STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MERRILLVILLE CARE CENTER	8800 VIRGINIA PLACE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00393922, IN00393929, IN00394035, IN00397053, IN00399301, and IN00399676. Complaint IN00393922 - Substantiated. Federal/State deficiencies related to the allegations are cited at F693. Complaint IN00393929 - Substantiated. Federal/State deficiencies related to the allegations are cited at F925. Complaint IN00394035 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00397053 - Unsubstantiated due to lack of evidence. Complaint IN00399301 - Substantiated. Federal/State deficiencies related to the allegations are cited at F917. Complaint IN00399676 - Substantiated. Federal/State deficiencies related to the allegations are cited at F692. Survey dates: January 24, 26, 27, and 30, 2023 Facility number: 000253 Provider number: 155362 AIM number: 100266660 Census Bed Type: SNF/NF: 131 Total: 131	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Seip		02/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census Payor Type: Medicare: 6 Medicaid: 80 Other: 45 Total: 131 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/1/23.			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident who was a fall risk had a care-planned intervention in place related to a floor mat next to the bed for 1 of 3 residents reviewed for falls and fall risk interventions. (Resident M) Finding includes: Resident M was observed lying in bed on 1/24/23 at 11:51 a.m., 1/26/23 at 10:36 a.m., and 1/26/23 at 10:58 a.m. There was no floor mat next to the bed. Resident M's record was reviewed on 1/26/23 at 11:35 a.m. The diagnoses included, but were not limited to, dementia and repeated falls.	F 0689	F-689 Free of Accident Hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Staff immediately ensured that Resident M's floor mat was put back into place. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	02/28/2023

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	A Quarterly Minimum Data Set assessment, dated 12/16/22, indicated a severely impaired cognitive status, required extensive assistance of one for bed mobility, and limited assistance of one for transfers. Staff were required for stabilization for transfers and had no falls. A Care Plan, dated 10/6/21, indicated a she was a risk for falls. The interventions included a mat was to be placed on the floor next to the bed. During an interview on 1/26/23 at 12:09 p.m., CNA 3 indicated there was a Resident Care Sheet at the Nurses' Desk with interventions to be followed and there had not been a mat at the bedside. A Resident Care Sheet, received from CNA 3 as current on 1/26/23 at 12:15 p.m., indicated the resident was a two person mechanical lift for transfers and a floor mat was to be placed next to the bed. This Federal tag relates to Complaint IN00394035. 3.1- 45(a)(2)		All residents who are at high risk for falls have the potential to be affected. Residents at high risk for falls were reviewed and no adverse effects were noted. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: All staff were educated to ensure that resident fall interventions are in place in the resident's room. Audits will be completed on all residents to ensure their fall interventions are up to date and match what is in place in the resident room. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Rounding Managers (resident advocates)/ clinical staff /designee will audit 5 residents 3 times per week x 3 months, then 3 residents every other week x 1 month, then 3 residents monthly x 2 months. Audits will be completed during all 3 shifts and will include all units and the weekend. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a	

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			minimum of six months and until substantial compliance is achieved.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview the facility failed to ensure a resident who was a nutritional risk received a therapeutic diet as ordered related to fortified foods omitted from the diet for 1 of 3 residents reviewed for nutrition. (Resident M) Finding includes:	F 0692	F-692 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? was given the order for fortified foods for all meals for Resident M	02/28/2023

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	During an observation on 1/26/23 at 11:47 a.m., Resident M was sitting in a high back chair in the dining room. She received her lunch meal, which consisted of ground turkey and gravy, sweet potatoes, peas, and chocolate chip cookies. The tray card indicated a mechanical soft regular diet. The staff assisted her with her meal and she consumed 100% of the sweet potatoes, 90% of the turkey, and bites of the peas, then indicated she was through with her meal. Resident M's record was reviewed on 1/26/23 at 11:35 a.m. The diagnoses included, but were not limited to, dementia and mild protein calorie mal-nutrition. A Quarterly Minimum Data Set assessment, dated 12/16/22, indicated a severely impaired cognitive status, supervision of one staff for eating, and had no significant weight loss or gain. A Care Plan, dated 12/9/22, indicated a diet alteration due to dysphagia, was on a mechanically altered diet, had an underweight status, and was a risk for malnutrition. The interventions included a diet as ordered would be served. The weight in pounds on 6/1/22 was 103, on 7/7/22 was 100, 11/2/22 was 94, 12/7/22 was 95, and 1/3/23 was 95. A Registered Dietician's Nutritional Assessment, dated 12/9/22, indicated the ideal body weight was 95-116 pounds and the body mass index was less than 19 at 17.9 and she was underweight.. The calorie needs were 1440-1680 per day and she was consuming 51-100% of her mechanical soft diet. The estimated nutritional needs for gradual weight		and fortified foods at all meals was added to the tray ticket. Resident M is receiving fortified foods for all meals per MD orders. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Residents who are nutritionally at risk have the potential to be affected. Residents were audited to ensure that their orders for fortified foods match what is on the tray ticket. Residents whose tray tickets do not match will immediately have their tray ticket updated in the tray ticket system. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: A new system has been put in place, nursing will print out new orders and directly hand it to the kitchen to inform them of the diet change. Both nursing staff and kitchen staff were educated on the new communication system. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Dietary Director /designee will audit dietary orders and tray	

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	gain was desired and fortified foods at all meals to aid in weight status was recommended. The Physician's Orders included on 11/1/21 a regular mechanical soft diet and on 12/12/22 fortified foods were to be served with all meals. During an interview on 1/26/23 at 12:10 p.m., Nurse 2 indicated fortified foods were not listed on the tray card. The Dietary Manager indicated there were no fortified foods served to the resident. She indicated if it was not listed on the tray card, she would not have been served the fortified foods. She had not received the order for the fortified foods so the tray card had not been changed. This Federal tag relates to Complaint IN00399676. 3.1-46(a)(2)		tickets 5 times a week x 3 months, then 3 times a week x 3 months to ensure residents are receiving diets as ordered and fortified foods appear on the tray tickets. Audits will be completed during advocate rounds after every dietary shift and will include the weekend. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until substantial compliance is achieved.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and			

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	§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure a g-tube (feeding tube) was verified for placement per professional standards of practice prior to the administration of medication for 1 of 1 resident with a g-tube observed for placement verification. (Resident G and Nurse 1) Finding includes: During a Medication Administration Pass observation on 1/24/23 at 12:30 p.m., Nurse 1 prepared Resident G's medication. Nurse 1 then entered the resident's room and stopped the liquid feeding being infused. She then placed air into the g-tube with a syringe and used a stethoscope on the abdomen and listened for air in the abdomen as verification of placement of the feeding tube. The medication was then administered after the g-tube was flushed with water. During an interview on 1/26/23 at 1:36 p.m., Regional Nurse 2 indicated the verification of placement of the g-tube should have been completed by aspiration of the gastric content. A facility policy for validation of placement of a feeding tube, dated 2019 and received from the Director of Nursing as current, indicated the	F 0693	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident G was and no adverse effect related to incorrect feeding tube placement verification prior to administration of medications was noted. Nurse 1 was immediately educated on the correct procedure for verification of placement of feeding tubes. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with feeding tubes have the potential to be affected. Residents receiving medications per feeding tube were assessed and no adverse effects were noted. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:	02/28/2023

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	gastric content was to be aspirated for verification of the g-tube placement prior to the administration of medication. This Federal tag relates to Complaint IN00393922. 3.1-44(a)(2)		Nurse 1 was immediately educated on the correct procedure for verification of placement of feeding tubes. Licensed nursing staff were in- regarding following the correct procedure for verification of feeding tube placement prior to medication administration. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: DON /designee will randomly audit residents with feeding tubes 5 times a week x 3 months, then 3 times a week x 3 months to ensure placement of feeding tube is verified utilizing the correct procedure prior to medication administration. Audits will occur on all shifts and units and will include weekends. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until substantial compliance is achieved.	
F 0917 SS=E Bldg. 00	483.10(i)(4), 483.90(e)(2)(3) Resident Room Bed/Furniture/Closet §483.10(i)(4) Private closet space in each			

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	resident room, as specified in §483.90 (e)(2)(iv) §483.90(e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. §483.90(e)(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (e)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety.			
	Based on observation and record review, the facility failed to ensure each resident had adequate furniture in their rooms related to no regular chairs for residents and/or visitors to sit were observed in 36 of 64 rooms observed on 3 of 3 units. (Units B, C & D) Finding includes: During an observation on 1/24/23 from 9:38 a.m. through 10:10 a.m., there were no regular chairs for residents and/or visitors in rooms 2, 3, 5, 7, 9, 10, 12, 18, 20, 207, 210, 212, 219, 221, 223, 225, 227, 229,	F 0917	F-917 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Identified resident rooms were immediately brought additional seating. How other residents having the potential to be affected by the same deficient practice will be	02/28/2023

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	231, 303, 304, 306, 307, 308, 312, 313, 314, 320, 321, 323, 325, 329, 331, 332, 333, and 334. Resident R was interviewed on 1/24/23 at 9:42 a.m. and indicated when she had visitors, they had to sit on her bed. Resident S was interviewed on 1/24/23 at 9:48 a.m. and indicated when he had visitors, they either sat in his recliner, bed, or in his wheelchair. Resident O was interviewed on 1/26/23 at 10:15 a.m. and indicated he would like a chair in his room. When he had visitors, they had to ask for a chair. Resident P was interviewed on 1/26/23 at 10:20 a.m. and indicated when she had visitors come in, they either sat on the bed with her or in her wheelchair and she would like to have a regular chair in the room so her visitors would have somewhere to sit. Resident N was observed on 1/26/23 at 10:21 a.m. sitting in her wheelchair. She currently had a visitor in the room who was sitting on the heater in the room. Resident Q was interviewed on 1/26/23 at 10:48 a.m. and indicated he would like to have a chair in his room so his visitors would have somewhere to sit when they visited. During an interview on 1/27/23 at 9:50 a.m., the Administrator indicated the facility had chairs available for the resident rooms. The staff would remove the chairs or if the resident had more than one visitor, they would take the chairs out of another room and they would not be replaced/returned to that room.		identified and what corrective action(s) will be taken: All residents who reside in the facility have the potential to be affected. Rooms were audited to determine if the residents had sufficient seating for themselves and visitors. Residents who expressed that they did not have sufficient seating in their room were provided additional furniture. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: All staff were educated resident room guidelines. Additional chairs will be added to resident care areas to ensure adequate seating for residents and visitors. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Rounding Managers (resident advocates) /designee will audit 3 resident rooms 2 times per week x 2 months, then 3 resident rooms every other week x 1 month, then 3 resident rooms monthly x 3 months. Audits will be completed will include the weekend. Any negative trends will be reviewed in the monthly QAPI program.	

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	This Federal tag relates to Complaint IN000399301. 3.1-19(m)(4)(C)		Any concerns will be monitored through the QAPI process for a minimum of three months and until substantial compliance is achieved.	
F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, record review and interview, the facility failed to follow recommendations from the Pest Control company to assist with keeping bugs at a minimum, related to fruit flies and the cleaning of a drain and a sink for 1 of 1 kitchen, which provided food for 122 of 131 residents who resided in the facility. (Main Kitchen) Finding includes: During an observation on the D-Unit on 1/27/23 at 8:30 a.m., a fruit fly was seen flying around in the hallway outside the dining room. The Pest Control Proof of Service forms were reviewed on 1/27/23 at 8:45 a.m. and included the following information: On 10/27/22, there was debris accumulated in a floor drain of the kitchen, which could lead to a pest infestation. The action recommended was to	F 0925	F-925 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The kitchen floor drain was immediately cleaned, and plumber scheduled to address the drain's water retention. A cover was placed over the garbage disposal when not in use. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who reside in the facility have the potential to be affected. Kitchen staff will immediately inform the maintenance director of copious water retention in the kitchen drain. What measure will be put into place or what systemic	02/28/2023

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BRICKYARD HEALTHCARE - MERRILLVILLE CARE CENTER	8800 VIRGINIA PLACE MERRILLVILLE, IN 46410

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	clean and remove debris in the floor drain. On 11/2/22, there was an accumulation in a floor drain in the kitchen. The action recommended was to clean and remove debris in the floor drain to prevent possible pest infestation. The comments included, "Interior service completed follow up done for fruit fly activity in kitchen. Drains still hadn't been clean [sic] since last service. Drains had even more food debris accumulated. This should be added to routine cleaning weekly to ensure no accumulation of organic matter to prevent breeding zones for small flies...Proper cleaning is mandatory to keep small flies down to a minimum..." On 12/22/22, floor drains/troughs needed cleaned. The action recommended indicated the drains needed opened, scrubbed and treated with a bio-cleaner. Debris accumulated in the floor drain and needed to be cleaned to prevent a possible pest infestation. The Treatment Notes, dated 12/22/22, indicated preventative treatment was completed for fruit flies in the kitchen. The drain were starting to build up with debris. The drains were not being maintained properly. There was no live activity sighted at the time of service, but could start if the recommendations were not followed. The kitchen drains and sinks were observed on 1/27/23 at 9:30 a.m. There were small fruit flies observed flying above the prep sink. The Dietary Manager (DM) indicated at the time of the observation, the drain by the food prep sink accumulated debris. The DM lifted the lid from the drain next to the prep sink, there was a large accumulation of debris		changes will be made to ensure that the deficient practices does not recur: Kitchen staff were educated on their sanitation check list to ensure the kitchen drains are checked and cleaned in accordance with facility policy and outside service provider recommendations. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Administrator/ Dietary Director /designee will audit the kitchen 5 times a week x 3 months, then 3 times a week x 3 months. Audits will be completed during advocate rounds after every dietary shift and will include the weekend. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	in the drain. She indicated a chemical was to be used to flush the drain every night that assisted with keeping the drain clean. She was unable to acknowledge the drain had been flushed on 1/26/23. She indicated the system would get backed up and the debris would clog the drain and this had been happening, "for a while". She indicated this was why the prep sink was not being used. The prep sink was observed to not have a strainer or cover over the garbage disposal and a large amount of onion peels and other substances were observed in the disposal. During an observation on 1/27/23 at 9:36 a.m with the Administrator present, he acknowledged the large amount of accumulation of debris in the drain and the DM indicated the sink was used on 1/27/23 to cut up onions earlier in the morning. This Federal tag relates to Complaint IN00393929. 3.1-19(f)(4)			