STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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 IN00443668. Complaint IN00443668 - Federal/state deficiencies related to the allegations are cited at F621. Survey dates: September 19, 20, 23, 24, 25 & 26, 2024 Facility number: 000045 Provider number: 155109 AIM number: 100291400 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 5 Medicaid: 54 Other: 5 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 10/9/2024	F 0000	**Brickyard 12th St Care 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.** We kindly request desk review	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on observation, record review, and interview the facility failed to notify the physician for significantly elevated blood glucose levels for 1 of 1 resident reviewed for blood glucose (Resident 45).	F 0580	Brickyard 12 St Care Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	11/01/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	Finding includes: On 9/23/2024 at 11:06 A.M., a record review was completed for Resident 45. Diagnosis included, but were not limited to: Type 2 diabetes A Physicians' order, dated 7/30/2024, indicated the provider was to be notified if Resident 45's blood glucose levels were below 60 mg/dl or above 400 mg/dL. A review of Resident 45's blood glucose results indicated the record lacked documentation the physician was notified of elevated blood glucose levels above 400 mg/dl for the following dates and times: - On 9/13/2024 at 12:33 P.M., Resident 45's blood glucose level was 420n mg/dl. - On 9/15/2024 at 1:08 P.M., the residents blood glucose level was 433 mg/dl. - On 9/20/2024 at 11:41 A.M., the residents blood glucose level was 450 mg/dl and at 5:06 P.M., the residents blood glucose level was 416 mg/dl. During an interview, on 9/23/2024 at 1:37 P.M., the Administrator indicated blood glucose levels that were out of parameters should have been charted in a nursing progress note or the triage book located on the unit. During an interview, on 9/23/2024 at 2:15 PM, the Director of Nursing (DON) indicated Resident 45 switched rooms recently and there were triage binders for each hall. The binder on his previous hall may have contained a notification to the Nurse Practitioner (NP). However, a review of the triage binders on both halls with the DON indicated there were no notes to the NP indicating		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F580 Notification of Changes It is the practice of the facility to ensure the facility promptly informs the resident, consults with the resident's physician, and notify the residents representative when there is a change requiring notification, such as a significantly elevated blood glucose level outside of order parameters. The Provider for resident #45 was notified of the elevated glucose levels. The alleged deficient practice resulted in no harm to the resident. ·All residents identified as having potential to be affected. All residents who have blood glucose monitoring were reviewed for the past 30 days to ensure that the provider was notified of glucose levels outside of order parameters. No other residents were identified to be affected by the alleged deficient practice. ·The facilities guidelines for notification of changes were reviewed. The DNS/Designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	she was contacted regarding the resident's out of range blood glucose levels. During an interview, on 9/24/2024 at 10:21 A.M., RN 5 indicated when a resident's blood glucose was out of range, he notified the doctor and put in a nursing progress note. RN 5 indicated there should have been a note associated with Resident 45's high blood glucose levels above 400 mg/dl, but there was not. A current facility policy, titled "Notification of Changes," undated and received from the Administrator on 9/23/2024 at 3:07 P.M., indicated the following: "Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the residents (sic) physician; and notifies, consistent with his or her authority, the residents representative when there is a change requiring notification." 3.1-5(a)(2)		in-service the IDT and Licensed nursing staff regarding notification of changes to ensure the guidelines are followed. ·DNS/Designee to review in clinical start up all residents with blood glucose monitoring, ensuring that the Provider and the resident's representative when applicable is notified of all elevated glucose levels beyond order parameters and there is proper documentation of such notifications. This review will take place 5x weekly x 3 months, then 3x weekly x 3 months. Results of the audits will be reviewed by QAPI for a minimum of 6 months to track for any deficient practice. If deficient practices are identified, then audits and re-education will be done based on QAPI recommendations. If no deficiencies are identified, then QAPI will review on a prn basis.	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances Based on observation, interview and record review, the facility failed to respond to a resident's grievance requesting services in a timely manner for 1 out of 1 residents reviewed for grievances.	F 0585	Brickyard 12 St Care Center please accept the following as the facility's credible allegation of compliance. This plan of	11/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	(Resident L) Finding includes: During an interview on 9/19/2024 at 2:23 P.M., Resident L indicated no one had done range of motion exercises with him, nor had he received any therapy. He indicated he came to the facility so he could get therapy, and he did ask the Administrator for therapy. A record review was completed, on 9/23/2024 at 2:13 P.M., for Resident L. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, spastic hemiplegia affecting left nondominant side, and colostomy status. A Grievance Form, dated 8/5/2024, indicated Resident L was concerned with the wait time in the morning to get his colostomy bag dumped, and wanting further therapy. The form indicated it was resolved on 8/5/2024 with a response of "discussed restorative options upcoming and the Medicaid payer. " During an interview on 9/25/2024 at 10:14 A.M., the Director of Rehab indicated she could not evaluate a new admission with straight Medicaid funding for a payer source for rehabilitation services without the permission of the Administrator. She believed the money to pay for skilled services came out of the daily rate Medicaid paid for long term services. She indicated she had been approached by Resident L indicating he wanted therapy. She indicated she had informed the Administrator, after his admission, that Resident L would benefit from therapy.		correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F585 Grievances It is the practice of the facility to allow residents to file grievances without fear of reprisal or discrimination. Such grievances include those with respect to care and treatment which has or has not been furnished. The grievance includes a summary statement of grievance, the steps taken to investigate the grievance, pertinent findings or conclusions regarding the resident's concern, whether the grievance is confirmed or not, and any corrective action taken or to be taken by the facility the grievance. These grievances are reviewed within 5 days and keep residents appropriately apprised of progress towards resolution of the grievances. Resident L's grievance was re-evaluated, and an appropriate resolution was made regarding the resident's desire to participate in physical therapy. ·All residents have the potential to be affected by the alleged deficient practice. All grievances for the past 30 days were re-evaluated to ensure satisfactory	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	During an interview on 9/27/2024 at 8:55 A.M., the Administrator indicated the facility did not offer a restorative program because she did not have anyone in that position. She indicated if someone came in with Medicaid as their payer source, the facility did not get any reimbursement for the therapy services and the facility had to "pay out of pocket." She confirmed there was a resident that had approached her to request therapy services and she had completed a grievance form related to the concern. The Administrator indicated the resident requesting therapy services got around in his motorized wheelchair and went outside and smoked cigarettes. A Physician's Order, dated 9/21/2024, indicated physical therapy three times a week for 12 weeks with skilled therapy services including therapeutic exercises, activities, gait training, group therapy, neuromuscular re-education, patient/caregiver education for the treatment diagnosis of muscle weakness and other abnormalities of gait and mobility. During an interview on 9/27/2024 at 9:49 A.M., the Administrator indicated she gave responses back from a grievance within 5 days. The Administrator gave no explanation as to why the grievance, filed by Resident L on 8/5/2024 was not addressed completely until 9/21/2024 when the resident was evaluated by the therapy department and a physician's order for therapy was received. On 9/26/2024 at 10:10 A.M., the Administrator provided a policy titled, "Resident and Family Grievances," revised 2/2023, and indicated it was the policy currently used by the facility. The policy indicated..."1. The Executive Director has been designated as the Grievance Official. 10.		resolution to the concerns of the residents. No other residents were found to be affected by the alleged deficient practice. ·The facilities process for grievance was reviewed. The Administrator/Designee in-serviced the IDT as well as all care staff to ensure that grievance processes were following the facilities guidelines. ·The Administrator/Designee will review/audit grievances going forward to ensure that grievances are appropriately addressed. These reviews/audits will be conducted 5 X weekly for 30 days, then 3 times weekly for 30 days, then weekly for a period of 4 months. The results of the review/audit will be discussed in QAPI and if there is any deficient practice noted, further recommendations will be made per the QAPI IDT. IF no deficiencies are noted, QAPI will review/audit on a prn basis thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	Procedure: d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. i. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. ii. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. "Prompt efforts" include acknowledgement of complaint/grievance and actively working toward a resolution of that complaint/grievance. e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances ....." 3.1-7(2)			
F 0621 SS=D Bldg. 00	483.15(b)(1)-(3)(c)(9) Equal Practices Regardless of Payment Source Based on observation, interview and record review the facility failed to provide equal access to services including specialized rehab to a resident with Medicaid payer source for 1 of 1 resident reviewed for rehab services. (Resident L) Finding includes: During an observation and interview on 9/19/2024 at 2:23 P.M., Resident L indicated no one had completed range of motion exercises with him, nor had he received any therapy. He indicated he came to the facility so he could receive therapy and he had asked for therapy. His left leg was no longer straight, he could not open up his hand and had lost range of motion to his left arm. He had received a soft splint to the left hand prior to his admission to the facility but had to ask for	F 0621	Brickyard 12 St Care 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. F 621 Equal Practices Regardless of Payment Source It is the practice of the facility to provide equal access to services including specialized rehab to a resident regardless of their payor source. ol="" role="list" start="1" Resident #37 is currently being provided with therapy services.	11/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	someone to put it on him. In addition, he also had an ankle foot orthosis (AFO) for his left foot but felt it was too tight. A record review was completed on 9/23/2024 at 2:13 P.M., for Resident L. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, spastic hemiplegia affecting left nondominant side, and colostomy status. An Admission Minimum Data Set (MDS) assessment, dated 7/1/2024, indicated Resident 37 needed partial/moderate assistance for personnel hygiene, required substantial/maximal assistance for shower/bathing and transfer needs, and had impaired range of motion, on one side of his body, to the left upper and lower extremity. A Baseline Care Plan, dated 6/26/2024, indicated "Therapy 1. Physical functional goals b. improve functional status, c. minimize decline, 2. Therapy services a. Physical therapy, b. occupational therapy." A Physician's Order, dated 9/21/2024, indicated physical therapy 3 times a week for 12 weeks with skilled therapy services including therapeutic exercises, activities, gait training, group therapy, neuromuscular re-education, patient/caregiver education for the treatment diagnosis of muscle weakness and other abnormalities of gait and mobility. A Physical Therapy Evaluation and Plan of Treatment, dated 9/21/2024, indicated "Reason for Therapy: Clinical Impression/Reason for Skilled Services: Based upon patient's body regions, systems and structures, patient presents with balance deficits, decreased dynamic balance,		All residents have the potential to be affected by the alleged deficient practice. Residents admitted in the past 30 days were reviewed to ensure that residents appropriate for therapy received these services. No other residents were identified as affected by the alleged deficient practice. The facilities policy regarding Specialized Rehabilitative Services was reviewed. The DNS/Designee in-serviced the IDT as well as direct care staff to include licensed nurses, certified nursing assistants and qualified medication aides to ensure that facility staff educated on such policy and to ensure that it is followed. The Administrator, DNS/Designee, and Director of Rehab Services will review/audit all residents admitted to the facility as well as readmits to ensure that any resident who requires rehab services are provided regardless of their payor source. The audits/reviews will take for all new admissions and readmits to the facility for a period of 5 times weekly x 30 days, then 3 times weekly X 30 days, then weekly times 4 months. All results will be reviewed in QAPI and if there is deficient practice noted, further recommendations will be made per the QAPI IDT. If no deficiencies are noted, QAPI IDT will be reviewed on a prn basis. IDR due to additional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	decreased functional capacity, decreased ROM, strength impairments and pain and in consideration of history, personal factors, and functional limitations documented in this eval summary, patient requires skilled PT services to increase LE ROM and strength, minimize falls, increase functional activity tolerance, improve dynamic balance and facilitate discharge planning, in order to return to prior level of functional abilities. Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for: falls , further decline in function and immobility." During an interview on 9/25/2024 at 10:14 A.M., the Director of Rehab (DOR) indicated she could not evaluate a new admission with Medicaid as a payer source for rehabilitation services without the permission of the Administrator. The DOR had been approached by Resident L who indicated he wanted therapy. She had informed the Administrator after his admission that she believed Resident 37 would benefit from therapy. The only evaluation she was allowed to complete was the power scooter mobility assessment for safety. The Administrator had approved Resident 37's therapy on 9/21/2024 and he was evaluated and placed on therapy services for physical and occupational therapy. She was not certain if Resident 37 had experienced a decline in mobility since she was not allowed to evaluate him upon his admission. There was no other explanation given by the Rehabilitation Director as to why there was a delay regarding completing an evaluation of Resident 37 for therapy needs since his admission and since he had requested to be evaluated. During an interview on 9/25/2024 at 2:00 P.M., the		documentation to show compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	Business Office Manager (BOM) indicated if a Resident who had Medicaid as a payer source had a physician's order for a therapy assessment, a physician's order for therapy services and there was an indication the resident needed therapy, they would be eligible to receive therapy services. During an interview on 9/26/2024 at 8:55 A.M., the Administrator indicated the facility did not offer a restorative program because she did not have anyone in that position. If a resident was admitted with Medicaid as a payer source, the facility did not receive any reimbursement for therapy services for that resident. She indicated the facility had to "pay out of the pocket" for the resident's skilled rehabilitation therapy. She confirmed there was a resident that had approached her requesting therapy and she indicated she had addressed the request in on a written grievance. She indicated Resident 37 had not experienced a decline and had not needed therapy services because he got around in his motorized wheelchair and went outside and smoked cigarettes. During an interview on 9/26/2024 at 9:49 A.M., the Administrator indicated Resident L came in at his " baseline" and the reason she offered him therapy services now was because in talking with the Director of Rehab, she indicated Resident L would benefit from upper body strengthening. During an interview on 9/26/2024 at 9:53 A.M., the DOR indicated therapy department would be working on transfers and overall strengthening. The DOR indicated, he currently needed assistance with transfers. On 9/26/2024 at 9:06 A.M., the Administrator provided a policy titled, "Specialized			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	Rehabilitation Services," and indicated the policy was the one currently used by the facility. The policy indicated..."5. Specialized rehabilitative services are considered a facility service and included within the scope of facility services; therefore, if services are not enumerated in the State plan, the facility will not charge a Medicaid recipient for specialized rehabilitative services....." This citation relates to Complaint IN00443668.			
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg Based on record review and interview, the facility failed to complete a Significant Change Minimum Data Set (MDS) assessment timely for 2 of 3 residents reviewed for Hospice services. (Residents 16 & 28) Findings include: 1. Resident 16's record review was completed on 9/23/2024 at 3:10 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, traumatic brain injury, depression, bipolar disorder and anxiety disorder. Resident 16 had a signed hospice contract, initiated on 3/28/2024. A current Physician's order indicated Resident 16 had been receiving Hospice services since 3/28/2024. A Quarterly MDS assessment, dated 3/19/2024, indicated Resident 16 was not receiving Hospice services. A Significant Change MDS assessment, dated	F 0637	Brickyard 12 St Care 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. F637 Comprehensive Assessment After Significant Change It is the practice of the facility to complete a Significant Change Minimum Data Set assessment for significant changes such as a resident having an order for hospice services. Residents #16 and #28 were identified as having a significant change requiring hospice and were identified as affected by the alleged deficient practice, which	11/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	6/19/2024, indicated the resident was receiving Hospice services. Resident 16's record lacked the documentation a Significant Change MDS had been completed timely after the Physician's order was received on 3/28/2024 for Hospice services. During an interview on 9/24/2024 at 9:50 A.M., the Regional MDS Nurse indicated a Significant Change MDS should be completed within 14 days of the initiation of Hospice services for any resident. She indicated Resident 16 should have had a Significant Change MDS assessment completed 14 days after 3/28/2024. 2. Resident 28's record review was completed on 9/24/24 at 9:30 A.M. Diagnoses included, but were not limited to: epilepsy, type 2 diabetes mellitus, Chrohn's disease, dysphagia, spinal stenosis and benign prostatic hyperplasia. Resident 28 had a signed Hospice agreement for Heart to Heart Hospice dated 8/2/2024. A current Physician's order indicated Resident 28 had been receiving Hospice services since 8/12/2024. A Quarterly MDS assessment, dated 6/14/2024, indicated Resident 28 was not receiving Hospice services. A Quarterly MDS assessment, dated 8/16/2024, indicated Resident 28 was receiving Hospice services. Resident 28's record lacked the documentation a Significant Change MDS assessment had been completed within 14 days from the Hospice order		resulted in no harm to the residents. All residents admitted to hospice in the last 30 days were reviewed to ensure a significant change assessment was completed timely. ·All residents with significant change have the potential to be affected. ·The facilities procedure for identifying residents with significant change requiring hospice services was reviewed. The MDS/Designee will in-service the IDT to ensure that the facility procedure is followed and MDS significant change of a resident requiring hospice services has been completed per the RAI manual. ·The MDS/Designee will review/audit in clinical startup any residents having a significant change requiring hospice services and ensure that the sig change assessment has been completed within 14 days of change. Audits will be conducted 5 x weekly for 2 months, then 3x weekly x 2 months, then weekly x 2 months. The results will be reviewed in QAPI for a minimum of 6 months. If deficient practice is noted, then the audits will be continued based	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	on 8/2/2024. During an interview on 9/24/2024 at 9:50 A.M., the Regional MDS Nurse indicated a Significant Change MDS assessment should be completed within 14 days of any resident starting hospice services. Resident 28 should have had a Significant Change MDS assessment completed 14 days after he was readmitted to the facility on 8/12/2024 with Hospice services. The Regional Nurse indicated the facility does not have a policy for MDS assessments, but they used the RAI (Resident Assessment Instrument) manual. 3.1-31(d)(1)		on QAPI recommendations. If no deficiencies are noted, then QAPI will review on a prn basis.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review and interview, the facility failed to complete and maintain grooming for 3 of 4 residents reviewed for activities of daily living (ADLs). (Residents 15, L and 21) Findings include: 1. During an observation and interview on 9/19/2024 at 1:53 P.M., and 9/20/2024 at 1:53 P.M., Resident 15's nails were long with a dark substance under them. He indicated no one had offered to clean or trim his nails. During an observation on 9/23/2024 at 9:14 A.M. and 9/24/2024 at 9:17 A.M., Resident 15's nails were long with a dark substance under them. A record review was completed, on 9/25/2024 at 11:36 A.M., for Resident 15. Diagnoses included, but were not limited to: Parkinson's Disease without dyskinesia, chronic kidney disease stage	F 0677	Brickyard 12 St Care 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. F677 ADL Care Provided for Dependent Residents It is the practice of the facility to provide ADL Care for dependent residents, who are unable to carry out activities of daily living, and resident will receive the necessary services to maintain good nutrition, grooming and personal care, as well as oral hygiene care with respect to resident right to refuse services offered.	11/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	3, and chronic embolism and thrombosis of deep veins of right upper extremity. An Admission Minimum Data Set (MDS) assessment, dated 8/9/2024, indicated Resident 15 required substantial/maximal assistance for personal hygiene and bathing. A current Care Plan, initiated on 8/1/2024, for activities of daily living indicated Resident 15 had a self- care deficit with shaving, washing his face and hands and combing his hair. A current Care Plan, dated 9/17/2024, indicated Resident 15 often refused to have his nails, beard and hair cut. A Review of the Electronic Medical Record for Resident 15, specifically of the Nursing Progress Notes and the Task section , indicated there was no documentation of any refusals of nail care since his admission. During an interview, on 9/25/2024 at 10:46 A.M., CNA 2 indicated when he provided morning ADL care he assisted with washing of the face, chest, peri care, applied body spray, dressed and brushed their hair. When he provided a shower, he assisted with washing, rinsing, drying, dressing and combing their hair. During an interview on 9/25/2024 at 10:54 A.M., CNA 3 indicated when she completed morning ADL care she assisted with a partial bath unless they wanted a complete bed bath. She then assisted the residents to get dressed and transferred them. If she provided a shower, she started with washing their hair, then worked her way down the body, dried the resident's body, then she applied lotion, deodorant, dressed the		Resident #15 nails were cleaned and trimmed. Resident L was shaved, and nails were trimmed. Resident #21 nails were cleaned and trimmed. ·All residents have the potential to be affected by the alleged deficient practice. All residents residing in the facility were observed for grooming and personal care needs and provided care if so desired. A review of resident's preferences regarding ADL care was also conducted for current residents. No other residents were identified as being affected. ·The facilities, process and procedures for providing ADL Care as appropriate and as preferred by the residents were reviewed. The DNS/Designee in-serviced the IDT as well as all direct care staff to include Nurses, Certified Nurses Assistants, and Qualified Medication Aides regarding providing ADL care to include nail care and shaving. ·The UM/Designee will observe residents to ensure that their nails are clean, and they are shaven as appropriate. These observations will be random to include all units	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	resident and dried their hair. During an interview on 9/25/2024 at 11:02 A.M., CNA 4 indicated when she provided morning ADL care she washed their face and under their arms, provided peri care, applied deodorant body spray, dressed and brushed their teeth. If a shower was provided, she washed their body from clean to dirty, dried their body, applied lotion, clothing and if there were any skin issues, she told the nurse. During an interview on 9/25/2024 at 11:51 A.M., LPN 13 indicated any resident refusals of ADL care would be entered in the nursing progress notes by the nurse and CNA's documented refusals under the electronic application. 2. During an observation and interview on 9/19/2024 at 2:15 P.M., Resident L indicated staff had not offered to shave him. He wanted to grow a mustache and a goatee but wanted the sides/cheek/neck area shaved. He indicated the other day his Dad used the electric shaver but he preferred a closer shave with a razor. His left hand fingers were curled under into a fist and he could not open it unless he opened it with his right hand. Resident L's left arm had limited movement. During an observation and interview on 9/23/2024 at 9:16 A.M., Resident L indicated the Administrator had came into his room this morning and asked if he would like to be shaved and have his nails trimmed . During an observation and interview on 9/23/2024 at 1:32 P.M., he indicated no one had assisted him with shaving or nail care. During an observation and interview, on 9/24/2024		and will be conducted as follows: 3 residents /day x 5 times 2 months, then 3 residents/day x 3 times weekly x 2 months, then 3 residents/day weekly x 2 months. The results of the audits will be discussed in QAPI for a minimum of 6 months. If there is deficient practice noted, further recommendations will be made by QAPI IDT. If no deficiencies are noted, QAPI IDT will review on a prn basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	at 9:15 A.M. and 2:00 P.M., Resident L indicated he was not offered a shave and his finger nails were not trimmed yesterday. During an observation and interview on 9/24/2024 at 10:40 A.M., Resident L had increased growth of facial hair on his neck, sides/cheek of his face and a brown substance under his long nails. He indicated no one had offered to assist him with shaving or nail care. A record review was completed, on 9/23/2024 at 2:13 P.M., for Resident L. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, spastic hemiplegia affecting left nondominant side, and colostomy status. An Admission MDS assessment, dated 7/1/2024, indicated he needed partial/moderate assistance for personnel hygiene and he required substantial/maximal assistance for showering and bathing needs. A current Care Plan, initiated on 6/27/2024, titled "ADL self care deficit", included interventions for personal hygiene assistance with shaving, washing his face and hands and combing his hair. During an interview on 9/25/2024 at 10:46 A.M., CNA 2 indicated when he performed morning ADL care he assisted with washing of the face, chest, peri area, applied body spray, dressed and brushed their hair. When he provided a shower, he assisted with washing, rinsing, drying, dressing and combing their hair. During an interview on 9/25/2024 at 10:54 A.M., CNA 3 indicated when she provided morning ADL care she assisted with a partial bath unless			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	they wanted a complete bed bath, dressed them and transferred them. If she provided a shower, she started with washing their hair then worked her way down the body, dried the body, applied lotion, deodorant and then dressed and dried their hair. During an interview on 9/25/2024 at 11:02 A.M., CNA 4 indicated when she provided morning ADL care she washed their face, under their arms and their peri area, applied deodorant body spray, dressed and brushed their teeth. If a shower was provided, she washed their body from clean to dirty, dried the body, applied lotion, clothing and if any skin issues were noted, she told the nurse. During an interview on 9/25/2024 at 11:51 A.M., LPN 13 indicated any refusals of ADL care would be entered in the nursing progress notes by the nurse and CNA's documented refusals under the electronic application.3. During an observation on 9/20/2024 at 9:44 A.M., Resident 21 was found to have long fingernails with a dark brownish-black substance under them. During an observation on 9/23/2024 at 1:21 P.M., Resident 21's fingernails remained long with a dark brownish-black substance under them. A record review for Resident 21 was completed on 9/24/2024 at 2:52 P.M. Diagnoses included, but were not limited to, dementia, chronic obstructive pulmonary disease and mild intellectual disabilities. A Quarterly Minimum Data Set assessment, dated 7/19/2024, indicated Resident 21's cognition was moderately impaired. There were no behavior concerns and he required partial or moderate			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	assist with showers and set up assist for personal hygiene. A current Care Plan problem, initiated on 7/11/2024, indicated Resident 21 needed staff assist for ADLs and grooming. An intervention indicated the resident required assist of 1 staff member for hygiene and grooming. There was no documentation of Resident 21 had refused any hygiene or grooming assistance. During an interview on 9/25/2024 at 1:58 P.M., CNA 12 indicated when she provided personal care, for bathing or showering, she cleaned the resident from head to toe, assisted with oral care and provided nail care. If the resident refused care, she reported it to the nurse. On 9/25/2024 at 1:26 P.M. the ED provided a current policy, dated February 2023 and titled, "Activities of Daily Living (ADLs)." The policy included, but was not limited to, "...Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care;..." 3.1-38(3)(D)(E)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview and record review, the facility failed to ensure a resident received adequate treatment and monitoring for a pressure ulcer for 1 out of 3 reviewed for pressure ulcers. (Resident 37) Finding includes:	F 0686	Additional Documentation to show compliance Brickyard 12 St Care Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	11/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	During an interview and observation on 9/19/2024 at 11:04 A.M., Resident 37 indicated he had a sore on the back of his left upper thigh. He told the nurse about it 3-4 weeks ago. The dressing covering the sore came off and he told the nurse and she was going to replace it. He indicated the sore was caused by his wheelchair cushion and they gave me a new cushion. The residents skin was observed and there was a circular crater the size of a nickel with swollen, raised edges and loose skin around the edges. Resident 37 indicated staff placed a patch on the wound every couple of days when he asked for one. During an observation and interview on 9/20/2024 at 9:31 A.M., Resident 37 indicated the facility placed a patch on his wound yesterday around 1 P.M. There was a white dressing undated, no initials and there was visible drainage coming through the dressing. During an interview on 9/23/2024 at 3:07 P.M. Resident 37 indicated the dressing had been changed this morning and when he went to the wound clinic, they placed a new dressing on it. During an interview and observation on 9/24/2024 at 2:04 P.M., Resident 37 indicated no one had changed the wound dressing for the day. The wound was observed to have a gauze with tape over it, undated. He indicated he had to ask for the dressing to be changed but RN 7 changed it every weekend. A record review was completed on 9/24/2024 at 1:30 P.M., for Resident 37. Diagnosis included, but were not limited to: chronic venous hypertension with ulcer of bilateral lower extremity, and peripheral vascular disease.		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F686 Treatments/Services to Prevent Pressure Ulcer It is the practice of the facility to ensure that residents receive adequate treatment and monitoring for pressure ulcers. 1.Resident #37 is not identified as having a pressure ulcer. 2. All residents have the potential to be affected by the alleged deficient practice. All residents currently at the facility were provided with a full skin assessment. No other residents were identified as having skin issues not being treated and monitored. 3. The policy and procedures for completing skin assessments was reviewed. The DNS/Designee in-serviced the IDT and all direct care staff, to include Nurses for identifying and obtaining treatments and monitoring. Certified Nursing Assistants, and Qualified Medication Aides, with regards to identifying skin concerns and reporting any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	A Significant Minimum Data Set (MDS) assessment, dated 7/31/2024, indicated the resident had normal cognition. A Nursing Progress Note, dated 9/11/2024 at 10:32 A.M., indicated resident had 2 open areas on his posterior left leg, the first area measured 2 cm by 1 cm and the other area measured 1 cm by 1 cm. There was no odor, drainage or warmth of the wounds noted. The Physician, Unit Manager and Optum staff were made aware of the wounds, and nursing continued to monitor the wounds. A Weekly Skin Review, dated 9/13/2024, indicated Resident 37 skin was intact. A Weekly Skin Review, dated 9/20/2024, for Resident 37 indicated " Pre-existing open areas to BLE treated by wound clinic and wrapped. Continue with current wound care treatment to back and legs. No new open areas or skin concerns noted." A Progress Note from the wound care office, dated 9/16/2024, indicated "Patient present for care of wound to posterior leg. He notes it is likely from his wheelchair. He reports soreness. The left thigh measurements 1.5 by 1.7 by 0.1 depth, wound depth full, stage 2. The Assessment & Plan-[no debridement due to tenderness. We will dress with medihoney to help with enzymatic debridement. Follow up in 1-2 weeks. Wound Care Orders: "Cleanse with mild soap water, Change Frequency: once daily, Cover with: dry gauze secure with tape." A Progress Note from the wound care office, dated 9/23/2024, indicated "Patient presents for follow up to posterior left thigh. Measurement Pre Debridement 1.3 cm by 1.5 cm by 0.1 cm.		changes of the skin to the Licensed Nurse. 4. The UM/Designee will audit to ensure that all residents identified to have pressure ulcers will be monitored and receive treatment. Any new pressure ulcers will be audited to ensure that treatment and monitoring are in place. Audits will take place 5x weekly x 2 months, 3x weekly x 2 months, then 1x weekly x 2 months. All results of audits will be reviewed in QAPI for a minimum of 6 months. If deficiencies are noted, the QAPI IDT will make recommendations for further audits. If no deficiencies are noted, then the QAPI will review on a prn basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	moderate amount of serosanguineous exudate, Wound Depth: full, stage 2. Measurement Post Debridement: 1.4 by 1.6 by 0.1. The Assessment & Plan-was to continue with medihoney dressings. Follow up in 1 week. Wound Care Orders: "Cleanse with soap and water, Change Frequency: once daily, Dressing: Medihoney Gel, Cover with: dry gauze secure with tape. Offloading:cushion/Pressure relief." During an interview on 9/24/2024 at 9:21 A.M., RN 6 indicated Resident 37 did not have any wounds the facility monitored or treated. RN 6 indicated the resident received three different creams: one for his knee pain, Clotrimazole to his knee redness and Cetaphil lotion for his back. During an interview on 9/24/2024 at 11:18 A.M., RN 8 indicated if she found a new open area, she would do an assessment, document the location, measurements, note any drainage and stage the area. Under the assessment tab of the electronic medical record, she would document the wound on a skin weekly review form. She would notify the doctor, family and the manager on duty and then she would complete a risk assessment if it was a pressure area. During an interview and observation, on 9/24/2024 at 2:14 P.M., RN 7 indicated after reviewing his orders he did not have any dressing changes ordered, he used to have a wound treatment but now went to the wound clinic for his lower legs. RN 7 was requested and completed a skin assessment and noted the following area to the back of the upper thigh- a 1.5 centimeters (cm) by 2.0 cm, by 0.1 cm in depth circle with moderate amount of green yellow drainage with erythema (redness) around the area, measuring 3 cm by 4 cm. RN 7 indicated if had possibly been a blister			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	that had popped and he was going to have the wound nurse asses the wound and notify the DON. There was an undated dressing on the wound when RN 7 began his assessment. During an interview on 9/26/2024 at 10:01 A.M., the DON indicated a wound was measured once a week during wound rounds by the wound nurse. Staff documented wounds on the UDS's (Electronic Medical Record) under the assessment tab called "Skin Only Evaluation". If a nurse found a wound on a weekly skin assessment, the DON expected the nurse to document the new area, notify the nurse practitioner and obtain an order for treatment of the wound. In addition, a care plan would be initiated after the order for treatment was received. On 9/25/2024 at 9:20 A.M., the Regional Nurse provided a policy titled "Notification of Changes," dated 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance Guidelines: 3. Circumstances that require a need to alter treatment. This may include: a. New Treatment." On 9/25/2024 at 9:20 A.M., the Regional Nurse provided a policy titled, "Skin Assessment," dated 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury prevention and management. The policy includes the following procedural guidelines in performing the full body skin			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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
	assessment. Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury ....." On 9/26/2024 at 11:12 A.M., the Administrator provided a policy titled, "Clean Dressing Change," dated 2021, and indicated the policy was the one currently used by the facility. The policy indicated "... It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequently of changes ....." 3.1-40(a)(2)(3)			