STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155062	A. BUILDING 00 B. WING	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LAPORTE CARE CENTER	1700 I STREET LA PORTE, IN 46350

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00433611. Complaint IN00433611 - No deficiencies related to the allegations are cited. Survey dates: May 8, 9, 10, 13 and 14, 2024 Facility number: 000023 Provider number: 155062 AIM number: 100289400 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 7 Medicaid: 52 Other: 11 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/20/24.	F 0000		
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.			

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

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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	Based on observation and interview, the facility failed to ensure a resident who required staff assistance for activities of daily living (ADLs) received necessary services related to having the ability to reach the call light when ADL care was needed, for 1 of 1 resident reviewed for accommodation of needs. (Resident 32) Finding includes: During an interview on 5/8/24 at 10:12 a.m., Resident 32 indicated he had waited over 30 minutes to get help off the stool and he could not reach the call light to get help. On 5/8/24 at 10:20 a.m., Resident 32 was observed having attempted to reach for the call light from his wheel chair, but the call light was not within reach. The resident smelled of feces and had attempted to get help from staff. On 5/8/24 at 10:28 a.m., the resident was observed with the Director of Nursing (DON). The resident was seated in his wheelchair and had attempted to reach the call light. The DON witnessed his attempt and realized the call light was not within reach. She then moved the resident's bed several inches, which allowed the resident to pass through the space between the dresser and the bed and reach the call light. Resident 32's record was reviewed on 5/09/24 at 2:40 p.m. Diagnoses included, but were not limited to, hemiparesis (paralysis on one side of the body) following cerebral infarction affecting the right dominant side, chronic kidney disease, and diverticulosis (small pouches in the digestive tract). The Quarterly Minimum Data Set (MDS)	F 0558	=" " p=" "> =" " span=" ">The facility requests paper compliance for this citation. =" " span=" ">Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: The bed was for resident # was immediately re-positioned by the Director of Nursing (DNS) to allow him access to his call light and personal care was also provided at that time for the resident by the DNS. 2) How the facility identified other residents: Facility rounds were completed by the Director of Nursing Services (DNS) and the Unit Manager (UM) to identify any other residents affected with no other residents being identified. All residents have the potential to be affected by the alleged deficient practice. 3). Direct care staff to be re-educated by the Director of Clinical Education (DCE) or designee on the policy and procedure for Call Light Accessibility and Timely Response ensuring that all residents call lights are within	06/21/2024

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	assessment, dated 2/21/24, indicated the resident was dependent for toilet assistance and required partial to moderate assistance for toilet transferring. During an interview on 5/08/24 at 10:30 a.m., the DON indicated the resident was not able to reach the call light without his bed being moved, which then allowed the resident's wheelchair to fit through. 3.1-38(a)(2)		reach 4) How the corrective actions will be monitored: Director of Nursing (DNS) or designee to conduct observations of residents call lights to ensure that they are within resident reach. These observations will be conducted on 5 residents 3 times per week x 4 weeks then 3 residents weekly x , then 2 residents monthly x 3 months. These observations will be random and include all shifts and units. The results of these audits will be brought to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance.	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on record review and interview, the facility failed to protect the residents' right to be free from misappropriation of medication related to a staff nurse using a resident's insulin pen for her personal use, for 1 of 1 resident reviewed for misappropriation of medication. (Resident 25)	F 0602	Past noncompliance, no plan of correction required	05/14/2024

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	The deficient practice was corrected by 10/31/23, prior to the start of the survey, and was therefore past noncompliance. The facility thoroughly investigated the misappropriation of medication, notified the police, placed the nurse on suspension while the investigation took place, the resident's insulin pen was removed from the medication cart and discarded, a new insulin pen was reordered for the resident to use, the facility provided inservices to the entire staff regarding the misappropriation of medication, and completed random observations on all shifts to ensure compliance of the policy was implemented correctly. The random observations were completed 5 times a week for 4 weeks, weekly for 4 weeks, and then weekly for 4 months. LPN 4 was guilty of misappropriation of medication and was terminated. Finding includes: An IDOH Incident Report, dated 10/30/23, was reviewed on 5/12/24. The report indicated it was reported to the Director of Nursing and the Administrator by QMA 1 on 10/28/23 at 8:01 p.m., that LPN 4 used Resident 25's insulin pen for her own personal use. CNA 2 and CNA 3 had witnessed LPN 4 use the resident's insulin pen on herself. Immediate action was taken by the facility and LPN 4 was placed on suspension pending the investigation. The resident's insulin pen was removed from the medication cart, was re-ordered, and billed to the facility. The preventative measures taken were to provide inservices to the entire staff on resident abuse and misappropriation of medications, an inservice on medication administration guidelines and insulin pen usage, and re-education on insulin pens being a single resident usage and not to be shared. To ensure compliance, random			

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	observations were completed that included all units and all shifts. They were completed 5 times a weekly, and then weekly for 4 weeks, and then weekly for 4 months. The follow up was determined after the investigation and the staff member was found guilty of misappropriation of medication and was then terminated. Interviews were conducted with staff members/witnesses on 10/30/23. Staff in-services were completed, and was added to QAPI (quality assurance performance improvement). The QAPI meeting date was 10/31/23 and the facility planned to monitor compliance through the results of audits being brought to QAPI meetings monthly for 3 months. Record Review was completed on 5/9/24 at 1:19 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy. A Quarterly Minimum Data Set assessment, dated 2/28/24, indicated the resident was cognitively intact and required insulin usage. A Care Plan, dated 9/29/24, indicated alteration in blood glucose due to: Insulin Dependent Diabetes Mellitus. Interventions included administer medications as ordered. Medications included Insulin Glargine 100 UNIT/ML Solution pen-injector, Inject 55 unit subcutaneously every 12 hours related to TYPE 2 diabetes mellitus, ordered from 10/5/23 - 4/27/24. During an interview on 5/13/24 at 1:57 p.m., the Director of Nursing (DON) indicated LPN 4 used the resident's insulin pen on herself. The facility removed the insulin pen from the medication cart, discarded the pen in the trash can, suspended the			

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	employee, and launched an investigation, which was confirmed for misappropriation and the employee was terminated. A Policy titled, " Abuse, Neglect, and Exploitation", provided by the Administrator on 5/8/24 at 11:00 a.m., indicated, "...it is the policy of this facility to provide protections for the health, welfare and rights of each residents by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property..." 3.1-28(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependent residents related to nail care and the removal of facial hair, for 3 of 6 residents reviewed for ADL care. (Residents 23, 45, and 11) Findings include: 1. During random observations on 5/8/24 at 10:01 a.m. and 1:17 p.m., on 5/9/24 at 9:25 a.m., 11:55 a.m., and 1:08 p.m., and on 5/10/24 at 12:20 p.m., Resident 23 was observed in bed. At those times, the resident was unshaven. The record for Resident 23 was reviewed on 5/9/24 at 2:35 p.m., Diagnoses included, but were not	F 0677	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	06/21/2024

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	limited to, dementia with behaviors, high blood pressure, heart disease, major depressive disorder, and anxiety. The 2/13/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and needed substantial/maximal assist with personal hygiene. A Care Plan, revised on 1/18/24, indicated the resident had a physical functioning /self care deficit related to weakness, impaired mobility, and impaired cognition. The approaches were to provide personal hygiene with one assist. A Hospice CNA Progress Note, dated 5/10/24 at 8:30 p.m., indicated a bed bath was provided, however, there was no documentation the resident had a shave. During an interview on 5/13/24 at 11:00 a.m., the Director of Nursing indicated the resident received hospice services. A bed bath was provided 2 times a week from the Hospice CNA, however, there was no documentation the resident received a shave during the care. 2. During random observations on 5/8/24 at 9:27 a.m. and 1:10 p.m., Resident 45 was observed sitting in a wheelchair in her room. At those times, the resident had long and dirty fingernails. The record for Resident 45 was reviewed on 5/13/24 9:53 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, high blood pressure, depression , psychotic disorder, and traumatic subdural hemorrhage encounter. The Quarterly Minimum Data Set (MDS)		1) Corrective actions taken for those residents found to have been affected by the deficient practice: Nail care was immediately provided for resident #11 per her assigned CNA and per the Licensed nurse for resident #45. Facial hair was removed for resident # 23 per his assigned CNA. 2) How the facility identified other residents having the potential to be affected by the same deficient practice and the corrective actions taken: The facility determined that all residents have the potential to be affected by the deficient practice. The Director of Nursing (DNS) and the Unit Manager conducted a facility wide audit of all other residents in the facility to ensure all ADL needs were met with no other deficiencies	

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	assessment, dated 3/14/24, indicated the resident was not cognitively intact for daily decision making. The resident had no impairment to her upper extremities or lower extremities and needed partial to moderate assistance with personal hygiene. A Care Plan, revised on 6/27/23, indicated the resident had an ADL self care deficit related to Alzheimer's dementia, impaired mobility, impaired cognition, and weakness. The resident's shower days were Mondays and Thursdays in the morning. The shower documentation indicated she received a shower on Monday 5/6/24, however, there was no documentation her nails were trimmed. During an interview on 5/13/24 at 10:10 a.m., the Director of Nursing indicated nail care should have been completed as needed. 3. On 5/08/24 at 10:36 a.m., Resident 11 was observed lying in her room. Her fingernails on her right hand were long and appeared dirty. The resident's hair appeared wet, and she indicated that she would like her nails cleaned. On 5/9/24 at 10:01 a.m., Resident 11 was observed lying in her bed wearing a gown. She indicated she received a shower yesterday. Resident 11's nails continued to appear dirty and unkempt. The resident's record was reviewed on 5/19/24 at 1:19 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body) to the left side, mild cognitive impairment, and contracture of the left upper arm. The Quarterly Minimum Data Set assessment, dated 4/11/24, indicated the resident was		identified. 3) Measures put into place/ System changes: Nursing staff to be re-educated by the Director of Nursing or designee regarding the policy and procedure for providing assistance to residents who are unable to carry out activities of daily living. The DNS or designee to complete random ADL rounds focusing on grooming and nail care. These audits will be completed on 5 residents 3 times per week for 1 month then 3 residents weekly for 1 month then 5 residents monthly for 4 months. The rounds will be random and will include all 3 shifts and all units. Any deficiencies identified will be corrected immediately with re-education provided as needed. 4) How the corrective actions will be monitored: The DNS will provide the results of these reviews and audits to the QAPI committee monthly x 6	

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	cognitively intact and required dependent assistance for toileting and bathing. A Care Plan, dated 4/10/24, indicated the resident preferred to keep her fingernails long, as long as they were well-groomed. On 5/9/24 at 1:59 p.m., the resident's nails were observed with CNA 1. During an interview at that time, CNA 1 indicated the resident's nails were still dirty and she would cleaned them right away. 3.1-38(3)(E)		months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure an assessment was completed and devices were in place for a resident with limited range of motion	F 0688	=”” p=””>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the	06/21/2024

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	for 1 of 1 resident reviewed for range of motion. (Resident 45) Finding includes: During random observations on 5/8/24 at 9:27 a.m. and 1:10 p.m., on 5/9/24 at 9:28 a.m., 11:55 a.m., and 1:06 p.m., and on 5/10/24 at 12:30 p.m., Resident 45 was observed sitting in a wheelchair. At those times, the resident was observed with her left hand clenched and lying against her chest. On 5/13/24 at 11:00 a.m., the Director of nursing assessed the resident's left hand and indicated with passive range of motion, the ring finger could be straightened out, however, the middle finger would only extend up to 75 degrees. She indicated at the time, Occupational Therapy would be completing an assessment of the hand. The record for Resident 45 was reviewed on 5/13/24 9:53 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, high blood pressure, depression , psychotic disorder, and traumatic subdural hemorrhage encounter. The Quarterly Minimum Data Set (MDS) assessment, dated 3/14/24, indicated the resident was not cognitively intact for daily decision making. The resident had no impairment to her upper extremities or lower extremities and needed partial to moderate assistance with personal hygiene. A Care Plan, revised on 7/9/22, indicated the resident had a physical functioning deficit related to mobility impairment and self care impairment. The approaches were to monitor and report changes in physical functioning ability and rehab therapy services as ordered. Date initiated:		truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. ="" p="">The facility wishes to IDR this deficiency as we feel that we can demonstrate that we were in substantial compliance. 1) Immediate actions taken for those residents identified: Resident #45 was assessed per the Director of Nursing (DNS) on 5/13/24 and noted to have a 75% extension of her right hand second digit Resident's power of attorney and her physician were notified per the DNS and a new order for Occupational Therapy Evaluation was obtained. 2) How the facility identified other residents: Range of motion assessment to be completed on all residents per the Director of Nursing (DNS) or designee to identify any other residents with unidentified contractures without devices or therapy referrals in place. 3). Nursing staff to be re-educated per the DCE or designee related to Prevention of Decline in Range of Motion with an emphasis on identifying new contractures. DNS or designee to complete random range of motion assessments to identify any new contractures to ensure that there	

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	7/10/2021 A Functional and Abilities Assessment, dated 3/14/24, indicated the resident had impairment to one side for both upper and lower extremities. An Occupational Therapy (OT) Plan and Treatment, dated 3/8-4/6/24 indicated the resident had impaired left upper extremity strength for the shoulder and the elbow/forearm and wrist were all within normal limits. During an interview on 5/13/24 at 11:05 a.m., the Director of Nursing indicated she was unaware the resident had any range of motion limitations to the left hand and had no anti-contracture device for the left hand. A Nurses' Note, dated 5/13/24 at 11:24 a.m., completed by the Director of Nursing, indicated the resident was noted to have a limited extension (75%) of her right hand 2nd digit. The Physician was notified and a new order was received for OT to evaluate and treat. An Occupational Therapy Screen, completed on 5/13/24, indicated PIP (Proximal Interphalangeal Joint-knuckle) was 70 degrees. Pain was indicated by facial expressions and sounds, but when asked, patient denied pain. During an interview on 5/13/24 at 2:45 p.m., Certified Occupational Therapist Assistant (COTA) 1 indicated the resident had a limited range of motion at her knuckle of 70 degrees flexion. The resident will be picked up by OT for therapy. 3.1-42(a)(2)		is a device in place or that a therapy referral was completed. These audits will be completed on 5 residents per week for 1 month, then 3 residents weekly for 2 months then 1 resident monthly then monthly for 3 months. If any concerns or discrepancies are identified they will be corrected immediately, with 4) How the corrective actions will be monitored: The DNS or will report any trends to the QAPI committee on a monthly basis for recommendations and resolutions. Results of these reviews and audits will be brought to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance. ="" p="">	

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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 record review and interview, the facility failed to ensure meal consumption was monitored for a resident with a history of weight loss and/or were at nutritional risk for 1 of 2 residents reviewed for nutrition. (Resident 51) Finding includes: The record for Resident 51 was reviewed on 5/9/24 at 11:00 a.m. Diagnoses included, but were not limited to, pneumonia, diabetes, anemia, acute pancreatitis, and anxiety. The 2/26/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making, had no oral	F 0692	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state	06/21/2024

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	155062	A. BUILDING 00 B. WING	05/14/2024

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	problems and weighed 222 pounds with no significant weight loss. The resident needed setup or clean up assistance with eating. A Care Plan, dated 2/24/24, indicated the resident was at nutritional risk related to obesity, diabetes, and anemia. The approaches were to observe meal intakes. The resident weighed 204 pounds on 2/20/24 and 206 pounds on 3/6/24. A weight obtained on 4/12/24 indicated the resident weighed 189 pounds, which was an 8.25% weight loss in 30 days. Physician's Orders on the current 5/2024 Physician Order Summary, indicated the resident was to receive a controlled carbohydrate diet. The meal consumption intake logs indicated the following: - the breakfast meal was not documented on 3/16 and 4/18/24. - the lunch meal not documented on 3/11, 3/16, 3/20, 4/1, and 4/18/24. - the dinner meal was not documented on 3/10, 3/27, 4/13, 4/14, 4/16, 4/17, 4/21, and 4/29/24. During an interview on 5/13/24 at 1:00 p.m., the Director of Nursing indicated the resident's meal consumption intakes should be documented after every meal. 3.1-46(a)(1)		law. 1) Corrective actions taken for those residents found to have been affected by the deficient practice: Resident #51 was reviewed per the dietician on 5/27/24 with no interventions required related to weight loss as resident has shown a significant weight gain over the last 60 days. The facility was unable to correct the omitted meal consumption documentation. 2) How the facility identified other residents having the potential to be affected by the same deficient practice and the corrective actions taken The facility determined that all residents have the potential to be affected by the deficient practice. 3) Measures put into place/ System changes: Nursing staff to be re-educated by the Director of Nursing (DNS) or designee regarding the policy and procedure for documentation of meal consumption.	

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			The DNS or designee to review meal consumption documentation for completion 3 times weekly for 1 month then 2 times weekly for 2 months then weekly for 3 months. Any deficiencies identified will be corrected with re-education provided as needed. 4) How the corrective actions will be monitored: The DNS will provide the results of these reviews and audits to the QAPI committee monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance.	
F 0728 SS=D Bldg. 00	483.35(d)(1)-(3) Facility Hiring and Use of Nurse Aide §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training			

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	and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b).			
	Based on record review and interview, the facility failed to ensure a newly hired CNA was certified past 120 days of employment for 1 of 44 employees reviewed for licensure and certification. (Employee 1) Finding includes: Review of the employee records was completed on 5/14/24 at 10:02 a.m.	F 0728	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The	06/21/2024

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	Employee 1 was hired on 1/10/24. Employee 1's 120th day of employment was on 5/8/24. The employee's time card was reviewed and indicated she had worked on the following days as a CNA after her 120 days of employment without certification: 5/9/24, 5/13/24, and 5/14/24. During an interview on 5/14/24 at 10:47 a.m., the Payroll Coordinator indicated she was unaware they had only 120 days to work, she thought it was 120 shifts. Employee 1 was working the floor as a CNA today on 5/14/24. 3.1-14(e)		plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. What corrective Action will be accomplished for those residents found to have been affected by the deficient practice Employee 1 was immediately removed from the schedule as a CNA on 5/14/24 and is scheduled to take her CNA exam on 6/4/24. An audit was completed on all other CNAs to ensure everyone had a current active certification or was not working outside of the 120 days without being certified. No other CNA was identified to have been affected. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. Employee 1 was removed from the schedule as a CNA on 5.14.24 and is scheduled to take her CNA exam on 6/4/24. An audit was completed on all other CNAs to ensure everyone had a current active license or was not working outside of the 120 days without being certified. No other CNA was	

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			identified to have been affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Human Resources Director and The Director of Clinical Education (DCE) were educated on the Required Training, Certification, and Continuing Education of Nurse Aides policy. DCE/designee to audit every newly hired CNA to ensure that they have an active certification or do not work past 120 days without becoming certified. These audits to be completed x 6 months. How the Corrective actions will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place. Results of audits to be brought to monthly QAPI to track for any trends. If any trends identified than will continue audits based on IDT recommendations, otherwise will review on prn basis.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was prepared and stored under sanitary conditions related to a greasy deep fryer, improper labeling of food, and dried spillage in refrigerators in 1 of 1 kitchens and 2 of 3 pantries throughout the facility. (The Main Kitchen, A and C wing pantries) Findings includes: 1. During the Brief Kitchen Sanitation Tour on 5/8/24 at 9:12 a.m. with the Dietary Food Manager, (DFM) the following was observed: a. The deep fryer was noted with many food crumbs and was greasy on both sides, with the grease extending to the side of the convection oven.	F 0812	=" " p=" "> The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. What corrective actions will be accomplished for those residents found to have been affected by the	06/21/2024

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	During an interview at that time, the DFM indicated the deep fryer was cleaned weekly. 2. During an observation of the A-Wing pantry refrigerator on 5/9/24 at 9:10 a.m., there was a heavy accumulation of dried pink, orange, and red beverage spillage. The refrigerator housed the resident's food and other beverages. During an interview at that time, LPN 3 had no comment regarding the spillage. 3. During an observation of the C-Wing pantry refrigerator on 5/14/24 at 9:25 a.m., there was an open bottle of orange Gatorade with no open date or label on it inside the refrigerator. During an interview at that time, LPN 2 indicated she did not know whose Gatorade it was, and thought maybe it was a resident who recently had a colonoscopy. The current 11/6/16 "The Safe Food Procurement: Food from Outside Sources" policy, provided by the Administrator on 5/8/24 at 11:00 a.m., indicated food or beverages brought in from the outside will be labeled with the resident's name, room number and dated by nursing with the current date the item was brought in to the facility. 3.1-21(i)(3)		deficient actions: The fryer was cleaned inside and out on 5/8/24. The steamer (identified as the convection oven in the 2567) was also cleaned inside and outside on 5/8/24. All nourishment pantry refrigerator/freezers were cleaned inside and out on 5/9/24 and 5/14/24. Outdated items and items with no date or resident names on them were discarded at that time How other residents having the potential to be affected will be identified All residents have the potential to be affected by the deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur: The fryer, steamer, and all nourishment pantries will be audited by the DSM or designee. Audits will be completed 5 times/week for 4 weeks, then 3 times/week for 8 weeks and then weekly for 3 months (total of 6 months). How the corrective action will be monitored to ensure the deficient practice will not recur Monitor/audit findings and trends will be reviewed in QAPI monthly for 6 months, unless further monitoring is deemed necessary.	

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			If no trends are identified in 6 months, the audits will be completed on a prn basis	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in			

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	compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, record review, and interview, the facility failed to ensure clinical records were accurately documented related to	F 0842	The facility requests paper compliance for this citation. This Plan of Correction is the	06/21/2024

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	weekly skin assessments and nutritional supplements for 1 of 1 residents reviewed for skin conditions and 1 of 2 residents reviewed for nutrition. (Residents 16 and 51) Findings include: 1. During a random observation on 5/8/24 at 9:36 a.m., Resident 16 was observed with many bloody and dried scabs all over his upper body including his arms and trunk. The record for Resident 16 was reviewed on 5/10/24 at 12:42 p.m. Diagnoses included, but were not limited to, pulmonary disease and fibrosis, type 1 diabetes, major depressive disorder, high blood pressure, heart disease, anxiety, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 4/1/24, indicated the resident was cognitively intact for daily decision making and did receive applications of ointment other than the feet. The Care Plan, revised on 3/25/24, indicated the resident had altered skin integrity, non-pressure related to a rash to bilateral upper and lower extremities including his trunk. The approaches were to conduct a weekly skin inspection. Physician's Orders, dated 1/11/24, indicated Triamcinolone Acetonide External Cream 0.1 %, apply to the trunk, bilateral upper and lower extremities every evening and night shift. The Weekly Skin Review, dated 3/26/24, indicated the resident's skin was intact. The resident still had small scabs to arms and trunk. The Weekly Skin Review, dated 4/9/24, indicated		center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. What corrective action will be accomplished for those residents found to have been affected by the deficient practice A skin assessment was completed on 5/14/24 for Resident 16 that accurately reflects the resident's current skin condition. The duplicate order for ensure supplement twice daily was discontinued on 5/5/24 for Resident 51. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action be taken. Skin assessments for all other residents that were completed in the last 7 days were reviewed to ensure they were documented accurately. Any resident identified to have been affected by the deficient practice had a new skin assessment completed. Residents with new orders for supplements in reviewed	

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	the resident's skin was warm, dry and intact. The comment section indicated the resident does have a chronic rash to his extremities and a treatment was in place. The Weekly Skin Review, dated 4/30/24, indicated the resident's skin was intact. During an interview on 5/13/24 at 1:00 p.m., the Director of Nursing indicated she believed the nurses were thinking his skin was intact because he had no pressure ulcers, however, there was a spot on the weekly skin assessment to check off if the resident had a rash, redness, blisters, or skin tears and if they were pre-exiting. The above skin reviews were inaccurately documented. 2. The record for Resident 51 was reviewed on 5/9/24 at 11:00 a.m. Diagnoses included, but were not limited to, pneumonia, diabetes, anemia, acute pancreatitis, and anxiety. The 2/26/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making, had no oral problems and weighed 222 pounds with no significant weight loss. The resident needed setup or clean up assistance with eating. A Care Plan, dated 2/24/24, indicated the resident was at nutritional risk related to obesity, diabetes, and anemia. The approaches were to observe meal intakes. The resident weighed 204 pounds on 2/20/24 and 206 pounds on 3/6/24. A weight obtained on 4/12/24 indicated the resident weighed 189 pounds, which was an 8.25% weight loss in 30 days.		to ensure accuracy and that there were no duplicate orders. Orders were corrected for any resident found to have been affected by the deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Licensed nursing staff to be re-educated on the Skin Assessment Policy and Nutritional and Dietary Supplements Policy. Unit manager (UM)/designee to audit skin assessments weekly to ensure that skin assessments are documented correctly. These audits will be conducted on 5 skin assessments weekly x , then 3 skin assessments weekly x 30 days then 2 skin assessments weekly x 4 months. DNS/designee to review all new supplement orders to ensure that the order is entered into the system accurately and to ensure there is not a duplicate supplement ordered. These audits will be conducted 5 times weekly x then 3 times weekly x 30 days, then weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of all audits to be brought to QAPI monthly x 6 months to track for any trends. If any trends are identified we will continue the audits based on IDT	

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	Physician's Orders, dated 3/30/24, indicated Ensure (a nutritional supplement) 237 milliliters (ml) at 9:00 a.m. and 6:00 p.m. Physician's Orders, dated 4/5/24, indicated Ensure 237 ml for 30 days at 8:00 a.m. and 4:00 p.m. The Medication Administration Record (MAR) for 4/2024 indicated both Ensure supplements were documented and signed out as being administered 4/5/24 through 4/30/24. The documentation indicated the resident received 4 cans of Ensure and only 1 hour difference in time. During an interview on 5/13/24 at 1:00 p.m., the Director of Nursing indicated the resident was only supposed to receive 2 cans of Ensure a day, not 4 cans. Nursing staff should have discontinued one of the orders so there would be no confusion. 3.1-50(a)(2)		recommendations, will on a prn basis.	
F 0880 SS=E 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. §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:			

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	155062	A. BUILDING 00 B. WING	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LAPORTE CARE CENTER	1700 I STREET LA PORTE, IN 46350

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	§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 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.			

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	§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, record review, and interview, the facility failed to maintain an infection control program related to incomplete documentation of the infection control program, incomplete mapping of infections and lack of glove use during insulin administration during a medication pass for 1 of 8 residents observed during medication pass. (Resident 51 and LPN 1) Findings include: 1. The Infection Control Program was reviewed on 5/9/24 at 9:00 a.m. The January, February, March and April 2024 Infection Surveillance Data Collection Forms included the following: - resident's name and room number - infection type - infection onset date - antibiotic name - antibiotic start and stop date - comments The Infection Control Logs lacked any documentation of diagnostic lab or x-ray results or if criteria for a true infection were met. Five	F 0880	=”” span=””>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident #51 was assessed by the Director of Nursing Services (DNS) with no adverse effects noted related to the alleged deficient practice. LPN 1 was immediately re-educated by the DNS regarding the proper use of the Personal Protective	06/21/2024

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	residents in March and ten residents in April lacked documentation of signs or symptoms associated with the infection. During an interview on 5/9/24 at 9:30 a.m. with the Infection Preventionist (IP), she indicated she did not include the infection criteria or diagnostic results on the Infection Log because the information was available elsewhere in the record. She also indicated she was unsure why there were no signs or symptoms documented on some of the entries. The current policy, "Infection Surveillance", indicated, "...refers to an ongoing systematic collection, analysis, interpretation and dissemination of infection-related data...." 2. The January 2024 Infection Control Log indicated there were seven residents with urinary tract infections (UTI). The January 2024 map had no residents documented as having a UTI. The March 2024 Infection Control Log indicated there were six residents with respiratory infections. The March 2024 map had no residents documented as having a respiratory infection. During an interview on 5/9/24 at 1:48 p.m., the IP nurse indicated infections were color coded and mapped monthly to identify trends. She indicated some of the missed infections had been carried over from the previous month, but several had been missed on the maps. The current policy, "Infection Surveillance", indicated, "...The facility will collect data to properly identify possible communicable diseases or infections among resident and staff before they spread by identifying...The infection site, pathogen (if available), signs and symptoms, and		Equipment (PPE) with insulin administration. 2) How the facility identified other residents: All residents could be affected by the alleged deficient practice. 3). Director of Clinical Education/Infection Preventionist (DCE/IP) or designee to re-educate all licensed nursing staff and Insulin certified Qualified Medication Aides (QMAs) regarding appropriate PPE use with Insulin administration. DNS or designee to re-educate the IP on the Infection Surveillance Policy with regards to the completion of the infection control logs including documentation of signs and symptoms associated with the infections and diagnostic, lab or x-ray results and documentation if criteria of a true infection was met. The DNS or designee to also re-educate the IP on the monthly mapping of infections per facility policy. DNS/IP/designee to observe all licensed nursing staff and insulin certified QMAs administering insulin to ensure the proper use of PPE. 4) How the corrective actions will be monitored: DNS/IP/designee to observe licensed nursing staff and insulin certified QMAs administering insulin to ensure proper use of PPE and complete re-education as needed. DNS to review Infection Control Logs and	

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	resident location, including a summary and analysis of the number of resident who developed infections...", and, "...the identification of unusual or unexpected outcomes, infection trends or patterns...." 3. On 5/8/24 at 11:35 a.m., LPN 1 was observed administering medications. Resident 51 was to receive 3 units of Novolog (insulin). The nurse prepared the insulin pen and administered the medication to the resident. She did not don gloves prior to administering. During an interview following the observation, the LPN indicated she didn't think she was supposed to wear gloves during insulin administration. The current policy, titled "Insulin Pen", indicated, "...11. Procedure ... b. perform hand hygiene. c. don gloves...." 3.1-18(b)(1)		mapping weekly for 8 weeks then monthly and will complete re-education as needed. Observations to be conducted with 3 nurses weekly x 4 weeks then 1 nurse weekly for , then 1 nurse monthly for 3 months. These observations will be random and include all shifts and units. The results of these audits will be brought to QAPI meeting monthly per the IP or for 6 months or until 100% compliance is achieved for 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance.	