, apply silver alginate to base of the wound, secure with superabsorbent (dressing), change BID (twice a day) every day and night shift for stage three pressure area to left gluteal/buttock. Wound #2 coccyx pressure treatment recommendations: Cleanse with 0.25% Dakins solution. apply silver alginate to base of the wound, secure with superabsorbent (dressing), change BID, every day and night shift for stage four pressure area to coccyx. Wound #3 right gluteal pressure treatment recommendations: Cleanse with 0.25% Dakins solution, apply silver alginate to base of the wound, secure with superabsorbent (dressing), change daily, every day and night shift for stage four pressure area to right gluteal/buttock. Current care plans included, but were not limited to: (Resident) has personal preference to be changed on his time and not when staff come in to do it. Honor personal preference as safely able. Notify MD (doctor) of resident preference; Date initiated 1/18/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following progress notes indicate times and dates during the past month when Resident 8 refused treatment, while sleeping, and further attempts to change dressings during wake hours were not documented. 7/11/24 4:37 A.M. (Resident) is currently asleep and does not want this nurse to change dressings on foot or buttocks and coccyx. 7/8/24 11:50 P.M. (Resident) states he just got comfortable and doesn't want to move. 7/6/24 5:34 A.M. Resident refused this nurse to do treatment stating he was trying to sleep and didn't feel like doing it. 6/30/24 12:35 A.M. Resident refused to have treatments done. Wanted to sleep. 6/29/24 4:21 A.M. Resident did not want this nurse to complete dressing changes while resident trying to sleep. 6/23/24 10:41 P.M. (Not administered) Resident sleeping 6/22/24 2:21 A.M. (Resident) refused to have treatments done. Resident was tired and just wanted to go to sleep. During an interview on 7/12/24 at 9:23 A.M. Physician 12 indicated she had not been notified of wound treatment refusals or change in preference time of treatments for Resident 8. During an interview on 7/12/24 at 11:09 A.M., the Regional Support Consultant read results, from the MRI performed on Resident 8 on 7/9/24, and indicated Resident 8 was positive for osteomylitis (bone infection) and the results had not yet been sent to Resident 8's physician, but she would send them at this time. On 7/15/24 at 12:10 P.M., the Administrator provided a policy titled Promoting/Maintaining Resident Self-Determination, dated 2024, that indicated The facility will accommodate the resident preferences to the extent possible and as agreed upon by the resident sponsor and physician. A policy relating to physician notification was requested but was not provided. 3.1-5(a)(3)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on record review and interviews, the facility failed to protect the resident's right to be free from physical abuse by staff for 1 of 1 resident's reviewed for facility reported incidents of staff to resident physical contact. (Resident 8) Finding includes: On 7/9/24 at 8:45 A.M., a facility reported incident, dated 3/13/24 at 3:01 A.M., was reviewed. The incident form indicated Resident 8 reported that during PM (evening) care, Employee 13 made contact to Resident's head. Employee 13 was immediately suspended pending investigation. A follow up added 3/21/24 indicated Resident 8 showed no signs of distress and Employee 13 chose not to participate in the investigation and resigned from employment. On 7/10/24 at 10:39 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on [DATE]. Current diagnoses included, but were not limited to, quadriplegia and contracture of muscle/joint. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/22/24, indicated Resident 8 was cognitively intact, and was fully dependent on staff for eating, toileting, bathing, and transfers. During an interview on 7/9/24 at 8:55 A.M., the Administrator provided clarification that the verbiage made contact was intended to mean Resident 8's head bent forward and touched Employee 13's chest when Employee 13 was assisting Resident 8 with changing Resident 8's shirt. The investigation file was provided and the following was included: A screenshot of a text message from QMA 15 reads I was passing meds (medications) with my back to (employee 13) and (Resident 8). (Resident 8) all of a sudden says why did you slap me? So I turned around and said what? (Employee 13) instantly started to apologize saying I thought you bit me. An email from the Social Service Director dated 3/15/24 at 4:00 P.M. indicated on 3/12/24, while Resident 8 was being provided care, Employee 13 was attempting to remove Resident 8's shirt when Resident 8 involuntarily moved forward and his head touched Employee 13's nametag, and Employee 13 immediately took her hand and hit Resident 8's face. A statement dated 3/13/24, signed by Employee 13, indicated she was helping Resident 8 change his shirt when Resident 8 acted like he was going to bite Employee 13 so she put her hand up to his face and pushed him back and he stated wow I just got slapped. During an anonymous interview on 7/10/24 at 8:31 A.M., the anonymous person indicated an incident that happened on 3/12/24 between Employee 13 and Resident 8, where Employee 13 slapped Resident 8 in the face. The anonymous person indicated since Employee 13 was fired, she and her spouse had harassed Resident 8 about reporting the the incident while Resident 8 was out in the community with family. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/15/24 at 8:59 A.M., the Administrator indicated she didn't recall the timeline of the incident that happened, that she was gone from the building for training at that time because administration was switching and there wasn't great communication between the old administrator about incidents going on in the building. The Regional Support Consultant states she is the one who made the report and even though employee 13 had given a written statement, she reported on the State Incident Form that Employee 13 had not given a statement because Employee 13 would not come to the building to talk to administration in person. On 7/9/24 at 9:45 A.M., the Administrator provided a policy titled Abuse, Neglect, and Exploitation, dated 2022, that indicated The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of residents property, and exploitation. The facility will have written procedures that include reporting of alleged violations to the Administrator, state agency, adult protective services and all other required agencies (law enforcement when applicable) Immediately, but not later that 2 (two) hours after the allegation is made, even if the events that cause the allegation involve abuse or result in serious bodily injury. Assuring that reporters are free from retaliation or reprisal. 3.1-27(a)(1)

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	155390	A. Building B. Wing	07/15/2024

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to transport residents with proper documents, or transfers residents with legible documents for 2 of 3 residents reviewed for hospitalization s. (Resident 8 and Resident 54) Findings include: 1. On 7/10/24 at 10:39 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on [DATE]. Current diagnoses included, but were not limited to, quadriplegia, post traumatic seizures, COPD (chronic obstructive pulmonary disease), stage four (4) pressure ulcers, and contracture of muscle/joint. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/22/24, indicated Resident 8 was cognitively intact, and was fully dependent on staff for eating, toileting, bathing, and transfers. The clinical record indicated during the past year, Resident 8 was discharged from the facility and admitted to the hospital on 9/4/23 and 5/10/24. A progress note dated 5/10/24 at 9:39 A.M., indicated Resident (was) sent to ER (emergency room). Transfer log, order summary, post form, and bed hold policy sent with resident. During an interview on the Regional Support Consultant indicated there were no documents sent with Resident 8 during the hospital visit on 9/4/23. The transfer/discharge forms sent with Resident 8 on the 5/10/24 hospital visit were provided, however, the Administrator and Regional Support Consultant were unable to read the documents and indicated the paperwork sent with Resident 8 was not legible, and new forms would have to be printed to be able read them. 46758 2. On 7/11/24 at 2:49 P.M., Resident 54's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease and essential (primary) hypertension, The current Admission MDS (Minimum Data Set) Assessment, dated 5/1/24, indicated Resident 54 was cognitively intact and needed supervision for eating, dressing, and mobility. A Significant Change Nurse's Progress Note, dated 5/27/24 at 2:26 P.M., indicated the resident was having chest pain and shortness of breath. Vital signs indicated Blood Pressure 224/125, Pulse 86, Respirations 18, and Oxygen Saturation of 92%. Nurse Practitioner was called, and the new orders were received to transfer the resident to the emergency room . The record lacked an order to transfer and paperwork for transfer, discharge, and bed hold. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/15/24 at 8:53 A.M., the Regional Support Person indicated that the facility could not locate any transfer/discharge/ bed hold information requested for 5/27/24. On 7/15/24 at 8:53 A.M. the Administrator provided a policy titled Transfer and Discharge, dated 2024, that indicated the facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. For transfer to another provider, for any reason, the following information must be provided to the receiving provider: Contact information of the practitioner who is responsible for the care of the resident; Resident representative information, including contact information; all advanced directive information; all other information necessary to meet the residents needs . The original copies of the transfer form and Advance Directive accompany the resident. Provide a notice of transfer and the facility's bed hold policy to the resident and representative. The Social Services Director will provide copies of notices for emergency transfers to the Ombudsman. 3.1-12(a)(16)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on record and interview the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 1 of 2 residents reviewed for unnecessary medications and bladder.(Resident 4) Findings include: On 7/10/24 at 8:31 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy and flaccid neuropathic bladder, not elsewhere specified. The current Quarterly MDS (Minimum Data Set) assessment dated [DATE]. The MDS indicated Resident 4 was cognitively intact and was dependent on transfer, eating, and mobility. The Bowel and Bladder section indicated Resident 4 had an indwelling, suprapubic and external catheters with a colostomy. A Significant Change MDS dated [DATE] indicated that Resident 4 had an indwelling, suprapubic catheter and no external catheter or colostomy. Physician orders included but were not limited to: Change suprapubic catheter drainage bag weekly and PRN (As Needed) dated 3/27/2024. Change catheter as needed (occlusion, dislodgement, possible infection, etc.) as needed for catheter use dated 10/10/2023. During an interview on 7/10/24 at 9:47 A.M., the MDS nurse indicated the MDS was wrong for Resident 4 and needed to be corrected. During an interview on 7/15/24 at 11:40 A.M., the Regional Support Person indicated the facility would follow the RAI (Resident Assessment Instrument) and may have a policy for the accuracy of MDS. A current, nondated policy Conducting an Accurate Resident Assessment. The policy indicated .an assurance that all residents receive and accurate assessment, reflective of the resident's status at the time of the assessment .qualified staff who knowledgeable about thee resident will conduct and accurate assessment addressing each resident's status, needs, strengths, and areas of decline .information provided by the initial comprehensive assessment establishes baseline data the ongoing assessment of resident progress.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on observation, record review, and interview, the facility failed to implement physician orders or develop care plans for 3 of 5 resident's reviewed for unnecessary medications. (Resident 4, Resident 9, Resident 15) Findings include: 1. On 7/10/24 at 8:31 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder, anxiety state, unspecified, chronic pain, essential primary hypertension and osteoarthritis. The current Quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated Resident 4 was cognitively intact and was dependent on transfer, eating, and mobility. During the 7 days look back period the resident was noted to be on the following types of medications: Antidepressant, Antianxiety, Antipsychotc, Opioid, and Diuretic. Current physician orders included: Norco Oral Tablet 7.5-325 MG (Milligrams) (Hydrocodone-Acetaminophen)(pain medication).Give 1 tablet by mouth every 6 hours as needed for Pain related to PRIMARY GENERALIZED (OSTEO)ARTHRITIS dated 4/8/24. Pain monitoring q(every) shift, record any interventions (Pharmacological and Non-pharmacological every shift related to OTHER CHRONIC PAIN dated 1/1/24. ClonazePAM Tablet 0.5 MG (Anti-Anxiety Medication).Give 1 tablet by mouth two times a day related to ANXIETY DISORDER, UNSPECIFIED dated 10/10/2023. Monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications-drowsiness, morning, hang over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence every shift related to ANXIETY DISORDER, UNSPECIFIED dated 10/11/23 Dyazide Oral Capsule 37.5-25 MG (Triamterene and Hydrochlorothiazide)(Diuretic). Give 1 capsule by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION dated 5/27/24. Monitor for S/S (Signs and Symptoms) of electrolyte imbalance related to diuretic use Q shift. Document and notify MD of Irregular Heartbeat, increased heart rate, fatigue, lethargy, convulsions/seizures, N/V/D(Nausea/Vomiting/Diarrhea), Constipation, muscle/abdominal cramping, confusion, headache every shift for Dyazide medication therapy related to ESSENTIAL (PRIMARY) HYPERTENSION dated 1/2/2024. Sertraline HCl Tablet 100 MG (Antidepressant).Give 200 mg by mouth one time a day for depression related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE dated 10/11/23. (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Trazodone HCL Oral Tablet 200 MG (Antidepressant). Give 1 tablet at bedtime related to MAJOR DEPRESSIVE , RECURRENT, MODERATE dated 10/10/23. Monitor for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain every shift related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE dated 10/11/23. Risperidone Tablet 1 MG (Antipsychotic).Give 2 tablets by mouth two times a day related to MAJOR DEPRESSIVE DISORDER; RECURRENT, MODERATE,UNSPECIFIED MOOD [AFFECTIVE] DISORDER dated 10/10/23. Monitor for side effects and report to physician: Antipsychotic medication-sedation, drowsiness, dry mouth, constipation, blurred vision, EPS (Extrapyramidal Symptoms), weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention every shift related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE dated 10/11/23. The current care plan indicated that the resident has a potential for drug related complications associated with the use of antidepressant, antianxiety, and antipsychotic medications. Interventions included, but were not related to, Monitor for side effects and report to physician: Antipsychotic medication-sedation, drowsiness, dry mouth, constipation, blurred vision, EPS (Extrapyramidal Symptoms), weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention, Monitor for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain, Monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications-drowsiness, morning, hang over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss dated 10/12/23 The resident takes hypertension medication and will remain free of complications. Interventions include Monitor for S/S (Signs and Symptoms) of electrolyte imbalance related to diuretic use Q shift. Document and notify MD of Irregular Heartbeat, increased heart rate, fatigue, lethargy, convulsions/seizures, N/V/D(Nausea/Vomiting/Diarrhea), Constipation, muscle/abdominal cramping, confusion, headache dated 10/20/23. The resident is at risk for pain related to osteoarthritis and adequate pain level will be maintained date 10/20/23. Interventions included but were not limited to administering pain medications as ordered and utilize pain monitoring tool to evaluate effectiveness of interventions dated 10/20/23. On 7/11/24 at 2:10 P.M ., the June MAR (Medication Administration Record) and TAR (Treatment Administration Record) was reviewed, and the following dates and shifts lacked documentation: MAR AND TAR reviewed for June 2024 indicated: Lacked documentation for antianxiety interventions evenings 6/8/34 (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lacked documentation for electrolyte imbalance interventions evenings-6/8/24 Lacked documentation for antipsychotic interventions evenings-6/8/24 Lacked documentation for antidepressant interventions evenings 6/8/24 Lacked documentation of pain monitoring interventions evenings 6/8/24 and 6/9/24 TAR and MAR for April 2024 Lacked pain monitoring q shift interventions days 4/5/24 and 4/19/24 evenings 4/6 4/10 days 4/8 4/18 Lacked monitoring for electrolyte monitoring interventions even 4/6 night 4/5 4/19 days 4/8, 4/10 4/15 Lacked monitoring documentation for antianxiety interventions evenings 4/6/24 nights 4/6/24 and 4/19/24 days 4/8/24, 4/10/24 and 4/15/24 Lacked monitoring documentation for antidepressant interventions nights- 4/5/24 and 4/19/24 evening- 4/6/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155390	A. Building B. Wing	07/15/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days- 4/8/24, 4/10/24, and 4/15 /24 Lacked monitoring documentation for antipsychotic interventions nights- 4/5/24 and 4/19/24 evening -4/624 days- 4/8/24, 4/10/24, and 4/15/24 MAY MAR AND TAR Lacked documentation of monitoring for electrolytes interventions days 5/2/24 nights 5/1024 Lacked documentation of antianxiety interventions days 5/2/24 nights 5/10/24 Lacked documentation of antidepressant interventions days- 5/2/24 nights- 5/10/24 Lacked documentation of antipsychotic interventions days 5/2 nights 5/10 Duplicate pain monitoring days 5/2/10 nights 5/10/24 During an interview on 7/11/24 at 2:05 P.M., the DON (Director of Nursing) indicated if there is a refusal or reason the medication was not given should be documented in the progress notes. 2. On 7/11/24 at 9:27 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to non-specified dementia, unspecified severity, with other behavioral disturbance, generalized anxiety order, bipolar disorder, and major depressive disorder, recurrent. (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current Quarterly MDS assessment dated [DATE] indicated Resident 9 was cognitively impaired and needed supervision with eating, dressing, toileting, and transferring. During the 7 days look back period the resident was on the following types of medication antipsychotic, antianxiety, antidepressant, and opioid. No behaviors were exhibited during this time. Current physician orders included but not limited to: Diazepam Oral Tablet 5 MG (Milligrams) (Diazepam) (antianxiety).Give 1 tablet by mouth three times a day related to GENERALIZED ANXIETY DISORDER,BIPOLAR DISORDER, UNSPECIFIED dated 4/22/2024. Monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications-drowsiness, morning, hang over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence every shift for Diazepam related to GENERALIZED ANXIETY DISORDER dated 3/9/2024. Risperdal Oral Tablet 3 MG (Risperidone)(Antipsychotic).Give 1 tablet by mouth in the morning related to UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCE dated 4/15/2024 Risperdal Oral Tablet 2 MG (Risperidone)(Antipsychotic). Give 1 tablet by mouth in the evening related to UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCE dated 4/15/2024. Monitor for side effects and report to physician: Antipsychotic medication-sedation, drowsiness, dry mouth, constipation, blurred vision, EPS, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention every shift for side effect monitoring for antipsychotic dated 7/31/23. Zoloft Oral Tablet 100 MG (Sertraline HCl)(Antidepressant).Give 200 mg by mouth one time a day related to BIPOLAR DISORDER, UNSPECIFIED.MAJOR DEPRESSIVE DISORDER, RECURRENT, MILD dated 2/4/2024. Monitor for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain every shift related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MILD dated 3/9/24. Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen)(Pain medication).Give 1 tablet by mouth two times a day for Pain dated 7/27/2023. Rivastigmine Transdermal Patch 24 Hour 13.3 MG/24HR (Rivastigmine).Apply 1 patch transdermal in the morning related to UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCE and remove per schedule dated 7/3/24. Namenda Oral Tablet 10 MG (Memantine HCl)(Dementia).Give 1 tablet by mouth two times a day related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, MILD, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY dated 2/8/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155390	A. Building B. Wing	07/15/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behavior monitoring for: UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCE Interventions: 1-1 on 1, 2-Activity, 3-Adjust room temperature, 4-Backrub, 5-Change position, 6-Give fluids, 7-Give food, 8-Redirect, 9-Refer to nurse's notes, 10-Remove resident from environment, 11-Return to room, 12-Toilet, 13-Other: Outcomes: I(Improved), S(Same), W(Worsened) every day and night shift dated 7/6/24. The current care plan indicated the resident take any psychotropic, antianxiety, and antidepressant medications and is at risk for side effects. Interventions included, but not limited to, observe for side effects and report to physician: Anti-anxiety/Hypnotic medications drowsiness, morning, hang over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence dated 12/13/2022. Observe for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain dated 12/13/22. Observe for side effects and report to physician: Antipsychotic medication-sedation, drowsiness, dry mouth, constipation, blurred vision, EPS, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention dated 12/13/22. There is a current care plan indicated the resident has impaired cognitive function, dementia or impaired thought process related to dementia. Interventions include but not limited to administer medications as ordered dated 12/13/22. On 7/11/24 at 2:00 P.M., the MAR (Medication Administration Record) and TAR (Treatment Administration Record) was reviewed Rivastigmine Transdermal Patch used for Dementia was not administered on 6/3/24, 6/4/24, 6/5/24, 6/9/24, and 6/22/23 for administration and removal was administered on 6/28/24 but not removed at 6:30 P.M. on 6/29/24 there was no reason for not administration noted in progress notes. Diazepam 5 mg not given on 6/7/24 at 2:30 P.M ,6/22/24 at 6:00 A.M. and 6/29/24 at 2:30 P.M. there was no reason for not giving in the progress notes. Lack documentation to monitor for side effects 6/8/24 evening shift- antianxiety, antidepressant, antipsychotic and mood stabilizer. Lacked documentation to monitor for side effects of mood stabilizer for 6/9/24 evening shift. During an interview on 7/11/24 a 11:27 P.M., RN (Registered Nurse) indicated there has to be some indication why the medication was not given. During an interview on 7/15/24 at 12:10 P.M., the Regional Support Person indicated the facility did not have policy for following physician order but would follow the physician written orders. 48147 (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 7/11/24 at 10:13 A.M., Resident 15's clinical record was reviewed. Diagnosis included, but was not limited to, nonrheumatic aortic valve stenosis. The most current Annual Minimum Data Set (MDS) Assessment, dated 6/3/24, indicated Resident 15 was cognitively intact, required supervision for eating, and received an antiplatelet medication during the 7-day look back period. Current physician orders included, but were not limited to: Aspirin (an antiplatelet medication) 81 mg (milligrams) Oral Tablet Delayed Release - Give 81 mg by mouth one time a day, dated 2/8/24 The clinical record lacked an order to monitor for side effects for an antiplatelet medication including bleeding. The clinical record lacked a care plan for an antiplatelet medication or bleeding. On 7/12/24 at 2:30 P.M., the Director of Nursing (DON) indicated monitoring for side effects of an antiplatelet medication would be in the orders. On 7/15/24 at 8:44 A.M., the MDS Coordinator indicated care plans would include a care plan for antiplatelets or to monitor for bleeding if the resident received an antiplatelet. On 7/15/24 at 10:50 A.M., the Administrator provided a Comprehensive Care Plans policy, dated 2023, that indicated The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 3.1-35(a) 3.1-35(b)(1)

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	155390	A. Building B. Wing	07/15/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48147 Based on observation, interview, and record review, the facility failed to ensure medication was being properly administered for 1 of 1 random observations of insulin administration. (Resident 25) Finding includes: On 7/10/24 at 12:06 P.M., Registered Nurse (RN) 3 was observed preparing a Humalog Insulin Kwikpen for insulin administration for Resident 25. An AccuCheck (blood glucose test) indicated the resident had a blood sugar of 200. RN 3 indicated the resident received sliding scale insulin and was to receive 4 units of insulin lispro (a fast acting insulin) for a blood glucose reading of 200. RN 3 set the insulin pen to 6 units and indicated the resident got 4 units of insulin plus 2 units of insulin to prime the pen. She cleaned the tip of the pen, attached the needle, and administered 6 units of insulin to Resident 25 in her left arm. On 7/12/24 at 11:51 A.M., Licensed Practical Nurse (LPN) 6 indicated insulin pens do not have to be primed and she had never primed an insulin pen before. On 7/12/24 at 1:46 P.M., the Humalog Kwikpen user manual was reviewed. It indicated Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 8 times. If you still do not see insulin, change the needle and repeat priming steps 6 to 8. On 7/12/24 at 2:30 P.M. the Director of Nursing (DON) indicated that an insulin pen should be primed with 2 units before administration of the required insulin dose. On 7/12/24 at 12:46 P.M., the Administrator provided an Insulin Pen policy, dated 2024, that indicated Prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. 3.1-35(g)(1)

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	155390	A. Building B. Wing	07/15/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on observation, record review, and interview, the facility failed to provide timely showers for 4 of 4 dependent residents reviewed for ADL (Activities of Daily Living (Resident 4, Resident 2, Resident 13, and Resident 7) Findings include: 1. On 7/10/24 at 8:31 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy and flaccid neuropathic bladder, not elsewhere specified. The current Quarterly MDS (Minimum Data Set) assessment dated [DATE]. The MDS indicated Resident 4 was cognitively intact and was dependent on transfer, mobility, eating, and hygiene. Physician orders included but not limited Weekly skin review on Saturdays on Day Shift dated 10/11/23 Showers are scheduled for Wednesday and Saturday and the day shift is 7-3 P.M. The current care plan indicated that Resident 4 has a self-care deficit related to primary diagnosis of cerebral palsy. Interventions included bathing assistance of dependent dated 10/20/23. The current care plan also indicated Resident 4 has incidents of being uncooperative/refusal of showers dated 5/6/24. Interventions included but are not limited to explaining all risks of not cooperating with care in simple terms and offer bed bath when showers refused dated 5/6/24. During an interview on 7/9/24 at 10:22 A.M., Resident 4 indicated that showers were not given on shower days of Wednesday and Saturday. On 7/12/24 at 9:00 A.M., the Administrator provided showers recorded from the Task Charting in the facility charting program that the CNA(Certified Nurse Aide) do when care is provided from January 2024 until July 2024 Showers dates missed: 2/7/24- Wednesday no shower 3/6/24 Wednesday no shower 3/27/24 Wednesday no shower 4/24/24 Wednesday no shower 6/12/24 Wednesday no shower 6/22/24 Saturday no shower (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/11/24 at 9:19 A.M., CNA 7 indicated Resident 7 will refuse a lot but should be encouraged to take and will offer alternative. 48057 2. On 7/11/24 at 10:13 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease, hypertension, and dementia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/3/24, indicated Resident 13 was cognitively intact and required moderate assistance from staff for toileting and bathing. A physical functioning deficit care plan, dated 7/1/22, indicated Resident 13 had self-care impairment and required substantial assistance of one staff for bathing. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated the Resident received showers on Tuesdays and Fridays. Resident 13 did not receive or refuse a shower on the following days in 2024: January 2, 12, 26 May 24, 31 June 14, 18, 24 3. On 7/12/24 at 8:52 A.M., Resident 2's clinical record was reviewed. Resident 2's diagnoses included, but were not limited to, dementia, weakness, and intellectual disabilities. The most recent Quarterly MDS (Minimum Data Set Assessment, dated 6/3/24, indicated Resident 2 was severely cognitively impaired, required substantial assistance of staff with toileting and transfers, and was dependent on staff for bathing. A physical functioning deficit care plan, dated 4/27/17, indicated Resident 2 had self-care impairment and required total assistance of one staff for bathing. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated the Resident received showers on Wednesdays and Saturdays. Resident 2 did not receive or refuse a shower on the following days in 2024: January 31 February 3, 7, 17, 28 March 2, 6, 20 May 4, 25 June 1, 8 (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	July 6 48147 4. On 7/9/24 at 9:44 A.M., Resident 6 indicated she was supposed to get her showers on Wednesdays and Saturdays but hadn't received a shower for the past 2 weeks. On 7/9/24 at 2:58 P.M., Resident 6's clinical record was reviewed. Diagnosis included, but was not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 6/21/24, indicated Resident 6 was cognitively intact, was dependent on staff for bathing, and had no rejection of care during the 7-day look back period. A Preference Evaluation, dated 6/25/24, indicated Resident 6 preferred showers at any time of the day. An Activities of Daily Living (ADL) care plan, dated 12/20/22, indicated Resident 6 had a self-care deficit and was dependent on one staff for bathing assistance. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated the Resident received showers on Wednesdays and Saturdays. Resident 6 did not receive or refuse a shower on the following days in 2024: January 3, 6, 10, 20, 27 February 10, 14, 17, 24 May 4, 25 June 1, 5, 22, 26 On 7/10/24 at 9:51 A.M., the Administrator indicated the facility did not use shower sheets. If a resident refused a shower, it was documented in POC Tasks. On 7/15/24 at 8:53 A.M., the Administrator provided a Resident Rights policy, dated 2024, that indicated The resident has .the right to receive the services and/or items included in the plan of care. 3.1-38(a)(3)(B)

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	155390	A. Building B. Wing	07/15/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview, and record review, the facility failed to ensure residents who required restorative services received services in their plan of care for 3 of 4 residents reviewed for restorative nursing. (Resident 2, Resident 7, Resident 13) Findings include: 1. On 7/12/24 at 8:52 A.M., Resident 2's clinical record was reviewed. Resident 2's diagnoses included, but were not limited to, dementia, weakness, and intellectual disabilities. The most recent Quarterly MDS (Minimum Data Set Assessment), dated 6/3/24, indicated resident 2 was severely cognitively impaired, required substantial assistance of staff with toileting and transfers, and was dependent on staff for bathing. Care plans included, but were not limited to: Nursing rehab/restorative AROM (active range of motion) program: AROM to BLE (bilateral lower extremities), hips, knees, and ankles, 20 reps 1-2 sets daily; date initiated 9/13/22. On 7/12/24 at 12:14 p.m., the Administrator provided restorative nursing minutes documented in the clinical record for Resident 2. The following dates were documented with no restorative active range of motion provided in 2024: January 3, 5, 26 February 4 March 10, 17, 23 April 3, 5, 7, 26, 29 May 4, 6, 9, 10, 14, 16, 18, 19, 21, 25, 26 June 1, 8, 11, 13, 14, 20, 25, 28, 29 July 5, 6, 7, 8, 9, 11 2. On 07/11/24 at 9:08 A.M., Resident 7's clinical record was reviewed. Resident 7 was admitted on [DATE]. Diagnoses included, but were not limited to, Parkinson's disease and dementia. The most recent Annual MDS (Minimum Data Set) Assessment, dated 5/31/24, indicated Resident 7 was cognitively intact, required moderate assistance from staff for bathing, and required supervision of staff for eating, toileting, and transfers. (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plans included, but were not limited to: I will perform (1) set of (20) reps of AROM (active range of motion) to (BLE) extremities daily; date Initiated: 5/1/23. On 7/12/24 at 12:14 p.m., the Administrator provided restorative nursing minutes documented in the clinical record for Resident 7. The following dates were documented with no restorative active range of motion provided in 2024: January 5, 7, 10, 12, 14, 16, 18, 29, 30 February 1, 5, 8, 13, 15, 16, 24, 25 March 2, 5, 9, 14, 23 April 3, 6, 7, 26, 30 May 5, 6, 15, 25, 26, 28, 31 June 8, 28, 29, 30 July 1, 3, 6, 8, 11 3. On 7/11/24 at 10:13 A.M., Resident 13's clinical record was reviewed. Resident 13 was admitted on [DATE]. Diagnoses included, but were not limited to, end stage renal disease, hypertension, and dementia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/3/24, indicated Resident 13 was cognitively intact, required moderate assistance from staff for toileting and bathing, and was receiving hemodialysis. Current care plans included, but were not limited to: Nursing rehab/restorative AROM (active range of motion) program: AROM seated AROM of BUE/BLE (bilateral upper and lower extremities) 20 reps 6 days a week; date initiated 3/13/24. On 7/12/24 at 12:14 p.m., the Administrator provided restorative nursing minutes documented in the clinical record for Resident 13. The following dates were documented with no restorative active range of motion provided in 2024: April 1, 2, 3, 4, 5, 6, 7, 8, 26, 27, 28, 29 May 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 28, 29, 30 June 20, 21, 24, 25, 26, 29, 30 July 5, 6, 7, 8, 9, 11 (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/24 at 2:45 P.M., Occupational Therapist 10 indicated it is a nursing staff task to perform restorative therapy and provided active range of motion exercises. On 7/15/24 at 8:53 A.M. the Administrator provided a policy titled Restorative Nursing Program, dated 2023, that indicated The restorative nurse is responsible for maintaining a current list of residents who require restorative nursing services, and for ensuring that all elements of each resident's program are implemented. 3.1-42(a)(2)

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	155390	A. Building B. Wing	07/15/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48147 Based on interview and record review, the facility failed to reduce the risk of falling for 1 of 3 residents reviewed for falls. Falls were not accurately documented, and the care plan was not updated with new interventions for a resident with multiple falls. (Resident 6) Finding includes: On 7/9/24 at 9:49 A.M., Resident 6 indicated she had recently fallen and broken her nose because she could not reach her call light. On 7/9/24 at 2:58 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and history of falling. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 6/21/24, indicated Resident 6 was cognitively intact, was dependent on staff for transfers, and had 1 fall with major injury since the previous assessment. A Fall Risk Assessment, dated 6/11/24, indicated the resident was at risk for falls. A falls care plan, dated 12/20/22, indicated the resident was at risk for falls due to deconditioning, gait/balance problems, incontinence, poor safety awareness, psychotropic drug use, hearing problems, and clutter in room, and included an intervention for the call light to be within reach. A Post Fall Evaluation, dated 7/20/23 at 5:57 A.M., indicated Resident 6 had an unwitnessed fall while reaching for an item in her room. An Interdisciplinary Team (IDT) Note, dated 7/20/23 at 12:51 P.M., indicated staff were to lay clothes out for the resident the night before to prevent reaching. The care plan was not updated with a new intervention. A nurse's progress note, dated 8/14/23 at 11:54 P.M., indicated Resident 6 was complaining of persistent stiffness and soreness following recent incident where resident was lowered to the floor by staff. The doctor was notified, and new orders were received for ibuprofen (a pain reliever) 800 mg (Milligrams), 1 tablet by mouth two times a day for inflammation. The clinical record lacked a post fall evaluation, IDT note, progress note, follow up, or updated care plan related to this fall. A Post Fall Evaluation, dated 9/3/23 at 7:43 P.M., indicated Resident 6 had an unwitnessed fall while reaching for an item in her room. Room ergonomics was added to the care plan on 9/5/23. A Post Fall Evaluation, dated 9/5/23 at 2:52 A.M., contained a physical assessment with vitals, but had no other details regarding the fall. The clinical record lacked an IDT note, progress note, follow up, or updated care plan related to this fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155390	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Woodbridge Care Center	816 N First Ave Evansville, IN 47710

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's progress note, dated 1/12/24 at 7:36 A.M., indicated that a 2nd shift CNA (Certified Nurse Aide) dropped the resident while putting her to bed the previous evening. An IDT Note, dated 1/15/24 at 5:14 P.M., indicated the fall happened on 1/12/24 at 9:00 A.M. The IDT Note indicated staff were educated on safe and proper transferring of the resident. The care plan was not updated with a new intervention. A Change of Condition note, dated 6/11/24 at 10:10 P.M., indicated Resident 6 had an unwitnessed fall while waiting for staff to assist her into bed. The resident sustained a laceration to the bridge of her nose and it was evident resident had suffered head trauma and required immediate assistance. The on-call Nurse Practitioner (NP) was notified, and the resident was sent to the emergency room (ER) for evaluation and treatment. An IDT note, dated 6/12/24 at 10:18 A.M., indicated the resident returned to the facility with Dermabond (a liquid skin adhesive) for closure of laceration to the bridge of the resident's nose and a fracture to the tip of the nose. Resident indicated to the Administrator during an interview that she fell because she was not able to reach her call light. Staff educated to keep call light within reach was added to the care plan on 6/12/24. A nurse's progress note, dated 6/13/24 at 12:38 P.M., indicated an inservice was provided to staff members for proper call light placement. On 7/12/24 at 12:13 P.M., a handwritten post it note from the Administrator indicated [Resident 6] 1-12-24 was staff assisted to the floor. A Post Fall Evaluation for the fall on 1/12/24 was not provided. On 7/12/24 at 2:30 P.M., the Administrator indicated that an intervention got added to the care plan every time a resident fell . On 7/15/24 at 8:44 A.M., the MDS Coordinator indicated every time a resident fell , an intervention was added to the care plan after the IDT met. The IDT met every morning where new falls were discussed. If education was provided to the staff or resident, that got added to the care plan, too. On 7/15/24 at 8:53 A.M., the Regional Support indicated she could not find any documentation about the resident's fall on 8/14/23 and was not sure about the circumstances surrounding that progress note. At that time, she indicated that the resident did not fall on 9/5/23 and that the nurse must have opened a new event and forgotten that the Post Fall Evaluation was triggered automatically after a resident fell . On 7/15/24 at 8:53 A.M., the Administrator provided a Care Plan Revisions Upon Status Change policy, dated 2023, that indicated The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change . The care plan will be updated with the new or modified interventions. On 7/15/24 at 8:53 A.M., the Administrator provided an Accidents and Supervision policy, dated 2023, that indicated Fall refers to unintentionally coming to rest on the ground, floor, or other lower level . Both the facility-centered and resident-directed approaches include evaluation hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk . implementation of interventions - using specific interventions to try and reduce a resident's risk from hazards in the environment. The process includes . documenting interventions . ensuring that the interventions are put into action. (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-45(a)(2)

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	155390	A. Building B. Wing	07/15/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on record review and interview, the facility failed to follow physician orders and implement plan of care relating to dialysis services for 1 of 1 resident's reviewed for hemodialysis. (Resident 13) Finding includes: On 7/11/24 at 10:13 A.M., Resident 13's clinical record was reviewed. Resident 13 was admitted on [DATE]. Diagnoses included, but were not limited to, end stage renal disease, hypertension, and dementia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/3/24, indicated Resident 13 was cognitively intact, required moderate assistance from staff for toileting and bathing, and was receiving hemodialysis. Current physician orders included, but were not limited to: Obtain weight after dialysis treatments one time a day every Monday, Wednesday, Friday; start date 6/21/24. Monitor left upper extremity for (signs and symptoms) of infection. Every day and night shift for fistula; start date 6/5/24. Dialysis diet, Regular texture; start date 5/27/24. Current care plans included, but were not limited to: Alterations in kidney function due to end stage rental disease; date initiated 8/22/22. Do not take blood pressure, blood samples, or insert IV in arm with access site; date initiated 8/22/22. Resident is on a dialysis diet; date initiated 7/15/22. Monitor weight per MD order; date initiated 7/15/22. During an interview on 7/12/24 at 11:04 A.M. LPN 14 indicated Resident 13 had a new fistula placed in the left upper extremity on 6/4/24. On 7/12/24 at 12:14 P.M., the Regional Support Consultant provided Resident 13's documented blood pressure readings. The following dates/times indicated staff obtained a blood pressure reading in Resident 13's restricted limb (left upper arm) since her fistula placement in June 2024: 6/5/24 10:07 A.M. (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/8/24 9:15 A.M. 6/13/24 9:09 A.M. 6/14/24 4:32 P.M. 6/14/24 5:30 P.M. 6/15/24 9:02 P.M. 6/20/24 3:20 P.M. 6/27/24 3:23 P.M. 6/29/24 5:59 P.M. 7/3/24 1:57 P.M. 7/4/24 10:44 P.M. 7/5/24 2:59 P.M. 7/6/24 1:44 A.M. 7/6/24 9:11 P.M. On 7/12/24 at 12:14 P.M., the Regional Support Consultant provided Resident 13's recorded weights. The following dates/times indicated staff failed to record a weight when Resident 13 returned from dialysis in the past month: 6/21/24 6/24/24 6/28/24 7/1/24 7/3/24 7/5/24 7/10/24 7/12/24 (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/24 at 10:50 A.M., the Administrator provided a policy titled Comprehensive Care Plans, dated 2023, that indicated The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. During an interview on 7/15/24 at 12:10 P.M., the Regional Support Consultant indicated the facility did not have policy for following physician order but indicated physician orders should be followed as written. 3.1-37(a)

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	155390	A. Building B. Wing	07/15/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46758 Based on observation, record review, and interview, the facility failed to ensure that food was served at palatable temperatures for 1 of 1 meal tray tested for food temperature. Findings include: On 7/10/24 at 12:09 P.M., a meal test tray was obtained on the 200 Unit Hall the following temperatures were obtained: chicken thigh- 126.5 degrees F (Fahrenheit) potato -125.5 degrees F cottage cheese 48.2 degrees F desert chocolate eclair pudding- 67.5 degrees F salad 53.6-degrees F During an interview on 7/8/24 at 11:21 A.M., Resident 15 indicated the food is cold. During an interview on 7/9/24 9:43 A.M., Resident 6 indicated the food is not always hot. The CNA's (Certified Nurse Aide) won't serve food right away. During an interview on 7/9/24 at 11:35 A.M., the Dietary Manager indicated the temperature for meats and vegetables should be greater than 165 degrees Fahrenheit and cold items should be less than 41 degrees Fahrenheit. On 7/15/24 at 8:55 A.M., the Administrator provided a current, nondated policy Record of Food Temperatures. The policy indicated .hot foods will be held at 135 degrees Fahrenheit or greater and . cold food temperatures will be kept at or below 41 degrees Fahrenheit. 3.1-21(a)(2)

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	155390	A. Building B. Wing	07/15/2024

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on observation, interview, and record review, the facility failed to ensure safe storage of foods brought in externally for 1 of 1 residents reviewed for resident refrigerators. (Resident 8) Findings include: During an observation on 7/9/24 at 9:39 A.M., Resident 8's refridgerator had two blank temperature logs, dated June 2024 and July 2024, taped to the outside door of the refrigerator; no temperatures were recorded. On 7/10/24 at 10:39 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on [DATE]. Current diagnoses included, but were not limited to, quadriplegia and contracture of muscle/joint. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/22/24, indicated Resident 8 was cognitively intact, and was fully dependent on staff for eating, toileting, bathing, and transfers. During an interview on 7/12/24 at 11:04 A.M., LPN 14 indicated each morning when staff do rounds to check on resident's, they record the temperature of resident room refrigerators on the paper on the outside of the refrigerator. On 7/12/24 at 12:45 P.M., the Regional Support Consultant provided a policy titled Resident Refrigerators, dated 2024, that indicated It is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators. Dormitory-sized refrigerators are allowed in a resident's room under the following conditions: The refrigerator is inspected and deemed safe prior to use and upon routine inspections. The refrigerator maintains proper temperature.

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	155390	A. Building B. Wing	07/15/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on observation, interview, and record review, the facility failed to ensure that documentation was completed entirely or accurately for 2 of 3 residents reviewed for wounds and 1 of 5 residents reviewed for unnecessary medications. Duplicate medication order was entered, therapeutic leaves were not tracked, and documented skin assessments were not completed accurately. (Resident 15, Resident 8, and Resident 26) Findings include: 1. On 7/11/24 at 10:13 A.M., Resident 15's clinical record was reviewed. Diagnosis included, but was not limited to, major depressive disorder. The most current Annual Minimum Data Set (MDS) Assessment, dated 6/3/24, indicated Resident 15 was cognitively intact, required supervision for eating, and received an antidepressant medication during the 7-day look back period. Current physician orders included, but were not limited to: Sertraline (an antidepressant medication) Oral Capsule 150 mg (milligrams) - Give 1 capsule by mouth at bedtime related major depressive disorder, dated 1/28/24. Sertraline 100 mg Tablet - Give 1 tablet by mouth at bedtime related to major depressive disorder. Give with 50mg to equal 150mg, dated 7/4/24. A medication administration note, dated 7/9/24 at 7:45 P.M., indicated the order dated 7/4/24 was a duplicate order, and the resident received one tablet of 100 mg sertraline and one tablet of 50 mg sertraline. A Medication Administration note, dated 7/10/24 at 7:51 P.M., indicated the order dated 7/4/24 was a duplicate order. The July MAR (Medication Administration Record) indicated the resident received medication from both orders on 7/7/24. On 7/12/24 at 9:25 A.M., the Regional Nurse provided a medication packet with Resident 15's name on it from the pharmacy that contained one 100 mg tablet of sertraline and one 50 mg tablet of sertraline. She indicated that the order was a transcription error and not a medication error. The orders were supposed to reflect that the resident was receiving a 100 mg tablet and a 50 mg tablet because that was how the pharmacy dispensed it. She indicated a nurse tried to fix the order by creating two orders, but made the order more confusing. She indicated she would correct the orders immediately. 48057 (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 7/10/24 at 10:39 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on [DATE]. Current diagnoses included, but were not limited to, quadriplegia, post traumatic seizures, COPD (chronic obstructive pulmonary disease), stage four (4) pressure ulcers, and contracture of muscle/joint. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/22/24, indicated Resident 8 was cognitively intact, and was fully dependent on staff for eating, toileting, bathing, and transfers. During an observation on 7/10/24 at 12:25 P.M., LPN 8 entered the exit door code and assisted Resident 8 outside. LPN 8 assisted Resident 8 with lunch on the outside patio, then went back into the building while resident 8 remained outside. During an interview on 7/12/24 at 11:04 A.M., LPN 14 indicated Resident 8 takes LOA (leave of absence) with family/friends almost daily and staff have to enter a code to let Resident 8 outside and back into the building but do not sign the LOA book for Resident 8 because Resident 8 usually verbally lets the nurse know when he is leaving. The clinical record lacked documentation each time Resident 8 left or returned from the building during therapeutic leaves. During an interview on 7/15/24 at 3:04 P.M., the Regional Support Consultant indicated Resident 8 did not have an evaluation for therapeutic LOA (leave of absence) and did not have a physician's order to go LOA. On 7/15/24 at 8:53 A.M., the Administrator provided a policy titled Therapeutic Leave, dated 2024, that indicated The nurse will obtain an order from the practitioner specifying approval for therapeutic leave. The facility will document in the medical records the resident's leave of absence, any medications sent with the resident, and any education given to the resident and/or representative prior to the leave. If a resident has not returned from therapeutic leave as expected, the facility will attempt to contact the resident and resident representative and document attempts in the medical record. 3. On 7/11/24 at 12:39 P.M., Resident 26's clinical record was reviewed. Resident 26 was admitted on [DATE]. Diagnoses included, but were not limited to, dementia and type 2 diabetes mellitus. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/3/24, indicated Resident 26 was cognitively impaired and required moderate assistance from staff for toileting, bathing, and transfers. A weekly skin review (assessment) completed on 6/10/24 by RN 9 indicated Resident 26's skin was intact and no alterations. A weekly skin review (assessment) completed on 6/17/24 by RN 9 indicated the only skin alteration Resident 26 currently had was a laceration to the chin. A physician's order for Mupirocin external ointment 2 % (antibacterial ointment) Apply to top of right foot topically three times a day for Abrasion for seven (7) Days, dated 6/10/24 through 6/17/24, was marked administered by RN 9 on 6/10/24, 6/12/24, 6/13/24, and 6/14/24. (continued on next page)

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	155390	A. Building B. Wing	07/15/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 2:15 P.M., RN 9 indicated she was unsure where wound on resident foot was, was unsure of what the treatment was, and would need to look at orders on computer. On 7/15/24 at 11:09 A.M., the Administrator provided a Documentation in Medical Record policy, dated 2024, that indicated Documentation shall be accurate, relevant, and complete . 3.1-50(a)(2)

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	155390	A. Building B. Wing	07/15/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48147 Based on observation, interview, and record review, the facility failed to ensure multi-resident use glucometers were cleaned according to manufacture instructions for 1 of 1 random observations. (100 unit) Finding includes: On 7/10/24 at 12:06 P.M., Registered Nurse (RN) 3 was observed cleaning a glucometer after acquiring a blood sugar from a resident. She wiped the machine with a Micro-kill Bleach wipe for 2 seconds and placed it in the medicine cart. On 7/11/24 at 12:58 P.M., Qualified Medication Aide (QMA) 4 indicated that to clean a glucometer you wipe the machine for 30 seconds using a bleach wipe and then let it air dry. On 7/15/24 at 9:53 A.M., the Infection Preventionist indicated that to clean a glucometer you wrap it in a bleach wipe for 3 minutes and place it in a water cup or on a paper towel so it became clean. On 7/11/24 at 10:15 A.M., the Administrator provided an EvenCare blood glucose monitoring system user's guide, dated 2022, that indicated Allow the surface of the meter or lancing device to remain wet at room temperature for the contact time listed on the wipe's directions for use. Wipe meter dry or allow to air dry. On 7/11/24 at 12:58 P.M., a Micro-kill Bleach Wipes user instructions were reviewed. It indicated A 30 second contact time is required to kill the bacteria and viruses on the label . Allow surface to air dry . On 7/15/24 at 8:53 A.M., the Administrator provided a Glucometer Disinfection policy, dated 2024, that indicated The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use . Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. 3.1-18(b)(1)

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	155390	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46758 Based on observation and interview, the facility failed to provide a safe and sanitary environment for residents, staff, and the public for 17 random observations on 5 of 6 days. Urine smells in unit hallways, conference rooms, common areas, stairwells.(100 Unit Hallway, 200 Unit Hallway, Basement Hallway, Conference Room, Stairwell off 100 Unit, Stairwell off 200 Unit) Findings include: 1. On 7/8/24 at 8:14 A.M., the smell of urine was observed in the 100 Unit Hallway. On 7/8/24 AT 8:15 A.M., the smell of urine was observed in the Stairwell off the 100 Unit Hallway. On 7/8/24 at 8:16 A.M., the smell of urine was observed in Basement Hallway. On 7/8/24 at 10:30 A.M., the smell of urine was observed in the 200 Unit Hallway and into the Common Area of the unit. 2. On 7/9/24 at 8:05 A.M., the smell of urine was observed in the 100 Unit Hallway. On 7/9/24 at 8:06 A.M., the smell of urine was observed in the Stairwell off the 100 Unit Hallway. On 7/9/24 at 8:17 A.M., the smell of urine was observed in Basement Hallway. On 7/9/24 at 10:30 A.M., the smell of urine was observed in the Basement Hallway. 3. On 7/11/24 at 8:10 A.M., the smell of urine was observed in the 100 Unit Hallway. On 7/11/24 at 8:11 A.M., the smell of urine was observed in the Stairwell off the 100 Unit Hallway. On 7/11/24 at 8:12 A.M., the smell of urine was observed in Basement Hallway. On 7/11/24 at 10:30 A.M., the smell of urine was observed in the 200 Unit Common Area. On 7/11/24 at 1:00 P.M., the smell of urine was observed in the 200 Unit Hallway. 4. On 7/12/24 at 10:04., the smell of urine was observed in the elevator going to the 200 Unit Hall. On 7/12/24 at 10:05 A.M., the smell of urine was observed in 200 Unit Hallway. On 7/12/24 at 10:23 A.M., the smell of urine was observed in 200 Unit Common Area. During an interview on 7/15/24 at 11:14 A.M., LPN (Licensed Practical Nurse) 8 indicated the facility should be free of smells. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155390	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Woodbridge Care Center	816 N First Ave Evansville, IN 47710

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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/15/24 at 8:54 A.M., the Administrator produced a current, nondated policy Safe and Homelike Environment. The policy indicated .the facility will provide a safe, clean . environment .housekeeping and maintenance services will be provided as necessary to maintain a sanitary,orderly, and comfortable environment .minimize odors by disposing of soiled linens promptly and reporting lingering odors . needing cleaning to Housekeeping Department. 3.1-19(f)