

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2022  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2022
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for the Investigation of Complaint IN00375600 and IN00369364.</p> <p>Complaint IN00375600 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00369364 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency is cited at F888.</p> <p>Survey dates: March 28 and 29, 2022.</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Census Bed Type: SNF/NF: 125 Total: 125</p> <p>Census Payor Type: Medicare: 2 Medicaid: 94 Other: 29 Total: 125</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on 3/31/22.</p>	F 0000		
F 0888 SS=A Bldg. 00	<p>483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff</p> <p>§483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2022
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.</p> <p>§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:</p> <ul style="list-style-type: none"> <li>(i) Facility employees;</li> <li>(ii) Licensed practitioners;</li> <li>(iii) Students, trainees, and volunteers; and</li> <li>(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.</li> </ul> <p>§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:</p> <ul style="list-style-type: none"> <li>(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and</li> <li>(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.</li> </ul>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2022
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:</p> <p>(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;</p> <p>(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;</p> <p>(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;</p> <p>(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;</p> <p>(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;</p> <p>(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2022
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:</p> <p>(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and</p> <p>(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;</p> <p>(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and</p> <p>(x) Contingency plans for staff who are not fully vaccinated for COVID-19.</p> <p>Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2022
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on observation, record review, and interview, the facility failed to ensure staff were fully vaccinated and/or had an exemption in place for 1 of 148 employees. This resulted in a 99.3% staff vaccination rate. The facility also failed to ensure unvaccinated staff were implementing the facility's extra precautions for preventing the spread of COVID-19, related to wearing an N95 face mask during their shift when residents were present for 1 of 3 employees with exemptions or partially vaccinated status who were reviewed. (Employee 1)</p> <p>Finding includes:</p> <p>The COVID-19 Staff Vaccination Matrix was reviewed on 3/29/22 at 3:00 p.m. The Matrix indicated Employee 1 was partially vaccinated and had no exemptions in place.</p> <p>On 3/29/22 at 4:00 p.m., Employee 1 was observed sitting next to a resident in her room on the C -Wing. He had on a face shield and a KN95 mask while in the room with the resident.</p> <p>Interview with Employee 1 at that time, indicated he had tried to console her as she was upset and had been crying. He indicated he had received one dose of the COVID-19 vaccine and "just had not had the time to go get the second dose of the COVID-19 vaccine series." He was unaware that he had worn a "KN95" mask while in the facility.</p>	F 0888	<p>p paraid="1430981159" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{162}" &gt;888</p> <p>p paraid="63305749" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{169}" &gt;Infection Prevention and Control</p> <p>p paraid="1249153876" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{177}" &gt;Res</p> <p>p paraid="480752967" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{184}" &gt;No residents</p> <p>p paraid="817080013" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{192}" &gt;Res Identified</p> <p>p paraid="527922349" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{199}" &gt;No residents were identified as being</p>	04/14/2022
--	--	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/29/2022
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>He had brought this KN95 mask from his car and had forgotten to replace it with an N95 mask.</p> <p>Interview with the Director of Nursing on 3/29/22 at 4:15 p.m., indicated she had corrected Employee 1 and he replaced his KN95 with an N95 mask after the concern was noted to the facility.</p> <p>The current "Employee COVID-19 Vaccination Policy" was provided by the Director of Nursing on 3/28/22 at 10:00 a.m. This policy indicated, "It is the policy of the facility to ensure that all eligible employees are vaccinated against COVID-19 as per applicable Federal, State and local guidelines...9. The facility will implement additional precautions to mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated for COVID-19. Staff will continue to practice social distance of 6 feet in lunch break areas and nurses' stations, N95 masks will be required in all resident care areas...."</p> <p>3.1-18(b)</p>		<p>affected. All residents have the potential to be affected. Employee 1 was immediately educated and immediately donned an N95 mask.</p> <p>p paraid="2063009578" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{209}" &gt;Others</p> <p>p paraid="481804422" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{216}" &gt;No residents were identified as being affected. All residents have the potential to be affected. Employee 1 was immediately educated on the need to wear an N95 mask when in the facility whenever residents are present.</p> <p>p paraid="1775290713" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{232}" &gt;Education</p> <p>p paraid="727551746" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{239}" &gt;Employee 1 was immediately educated on the need to wear an N95 mask when in the facility whenever residents are present. The DCE (Director of Clinical Education) in-serviced all unvaccinated staff and all staff with exemptions on</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/29/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BRICKYARD HEALTHCARE – MERRILLVILLE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 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
			<p>the "Employee COVID-19 Vaccination Policy" prior to 4.15.22.</p> <p>p paraid="251318105" paraeid="{6de1d9e4-ada3-44a2-9fe6-a2f645ea8d27}{253}" &gt;Audits</p> <p>p paraid="532736799" paraeid="{9d4fc2c0-bd44-43f3-8a2f-ecf7aaae98ac}{5}" &gt;The Infection Preventionist/designee will audit 3 random unvaccinated/exempted staff members to ensure they are wearing an N95 mask whenever residents are present. Audits will occur 3 times weekly for 4 weeks, then weekly for 5 months. Audits will occur on all shifts and units and will include weekend audits. Any negative trends will be reviewed in Monthly QAPI program.</p> <p>p paraid="545839755" paraeid="{9d4fc2c0-bd44-43f3-8a2f-ecf7aaae98ac}{25}" &gt;QAPI</p> <p>p paraid="773791986" paraeid="{9d4fc2c0-bd44-43f3-8a2f-ecf7aaae98ac}{34}" &gt;Audits will be submitted to QAPI monthly until 95% compliance is reached.</p>	