STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - PORTAGE CARE CENTER	3175 LANCER ST PORTAGE, IN 46368

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00411672 and IN00412791. Complaint IN00411672 - No deficiencies related to the allegations are cited. Complaint IN00412791 - Federal/State deficiencies related to the allegations are cited at F600. Unrelated deficiencies are cited. Survey dates: July 18 and 19, 2023. Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Medicare: 5 Medicaid: 92 Other: 17 Total: 114 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/24/23.	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance, preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report. Our plan of correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The facility respectfully requests paper compliance. Thank you for your consideration. Respectfully, Marsha Catherine Fulton	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

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

Marsha Fulton | Executive Director | 08/03/2023

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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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure a resident with a new onset of a rash was assessed and treatment orders were obtained for a random observation of one resident with a non-pressure skin condition. (Resident G) Finding includes: On 7/18/23 at 1:25 p.m., Resident G was observed sitting up in bed, naked with a sheet covering the lower half of his body. The resident's face, neck, and chest had several areas of red raised spots the size of a quarter that presented like a rash or hives. He was actively scratching his neck and face. On 7/18/22 at 2:15 p.m., the B-Wing Unit Manager and the DON (Director of Nursing) went into the resident's room for an assessment of the upper body rash. The resident informed the Unit Manager and DON that the rash/hives had been present for a week. The record for Resident G was reviewed on 7/18/23 at 1:35 p.m. Diagnosis included, but were not limited to, neurogenic bladder (loss of bladder control), quadriplegia (paralysis lower half of the body), anxiety, asthma (restrictive airway disease), stroke and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/23, indicated the resident	F 0684	F-684 Facility requests paper compliance/ desk review What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident G was and MD was notified 7.18.23. A new treatment order for the rash was obtained and treatment continues. 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 have the potential to be affected. A facility-wide skin sweep of residents was completed 7.26.23. No new skin issues were identified. All current areas have orders in place. All interventions are in place.	08/16/2023

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	was cognitively intact and had an indwelling catheter. Bed mobility, toileting, dressing and personal hygiene required extensive assistance with 1 person physical assist. Transfers required extensive assistance with 2+ person physical assist, and bathing required total dependence. Eating and locomotion off unit required supervision and 1 person physical assist. There was no documentation to indicate the Physician was notified of the the resident's rash or itching. Interview with the B-unit Nurse Manager, on 7/18/23 at 2:25 p.m., indicated she was unaware the resident had itching, or a rash/hives and she would call the Physician immediately to get the resident something for his itching. 3.1-37(a)		What measure will be put into place or what systemic changes will be made to ensure that the deficient practices do not recur: The DCE (Director of Clinical Education)/designee in- all nursing staff on the “Skin Assessment” and “Notification of Changes” policies. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The DNS (Director of Nursing Services)/designee will audit 5 residents with active treatments 5 times a week for 2 months, then 5 residents 3 times per week x 2 months, then 5 residents weekly x 2 months to ensure treatments are completed as ordered and will audit 5 random residents 5 times a week for 2 months, then 5 residents every 3 times per week x 2 months, then 5 residents monthly x 2 months to ensure the MD is notified of any new skin concern and a treatment order is obtained if applicable. Audits will occur on all shifts and units and include the weekends. Any negative trends will be reviewed in the monthly QAPI	

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			program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal			

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	incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure nursing staff provided suprapubic (urinary catheter inserted through a small incision or hole in the abdomen) catheter care every shift as ordered for 1 of 1 residents reviewed for catheters. (Resident G) Finding includes: On 7/18/23 at 1:25 p.m., Resident G was observed sitting up in bed, naked with a sheet covering the lower half of his body. A suprapubic catheter was observed with dried blood that was crusted around the stoma (entry) site. There was no split gauze covering the stoma site and it was left open to air. The sheet covering the resident was observed with multiple dried blood spots. The resident indicated the site had not been cleaned in awhile. On 7/18/22 at 2:15 p.m., the B-Wing Unit Manager and the DON (Director of Nursing) went into the resident's room for an assessment of the resident's stoma, suprapubic catheter and soiled linen. The linens were removed to view the dried blood stains, and the stoma was observed. There was a moderate amount of dried blood and crusty skin surrounding the stoma and catheter, and there was a small amount of fresh blood around the stoma site. The resident informed the Unit Manager and DON that staff only cleaned his catheter when they wanted to, which was not every day.	F 0690	F-690 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident G's catheter care orders were and catheter care was provided. The MD was notified of the redness and bleeding at the insertion site and the catheter care order was revised to reflect the need for MD notification if changes to the insertion site were noted. 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 other residents who have catheters have the potential to be affected. An audit was completed to ensure all residents with catheters had an order for catheter care that included MD notification for changes noted. No other	08/16/2023

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	During an interview with the resident, on 7/18/23 at 1:30 p.m., the resident indicated his sheet had been bloody since the previous day and had yet to be changed. The record for Resident G was reviewed on 7/18/23 at 1:35 p.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder (loss of bladder control), quadriplegia (paralysis lower half of the body), anxiety, asthma (restrictive airway disease), stroke and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/23, indicated the resident was cognitively intact and had an indwelling catheter. Bed mobility, toileting, dressing and personal hygiene required extensive assistance with 1-person physical assist. Transfers required extensive assistance with 2-person physical assist, and bathing required total dependence. Eating and locomotion off unit required supervision and 1-person physical assist. A Care Plan, dated 3/8/23, indicated the resident had a suprapubic catheter related to a diagnosis of neuromuscular dysfunction of bladder. Approaches were to provide indwelling catheter care every shift and as needed, observe for signs and symptoms (s/s) of skin breakdown such as swelling, redness, warm, discharge, odor and notify Physician of significant findings, change catheter as ordered, and provide thorough skin care after incontinent episodes and apply barrier cream as ordered. A Care Plan, dated 4/19/21, indicated the resident was at risk for complications related to anticoagulant use and routine aspirin therapy. Approaches were to observe for signs and		residents were affected by the deficient practice. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: The DCE/designee educated all licensed nurses regarding the “Catheter Care” policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The DNS/designee will audit all residents with indwelling catheters to ensure orders are in place and dressing changes/care are completed per MD orders. The DNS/designee will audit 5 residents with indwelling catheters 5 times per week x 2 months, then 5 residents 3 times a week x 2 months, then 5 residents weekly x 2 months to ensure that catheter care orders are in place and care is completed as ordered. Audits will be completed on different shifts and will include the weekends. Audits will occur on all shifts and units and include the weekends.	

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	symptoms of bleeding i.e., tarry stools, blood in urine, bruising, and petechiae (round spots on the skin). Observe for adverse reaction: fever, skin lesions, anorexia, nausea, vomiting, cramps, diarrhea, hemorrhage, and hemoptysis (coughing up blood). Monitor medication regime for medications which increase effects. A Care Plan, dated 4/27/21, indicated the resident was at risk for complications related to incontinence of bowel, use of supra pubic catheter, and impaired mobility. Approaches were to provide catheter care per staff, kept dry and clean per staff, MD and family notified as needed. A Physician's Order, dated 9/7/22 at 11:48 a.m., indicated to cleanse suprapubic insertion site with soap and water, pat dry and apply split drain sponge daily, every day shift for prophylaxis drainage. A Physician's Order, dated on 8/30/22, indicated suprapubic catheter care every shift and PRN (as needed). A Physician's Order, dated 7/6/22, indicated to observe for signs and symptoms of bleeding i.e., tarry stools, blood in urine, and bruising every shift. Notify MD if s/s bleeding noted, every shift for anticoagulant use. The Treatment Administration Record (TAR) for July 2023 indicated the order to cleanse the suprapubic catheter site with soap and water, pat dry and apply split drain sponge daily was signed out every day for the month of July 2023. Interview with the DON, on 7/18/23 at 2:07 p.m., indicated the resident was on an antibiotic, and had seen the Physician twice for periorbital		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 95% compliance of achieved.	

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	cellulitis. She did not see any documentation in progress notes or Physician assessment regarding suprapubic catheter bleeding or recent skin conditions. 3.1-41(a)(2)			