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	02/01/2024

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 IN00418370, IN00419359, and IN00420480. Complaint IN00418370 - No deficiencies related to the allegations are cited. Complaint IN00419359 - Federal/state deficiencies related to the allegations are cited at F686. Complaint IN00420480 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: January 31 and February 1, 2024. Facility number: 000253 Provider number: 155362 AIM number: 100266660 Census Bed Type: SNF/NF: 135 Total: 135 Census Payor Type: Medicare: 8 Medicaid: 104 Other: 23 Total: 135 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/5/24.	F 0000	Brickyard Merrillville Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests desk review.	
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Lyzenga	DNS	02/14/2024

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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Bldg. 00	Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services to promote healing for pressure ulcers, related to follow up with pressure ulcer treatment recommendations, for 1 of 3 residents reviewed for pressure ulcers. (Resident F) Finding includes: On 1/31/24 at 3:36 p.m., Resident F was observed lying in bed. The resident's pressure ulcers were observed with the Director of Nursing (DON) and 2 other staff. There was a dark maroon discoloration to her left heel, and a dark colored scabbed area to her right hip. No treatments were in place or completed to the areas at this time. The DON indicated the area to the right hip was hard like a scab. Record review for Resident F was completed on 1/31/24 at 12:00 p.m. Diagnoses included, but were not limited to, cerebral infarction, heart failure, and hypertension. The resident was	F 0686	=”” p=””>A treatment order was obtained for Resident F and the treatments were completed. The wound nurse was immediately re-educated regarding the "Pressure Injury Prevention” policy including the need to have a treatment order in place and the treatment applied for all residents with pressure ulcers. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current residents with wounds were reviewed and no other residents with wounds were noted to be affected by the deficient practice. The DCE (Director of Clinical Education)/designee educated all licensed nursing staff on the "Pressure Injury Prevention” policy prior to the date of compliance. The wound	02/23/2024

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	admitted to the facility on 1/23/24. A Progress Note, dated 1/23/24 at 8:13 p.m., indicated the resident had arrived at the facility. Small areas of abrasions were noted to the left posterior shoulder, buttocks, and right hip. Both heels were soft. Staff had offloaded the resident's heels and notified the Physician. No new orders were received. A Skin and Wound Note, dated 1/29/2024 at 4:38 a.m., was completed by the Wound Care Nurse Practitioner (NP). The resident had been seen by the Wound Care NP on 1/29/24 at 10:38 a.m. There was a deep tissue injury (DTI) to the left heel, measuring 2 centimeters (cm) by 4 cm by 0.1 cm, and the wound base was 100% epithelial. There was a DTI to the right hip, measuring 2 cm by 1.5 cm by 0.1 cm, and the wound base was 100% eschar. The treatment recommendations for the left heel were to cleanse with wound cleanser, apply betadine, and secure with rolled gauze daily. The treatment recommendations for the right hip were to cleanse with normal saline, apply medical grade honey, and secure with bordered gauze daily. The preventative measures indicated to float heels while in bed with use of prevalon boots. The Physician's Order Summary, dated 1/2024, lacked any treatment orders for the left heel or right hip. A Physician's Order, dated 1/29/24, indicated to apply boots to both feet for diagnosis DTI. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 1/2024, lacked documentation of any treatments to the left heel or right hip.		nurse/designee will audit all residents with wounds 3 times a week x one month, then 2 times a week x 1 month, then weekly x4 months to ensure all residents with wounds have a treatment order in place and the treatment has been completed per MD orders. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue. ="" p="">	

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	During an interview with the Administrator on 1/31/24 at 3:20 p.m., she indicated the Wound Nurse had worked last night and was not in the facility currently. The Administrator had spoken with her, and she had rounded with the Wound Care NP on 1/29/24. When the Wound Care NP rounded, they usually assessed the wounds but didn't usually voice any treatment recommendations at the time. The Wound Nurse would usually find out about any recommendations once she received the Wound Care NP's notes. The Wound Nurse had received the Wound Care NP's notes/treatment recommendations for Resident F later the night of 1/29/24, but had not agreed with them. She wanted to check with the resident's Nurse Practitioner (NP) before implementing the orders, so she left the recommendations in the NP's folder for her to see upon her next visit to the facility. The Wound Nurse had not called or followed up with the NP, and no treatment orders had been put into place. The Administrator indicated the Wound Nurse had observed the wounds daily, and there had been no change to the areas. Staff had now notified the NP and were waiting to hear back. This citation relates to Complaint IN00419359. 3.1-40(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility			

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	must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to properly prevent and/or contain COVID-19 related to the use of personal protective equipment in an isolation room. (Resident B) Finding includes: On 1/31/24 at 11:55 a.m., CNA 1 arrived to Resident B's door with her lunch tray. The resident's door indicated "Droplet/Contact Isolation. Proper Personal Protective Equipment (PPE): an isolation gown, protective eye wear, an N95 face mask, and gloves to both hands before entering." There was a PPE bin located right outside the door. The CNA set the tray down onto the PPE bin, and then proceeded to put on	F 0880	/p>Resident B was reviewed and did not have ill effects related to the deficient practice. CNA #1 was immediately re-educated regarding the "Transmissions Based (Isolation) Precautions" policy. The Infection Preventionist nurse and Central Supplies were educated regarding ensuring all appropriate PPE is available in the isolation bins. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No residents were noted to have ill effects related to the	02/23/2024

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	an N95 mask and a gown. The CNA then entered the resident's room with her room tray, and had not put on eye protection or gloves. Upon observation of the PPE bin, there was not any eye protection stored inside it. On 1/31/24 at 12:03 p.m., CNA 1 was observed sitting in a chair next to Residents B's bed. She was feeding the resident. The CNA had on a gown and an N95 mask. She was not wearing eye protection or gloves. The CNA indicated the resident had COVID-19. She indicated staff was supposed to wear gloves and eye protection when residents had COVID-19, but she forgot to put them on. During an interview on 1/31/24 at 12:08 p.m., the IP (Infection Preventionist) indicated the resident had COVID-19. The CNA should have put on eye protection and gloves before entering the room. If there was no eye protection inside the PPE bin, she should have asked for some. 3.1-18(b)		deficient practice. The DCE (Director of Clinical Education)/designee educated all staff on the "Transmissions Based (Isolation) Precautions" policy prior to the date of compliance. Unit Managers/designees will audit 3 random residents 3 times a week x one month, then 2 times a week x 1 month, then weekly x4 months to ensure the appropriate PPE is available and worn according to TBP. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue. ="" p=""> ="" p=""> ="" p="">	