STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TERRACE CARE CENTER	1900 ANDREW AVE 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. Survey dates: April 14, 15, 16, 17, and 18, 2024 Facility number: 000061 Provider number: 155136 AIM number: 100288620 Census Bed Type: SNF/NF: 127 Total: 127 Census Payor Type: Medicare: 10 Medicaid: 93 Other: 24 Total: 127 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/24/24.	F 0000	***Brickyard Terrace 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.*** ***Brickyard Terrace Care Center respectfully requests consideration for a desk review.***	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure a self-medication administration assessment was completed for residents with medications at the bedside for 2 of 2 random observations. (Residents 105 and 2)	F 0554	**F554 Resident Self Administer Meds** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**	05/05/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Shepperd	Executive Director	05/10/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Findings include: 1. On 4/15/24 at 9:34 a.m., Resident 105 was observed sitting on the side of her bed. There was a medication cup that contained a small amount of medication solution on top of the bedside table. The record for Resident 105 was reviewed on 4/15/24 at 2:15 p.m. The diagnoses included, but were not limited to, depression, diabetes, traumatic amputation of left foot, hypertension (high blood pressure), and urinary tract infection. The Admission Minimum Data Set (MDS) assessment, dated 1/29/24, indicated the resident was cognitively intact for daily decision making. A Physicians' Order, dated 3/30/24, indicated to give 30 milliliters (ml) of ProT Gold (supplement) once a day. There was no self-medication administration assessment. There was no Physician order to self-administer medications. During an interview on 4/16/21 at 11:20 a.m., the Director of Nursing (DON) indicated she understood the medication should not have been left at the bedside and had no additional information to provide. 2. On 4/14/24 at 11:39 a.m., Resident 2 was observed sitting in her wheelchair eating a snack. There was a bottle of acetaminophen on top of the bedside table. On 4/15/24 at 9:48 a.m., Resident 2 was observed		Medications/cream removed from bedside and thrown away for resident 105 and 2. No ill effect from alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents in the facility receiving medications/cream have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure self-administration orders were in place where applicable. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** Nursing educated on obtaining self-administration orders for all residents it's applicable for. DON /designee will audit 5 residents 5x each week x 6 months to ensure that there's no medications left at bedside and if so, there's self-administration orders in place for the resident timely. Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put**	

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	knitting in her wheelchair. There was a bottle of acetaminophen on the bedside table along with 2 tubes of pain-relieving cream. The record for Resident 2 was reviewed on 4/16/24 at 9:25 a.m. The diagnoses included, but were not limited to, heart failure, anxiety, depression, hypertension (high blood pressure), muscle weakness, and low back pain. The Quarterly Minimum Data Set (MDS) assessment, dated 3/28/24, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 1/9/24 at 6:45 p.m., indicated to give Tylenol (Acetaminophen) 250 milligrams (mg) by mouth every 4 hours as needed for pain. There was no self-medication administration assessment. There was no Physician's Order to self-administer medications. There was no Physician's Order for topical pain cream. During an interview on 4/16/21 at 11:25 a.m., the Director of Nursing (DON) indicated she understood the medication should not have been left at the bedside and had no additional information to provide. 3.1-7(a)(2)		**into place?** The DON/designee will complete audit tool to reflect proper self-administration orders are scheduled using attached audit sheet. The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
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			

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	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 dependant residents related to nail care and the removal of facial hair, for 1 of 2 residents reviewed for ADL care. (Resident 41) Finding includes: During an interview on 4/14/24 at 11:40 a.m., Resident 41 indicated his nails were long and dirty and someone usually came in to clean them, but they had not been done in awhile. At that time, the resident's nails were long with a dark colored substance underneath them. The resident was also unshaven. During random observations on 4/15/24 at 1:33 p.m. and on 4/16/24 at 9:00 a.m., the resident was observed in bed. At those times, the resident's nails were long and dirty and he was unshaven. The record for Resident 41 was reviewed on 4/15/24 at 2:40 p.m. Diagnoses included, but were not limited to, senile degeneration, high blood pressure, hallucinations, anxiety, and pain. The 2/6/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making and needed partial to moderate assist with personal hygiene. The Care Plan, revised on 11/27/23, indicated the resident had an ADL self care deficit. The Shower Sheets, dated 4/1 and 4/4/24,	F 0677	**F677 ADL Care for Dependent Residents** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident 41 nails cleaned and trimmed. Resident 41's facial hair trimmed. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents in the facility that require assistance with nail care and shaving have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents who require assistance with nail care and shaving are having that service provided timely. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** Nursing staff educated on the need to ensure proper assistance is provided with nail care as well as shaving for residents that require assistance with those ADL's.	05/05/2024

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	indicated the resident's nails were clipped. There was no other documentation his nails had been clipped and/or cleaned since then. There was no documentation indicating the last time the resident had been shaved. During an interview on 4/17/24 at 12:15 p.m., the Director of Nursing indicated the resident received Hospice services and now the CNA was only coming one time a week. She would expect nursing staff to make sure the resident's nails were clipped and cleaned and he was shaved. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)		DON /designee will audit 5 residents 5x each week x 6 months to ensure that residents requiring assistance with nail care and grooming of facial hair is completed. Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** The DON/designee will complete audit tool to reflect residents needing assistance with ADL care (nails, facial hair) is provided timely. The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
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 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,			

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	and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure non-pressure skin treatments were completed as ordered and TED (compression support stockings) hose were in use for a resident with edema, for 2 of 4 residents reviewed for non-pressure skin conditions. (Residents 64 and 122) Findings include: During a random observation on 4/14/24 at 1:30 p.m., Resident 64 was observed sitting in his wheelchair. At that time, the resident's lower legs were observed with dry scaly skin and were red in color. The resident indicated staff complete a treatment to them a couple times a week. The record for Resident 64 was reviewed on 4/15/24 at 2:12 p.m. Diagnoses included, but were not limited to, stroke, heart failure, cellulitis, high blood pressure, and atrial fibrillation. The Annual Minimum Data Set (MDS) assessment, dated 3/4/24, indicated the resident was not cognitively intact for daily decision making. The resident was at risk for pressure ulcers, but currently had none. The Care Plan, revised on 3/21/24, indicated the resident had cellulitis. Physician's Orders, dated 3/5/24, indicated Clotrimazole-Betamethasone (a cream used to treat redness and swelling for fungal infections) 1-0.05 % Cream, apply to bilateral lower extremities every day and evening shift for dryness. The Treatment Administration Record (TAR) for	F 0684	**F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident 64 tx applied. Resident had no ill effect due to alleged deficient practice. ·Resident #122 compression stockings applied. No ill effect due to the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents that have tx orders and orders for compression stockings have the potential to be affected by this alleged deficient practice. Full house audit completed of all residents in house with non-pressure tx orders and compression stockings to ensure tx are completed and compression stockings are in place. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·Clinical staff were educated on applying tx orders as prescribed by MD. ·Clinical staff were educated on applying compression stockings	05/05/2024

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	the month of 3/2024, indicated the treatment of Clotrimazole-Betamethasone 1-0.05 % Cream was not signed out as being completed on evening shift for 3/5, 3/9, 3/19, and 3/20/24. The TAR for the month of 4/2024, indicated the Clotrimazole-Betamethasone 1-0.05 % Cream was not signed out as being completed on the day shift on 4/9/24 and the evening shift on 4/12/24. During an interview on 4/17/24 at 2:00 p.m., the Director of Nursing indicated there might have been a QMA working on that cart on those days, however, the treatment was in their scope of practice, so she would expected the treatments to be done as ordered.2. On 4/14/24 at 11:28 a.m., Resident 122 was observed sitting on the side of his bed. His right lower leg was dry, red, and scaly, and his foot was swollen. The resident was wearing sweat pants and there was an indentation on the outside of his leg. The resident was not wearing TED hose. On 4/15/24 at 2:25 p.m., the resident was observed sitting on the edge of the bed. He was not wearing TED hose. On 4/16/24 at 8:58 a.m., the resident was observed sitting on the edge of the bed. Both lower extremities were dry, scaly, red, and swollen. The resident pushed lightly against both of his legs and demonstrated deep indentations. The resident had 4+ pitting edema (indentation that takes 2-3 minutes for skin to rebound). At 9:00 a.m., the resident's indentation in his legs had not yet rebounded. The resident was not wearing TED hose. On 4/17/24 at 9:32 a.m., Resident 122 was observed sitting up in bed with his sister at the		as ordered by MD. ·Director of nursing/designee will audit 5 residents per week x 6 months to ensure tx orders are completed. ·Director of nursing/designee will audit 5 residents per week x 6 months to ensure compression stockings are applied as ordered. **·All audits will include all shifts and units and weekends.** **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Director of nursing/designee will complete audit tool to ensure that all residents with non-pressure areas will receive treatment orders. ·The Director of nursing/designee will complete audit tool to reflect proper assessments are in provided for all residents with edema. The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	bedside. He was not wearing TED hose and he indicated he had been asking for them for weeks. The record for Resident 122 was reviewed on 4/16/24 at 1:24 p.m. The diagnoses included, but were not limited to, heart failure, respiratory failure with hypoxia, bipolar, anxiety, cellulitis (bacterial infection of the skin) of left and right lower limb and neuropathy (numbness and pain in feet). The Admission Minimum Data Set (MDS) assessment, dated 4/2/24, indicated the resident was moderately impaired for daily decision making. A Care Plan, dated 3/36/24, indicated the resident had congestive heart failure (CHF). Interventions included, elevating lower extremities, observe for signs and symptoms of CHF such as shortness of breath, dependant edema of the legs and feet, and obtain lab/diagnostic work as ordered. A Physician's Order, dated 4/1/24, indicated for the resident to wear bilateral TED hose every day and evening shift and off at night. A Nurse's Note, dated 4/14/24 at 12:38 p.m., indicated the resident had a critical lab result. The resident's brain natriuretic peptide (BNP, a test to indicate heart failure) level was 1107 (normal <100). The Physician and patient were made aware of the results. A Physicians' Note, dated 4/12/24, indicated the resident had a positive cardiovascular assessment with pitting edema in bilateral upper and lower extremities. The Treatment Administration Record (TAR) indicated the TED hose were not signed out as			

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	being on from 4/13/24- 4/17/24. During an interview on 4/17/24 at 10:18 a.m., CNA 1 indicated she had not cared for the resident in a while, but she had personally put his TED hose on when she previously provided care for him. During an interview on 4/17/24 at 10:30 a.m., CNA 2 indicated she had been assigned to the resident this week and was unaware the resident wore TED hose. During an interview on 4/17/24 at 2:25 p.m., the Memory Unit Manager indicated she was not aware the resident had not been wearing his TED hose all week and she would follow up immediately. During an interview on 4/17/24 at 3:07 p.m., the Memory Unit Manager indicated they provided a new set of TED hose to the resident and received alternate intervention orders by the Nurse Practitioner (NP) to apply ace wraps to the resident's legs if the resident's TED hose were unavailable. 3.1-37(a)			
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			

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	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 ankle braces were applied as ordered for 1 of 1 residents reviewed for limited range of motion (ROM). (Resident 40) Finding includes: On 4/14/24 at 8:41 a.m., 11:45 a.m., and 2:11 p.m., Resident 40 was observed in his broda chair (a positioning wheelchair). The resident was wearing his shoes and no ankle braces were in use. On 4/15/24 at 1:26 p.m., the resident was again observed in his broda chair. The resident had shoes on and no ankle braces were in use. On 4/16/24 at 8:42 a.m., the resident was seated in his broda chair by the nurses' station. He was wearing shoes and no ankle braces were in use. The resident's right foot was leaning on the right side of the foot rest. At 1:15 p.m., the resident's right foot was again leaning on the right side of the foot rest on the broda chair. No ankle braces were in use. At 3:35 p.m., the resident's left foot was leaning on the left side of the foot rest. Again, no ankle braces were in use. On 4/17/24 at 1:17 p.m., the resident was seated in	F 0688	**F688 increase/prevent decrease in ROM** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #40 physician's order for ankle braces discontinued. Resident with no ill effect from alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents that have orders for braces have the potential to be affected by this alleged deficient practice. Full house audit completed of all residents in house with orders for braces to ensure application of such devices are completed. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**	05/05/2024

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	his broda chair by the nurses' station. He was not wearing shoes and no ankle braces were in use. The record for Resident 40 was reviewed on 4/15/24 at 3:52 p.m. Diagnoses included, but were not limited to, spastic cerebral palsy and intellectual disabilities. The 3/7/24 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. He had a limitation in range of motion (ROM) to both sides of his upper and lower extremities. The resident had not received restorative services for splint or brace assistance during the assessment reference period. The resident did not have a current Care Plan related to the use of the ankle braces. A Physician's Order, dated 6/22/23 and listed as current on the April 2024 Physician's Order Summary, indicated the resident was to wear bilateral ankle braces for up to 3-4 hours at a time. Staff were to don/doff (put on and take off) the brace and perform skin checks every shift. Staff were to stop using the brace if any skin issues were noted. The order had not been transcribed onto the June 2023 thru April 2024 Medication or Treatment Administration Records. There was also no indication the ankle braces had been applied under the "Task" section of the electronic medical record for the last 30 days. During an interview on 4/17/24 at 3:00 p.m., the Director of Nursing indicated therapy was supposed to discontinue the order and the resident no longer wore the ankle braces.		·Clinical staff were educated on applying braces that the physician prescribes to residents. ·Director of nursing/designee will audit 5 residents per week x 6 months to ensure prescribed braces are applied as ordered. ·All audits will include all shifts and units and weekends. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Director of nursing/designee will complete audit tool to reflect proper orders are in place for wedge cushion devices. ·The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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(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
	3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to provide adequate supervision for a resident in the shower room which resulted in a fall, for 1 of 3 residents reviewed for accidents. (Resident 34) Finding includes: During an interview on 4/14/24 at 9:44 a.m., Resident 34 indicated she was left alone in the shower room, went to stand up to clean her buttocks, slipped and fell. She indicated the shower chair was not locked, "that's why I fell." Staff assisted her into the shower room and they knew she was in there by herself. During an interview on 4/17/24 at 1:30 p.m., the resident was asked again about her fall in the shower room. At that time, she indicated she was helped into the shower room by staff and there were other CNAs in the room talking. One of the CNAs helped her wash her back, and then after she was finished, she did not hear any more talking and indicated she knew was left alone in there, so she continued to wash herself and stood	F 0689	**F689 Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #34 care staff supervision for all showers. No ill effect from alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents left unattended in the shower, have the potential to be affected by this alleged deficient practice. · A full house audit completed to ensure that all current residents have supervision during their showers.	05/05/2024

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	155136	A. BUILDING 00 B. WING	04/18/2024

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	up to wash behind her, went to sit back down and fell to the floor because the wheels on the shower chair were not locked. She screamed out loud and "they all came running back in", including the nurse. The record for Resident 34 was reviewed on 4/16/24 at 1:00 p.m. Diagnoses included, but were not limited to, dementia without behaviors, ischemic heart disease, angina, history of falling, osteoporosis, pain, anxiety, and major depressive disorder. The 3/13/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and needed partial to moderate assistance with the task of shower/bathe self. The resident needed supervision or touch assistance with the tasks of tub/shower transfer (the ability to get in and out of a tub/shower) and the task of sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed). The Care Plan, revised on 1/23/24, indicated the resident was cognitively intact. The Care Plan, revised on 1/23/24, indicated the resident was at risk for falls. The approaches were to assist with transfers during showering. A Change of Condition, dated 4/10/24 at 11:00 a.m., indicated the resident was observed sitting on her buttocks in front of the shower chair in the shower room. There were 2 CNAs with the resident and the resident indicated she stood up to wash her bottom, and when she was done, she went to sit down and the shower chair slipped out from under her. The resident indicated the wheels were not locked.		**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All staff educated on the need for supervision in the shower rooms for all residents that require ADL's assistance. ·Director of nursing/designee will audit 5 residents 5x weekly x6 months to ensure supervision is provided during showers. ·All audits will include all shifts and units and weekends. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Director of nursing/designee will complete audit tool to reflect proper fall interventions are in place using attached audit sheet. ·The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	A Post Fall Evaluation, dated 4/10/24 at 3:28 p.m., indicated the resident's fall in the shower room was not witnessed. The reason for the fall was the wheels on the shower chair were not locked. The bathroom call light was on when the resident was found. The resident was taking a shower, stood up, went to sit back down, and slipped from the shower chair and landed on her buttocks. An IDT (Interdisciplinary Team) Fall Note, dated 4/13/24 at 8:23 a.m. and identified as a late entry, indicated staff noted the resident slipped and fell while attempting to sit on the shower chair. The staff were unable to intervene in time to prevent the fall. The resident was alert and oriented and slipped while attempting to sit on the shower chair. The IDT recommended the resident to be assisted times by 1 staff with transfers in the shower and shower socks upon arrival. There was no investigation regarding the resident's claims she was left alone in the shower room and the fact the wheels on the shower chair were unlocked. During an interview on 4/17/24 at 2:00 p.m., the Director of Nursing indicated she had gone back to speak with the resident regarding the fall. The resident told her a CNA had helped her wash her knees and then pulled the shower curtain around her. After the curtain was pulled, she did not hear anyone else talking any more. The DON asked the resident if it was possible the staff were still in the shower room, and behind the curtain, and the resident told her she did not think anyone was in the room because no one was speaking. She then stood up to continue bathing herself and went to sit down and fell. The DON had no other information to provide.			

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	3.1-45(a)(2)			
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 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.			

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	Based on observation, record review, and interview, the facility failed to ensure foley (urinary) catheter bags and tubing were kept off the floor, for 1 of 4 residents reviewed for catheters. (Resident 53) Finding includes: On 4/14/24 at 10:58 a.m., Resident 53 was observed sitting in his wheelchair. The foley bag was resting on the ground underneath the resident's wheelchair. On 4/14/24 at 11:25 a.m., the resident was observed sitting in his wheelchair asleep. The foley bag was resting on the floor underneath his wheelchair. On 4/14/24 at 2:16 p.m., the resident was observed sitting in his wheelchair watching his tablet. The foley bag remained resting on the floor beneath his wheelchair. The record for Resident 53 was reviewed on 4/15/24 at 1:44 p.m. Diagnoses included, but were not limited to, cerebral palsy, high blood pressure, urine retention, acute kidney disease, and obstructive uropathy. The Quarterly Minimum Data Set (MDS) assessment, dated 1/17/24, indicated the resident was cognitively intact and had a indwelling catheter. The resident was dependent with toileting hygiene. The Care Plan, dated on 2/19/24, indicated the resident had an urinary tract infection. The Care Plan, dated on 2/19/24, indicated the resident had an alteration in bladder elimination	F 0690	**F690 Catheter** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #53 foley bag removed from floor, no ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents in the facility that have indwelling catheters have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents who have indwelling catheters have their foleys free from the ground. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** Nursing staff educated on the need to ensure catheter bags are not dangling/touching the floor at any time. DON/designee will audit all residents with an indwelling catheter 5x each week x 6 months to ensure that catheter bags are not dangling or touching the ground. Audits will include all shifts, units, and weekends.	05/05/2024

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	due to having an indwelling catheter. Interventions included, keeping drainage bag off the floor and keep drainage bag of catheter below the level of the bladder at all times. A Physicians' Order, dated 4/11/24, indicated to give Nitrofurantoin Macrocrystal (an antibiotic) 100 milligrams (mg) by mouth two times a day for an urinary tract infection (UTI) for 5 Days A Physicians' Order, dated 4/10/24, indicated to give Cephalexin (an antibiotic) 500 mg by mouth four times a day for an UTI for 7 days. During an interview on 4/16/21 at 11:24 a.m., the Director of Nursing (DON) indicated she understood the concern with the foley bag on the floor and had no additional information to provide. 3.1-41(a)(2)		**How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** The DON/designee will complete audit tool to reflect catheter bags are not touching the ground or dangling. The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate, for 3 of 5 residents reviewed for respiratory care (Residents 228, 37 and 116)	F 0695	**F695 Respiratory, Trach Care, and Suctioning.** **What corrective action will be accomplished for those residents found to have been**	05/05/2024

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	Findings include: 1. During random observations on 4/14/24 at 9:10 a.m. and 11:10 a.m., Resident 228 was observed wearing oxygen per nasal cannula. At those times, the flow rate on the room concentrator was set at 2 liters per minute. On 4/15/24 at 9:30 a.m., and 1:25 p.m., the resident was observed wearing oxygen per nasal cannula. At those times the oxygen was above the 2 liter mark but below the 2.5 liter mark. The record for Resident 228 was reviewed on 4/15/24 at 1:50 p.m. Diagnoses included, but were not limited to, respiratory failure, congestive heart failure, heart disease, high blood pressure, and shortness of breath. The 3/27/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and used oxygen while a resident. The Care Plan, dated 3/22/24, indicated the resident required oxygen therapy related to chronic respiratory failure. The approaches were to administer oxygen as needed per Physician's Orders. Physician's Orders, dated 4/8/24, indicated continuous oxygen at 3 liters per minute per nasal cannula. During an interview on 4/17/24 at 2:00 p.m., the Director of Nursing indicated the oxygen should be on as ordered.2. On 4/14/24 at 11:27 a.m., Resident 37 was observed wearing oxygen via nasal cannula. The flow rate was above 2.5 and		**affected by the deficient practice?** Resident #228 oxygen settings adjusted to proper flow rate, no ill effect due to the alleged deficient practice. Resident #37, order placed for oxygen and care plan updated, no ill effect due to the alleged deficient practice. Resident #116 orders placed for oxygen and oxygen settings adjusted to proper flow rate no ill effect due to the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents in the facility that have oxygen have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents who have oxygen are receiving the correct liters and that an order is in place with care plans updated. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** Nursing staff educated on the need to ensure proper oxygen liters are in place for residents that require oxygen. Education provided on obtaining physician orders for oxygen as well as	

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	under 3 liters. On 4/15/24 at 9:46 a.m., the resident was observed sitting in his wheelchair. He was wearing oxygen at almost 3 liters via nasal cannula. On 4/16/24 at 10:25 a.m., the resident was in his wheelchair, he had oxygen on via nasal cannula. The flow rate on the portable oxygen tank was marked at 3 liters. The record for Resident 37 was reviewed on 4/15/24 at 3:18 p.m. The diagnoses included, but were not limited to, heart failure, stroke, cardiomyopathy, hypertension (high blood pressure), muscle weakness, urinary tract infection, chronic obstructive pulmonary disease (COPD), and anemia. The Admission Minimum Data Set (MDS) assessment, dated 4/5/24, indicated the resident was severely impaired with decision making. A Care Plan, dated 3/29/24, indicated the resident had altered respiratory status/difficulty breathing related to COPD. Interventions included, administer medications as ordered and observe for side effects and effectiveness. There was no care plan for oxygen use. A Physician's Order, dated 4/15/24 at 2:30 p.m., indicated to administer continuous oxygen at 2 liters per minute (lpm) via nasal cannula. There were no orders for the oxygen until 4/15/24. During an interview on 4/16/24 at 11:18 a.m., the Director of Nursing (DON) indicated she understood the oxygen concern and had no		ensuring that the residents have oxygen care plans in place. DON/designee will audit 5 residents 5x weekly to ensure oxygen liters are reflective of the order in the system. Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** The DON/designee will complete audit tool to ensure oxygen liters are reflective of the orders in the system, orders are in place for oxygen, and care plans updated to reflect oxygen use. The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	additional information to provide. 3. On 4/14/24 at 10:38 a.m., Resident 116 was observed asleep in his wheelchair. The resident was wearing oxygen via nasal cannula at 4.5 liters. During an interview at that time, the resident indicated on 4/13/24 he was having trouble getting air into his lungs. He was then started on oxygen and had been on oxygen therapy continually. On 4/14/24 at 11:18 a.m., the resident was wearing oxygen at 1.5 liters via nasal cannula. On 4/15/24 at 9:42 a.m., the resident was observed watching TV in his wheelchair. He wore oxygen via nasal cannula at 1.5 liters. On 4/15/24 at 1:37 p.m., the resident was observed asleep in his chair, and he wore oxygen via nasal cannula at 1.5 liters. The record for Resident 116 was reviewed on 4/15/24 at 12:56 p.m. The diagnoses included, but were not limited to, osteomyelitis, asthma, diabetes, heart failure, and chronic kidney disease. The Admission Minimum Data Set (MDS) assessment dated 2/8/24, indicated the resident was moderately impaired with daily decision making. A Care Plan, dated 2/8/24, indicated the resident required oxygen therapy related to ineffective gas exchange. Interventions included, administer oxygen as needed per physician order, monitor oxygen saturations on room air and/or oxygen, and monitor oxygen flow rate and response. A Physicians' Order, dated 4/14/24 at 1:56 p.m.,			

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	indicated to administer oxygen via nasal cannula at 2 liters per minute as needed. A Nurses Note, dated 4/13/24 at 10:45 p.m., the resident had a change of condition and was short of breath. The resident was placed on oxygen at 3 liters. There were no Physician's Order for oxygen therapy during the 4/14/24 observations. During an interview on 4/16/24 at 11:23 a.m., the Director of Nursing (DON) indicated she understood the oxygen concern and had no additional information to provide. During an interview on 4/17/24 at 2:17 p.m., the DON indicated the oxygen flow rate should follow Physician's Orders. 3.1-47(a)(6)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications were labeled with a date opened and not expired, related to a multi-dose insulin vial and insulin pens, for 2 of 3 medication carts observed. (Rainbow and Reflections medication carts) Findings include: 1. On 4/18/24 at 10:34 a.m., a medication cart on the Rainbow unit was observed. At that time, there was 1 multi-dose vial of Novolog insulin with an open date of 3/12/24. During an interview at that time, the Rainbow Unit Manager indicated it should have been discarded after 28 days. 2. On 4/18/24 at 10:46 a.m., a medication cart on the Reflections unit was observed. At that time, there was 1 Basaglar and 1 Lantus insulin kwikpens observed with no date opened. During an interview at that time, LPN 1 indicated both pens should have been labeled with a date opened. During an interview on 4/18/24 at 1:00 p.m., the Nurse Consultant indicated the pens were to be	F 0761	**F761 Label/Store Drugs and Biologicals** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Rainbow med cart: Expired insulin disposed of no ill effect from alleged deficient practice. Reflection med cart: Unlabeled insulin disposed of as well as expired insulin. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents in the facility that receive insulin have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all med carts are free from expired medications and that insulin is dated. **What measures will be put into place or what systematic changes will you make to**	05/05/2024

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	dated when opened and the Novolog multi-dose vial was expired. The current 2024 "Labeling of Medications and Biologicals" policy, provided by the Nurse Consultant on 4/18/24 at 1:12 p.m., indicated labels for multi-use vials must include the date the vial was initially opened or accessed and all opened or accessed vials should be discarded within 28 days unless the manufacture specifies a different date. 3.1-25(j) 3.1-25(o)		**ensure that the deficient practices do not recur?** Nursing staff educated on the need to ensure insulin is dated at all times and that expired medication is disposed of properly. DON/designee will audit all med carts 5x each week x 6 months to ensure there are no expired medications and that insulin is dated. Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** The DON/designee will complete audit tool to reflect expired medications are being disposed of and that all insulin is labeled. The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TERRACE CARE CENTER	1900 ANDREW AVE LA PORTE, IN 46350

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	§483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State			

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	plan. Based on record review and interview, the facility failed to provide dental services to a resident requesting dentures, for 1 of 1 resident reviewed for dental care. (Resident 19) Finding includes: During an interview on 4/15/24 at 2:35 p.m., Resident 19 indicated his dentures needed to be tightened up. The resident's upper denture was observed to be loose and flapped when the resident spoke. The record for Resident 19 was reviewed on 4/15/24 at 2:58 p.m. Diagnoses included, but were not limited to, high blood pressure, transient cerebral ischemic attack, type 2 diabetes, major depressive disorder, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 1/22/24, indicated the resident was moderately impaired for decision making and had no oral problems. A Care Plan, updated 2/19/2024, indicated the resident had oral/dental problems. A Dental Visit Note, dated 1/19/23, indicated all the resident's teeth were loose, decayed and broken down. The plan was to extract all remaining teeth and have a complete upper and lower denture made. There were no follow up visits made back to the dentist for the above recommendations, nor were there any follow up conversations documented with the resident if he would like new dentures and to continue with above plan.	F 0791	**F791 Routine/Emergency Dental Srvcs in NFs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #19 Social Services scheduled an appointment for resident to follow-up with dentist for additional consult regarding extractions. Resident had no ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents needing dental services have the potential to be affected by this alleged deficient practice. Audit completed of all residents in house requiring dental services, to ensure timely follow-up/services were scheduled. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Clinical and Social Service staff were educated on scheduling timely follow-up appointments for dental appointments.	05/05/2024

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	During an interview on 4/18/24 at 9:11 a.m., the Social Service Director (SSD) indicated the resident had declined dental services on 10/25/20. During an interview on 4/18/24 at 9:47 a.m., the SSD indicated someone added the resident to be seen by the dentist on 1/19/23 without a signed treatment consent, however the resident didn't refuse to be seen at that time. There were no follow up visits from the initial appointment because the resident declined dental services again in 10/2023. 3.1-24(a)(1)		Social Services/Designee will audit 5 residents a week x 6 months to ensure proper scheduling of dental appointments is taking place. All audits will include all units. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Director of nursing/designee will complete audit tool to reflect timely scheduling of dental appointments. The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;			

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	§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure palatable and attractive food was served for 1 of 2 meals observed and for 2 of 3 residents reviewed for food. (The breakfast meal, Residents 34 and 41) Findings include: 1. During the Resident Council interview on 4/16/24 at 1:57 p.m., 10 residents were in attendance. Over half of the residents in attendance indicated breakfast was not good that morning. They indicated the bacon looked raw and the eggs were discolored. One resident indicated her bacon was raw on one end and burnt on the other. Several of the residents indicated the fried eggs looked green and they didn't want to eat them. One resident stated, "the eggs looked like the Dr. Seuss book Green Eggs and Ham." Some of the residents also indicated the sausage patties served for the breakfast meal on 4/14/24 were hard like "hockey pucks." During an interview on 4/16/24 at 2:30 p.m., the Administrator indicated the facility had a new Dietary Food Manager and the Resident Council concerns would be addressed. 2. During an interview on 4/14/24 at 9:41 a.m., Resident 34 indicated the food was horrible and overcooked. During an interview on 4/15/24 at 1:30 p.m., the resident indicated the chicken served for lunch was tough and she did not eat.	F 0804	**F804 Nutritive value/appearance/palatable** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #34 food substitution offered. No ill effect due to the alleged deficient practice. ·Resident #41 food substitution offered. No ill effect due to the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents have the potential to be affected by this alleged deficient practice. Full house audits completed for food appearance to ensure the food presentation is desirable. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All staff were educated on food presentation. ·Dietary manager/designee will audit 5 random meals/residents each week x 6 months to ensure food presentation is appealing for residents.	05/05/2024

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	During a random observation on 4/16/24 at 7:30 a.m., the resident was observed in bed and her breakfast tray was on the over bed table with the dome lid on top of it. The lid was removed and an overcooked fried egg (crisp all around the edges) and an under cooked piece of bacon was observed. The resident indicated at that time, the bacon looked raw and she was not eating the overcooked egg. During an interview on 4/17/24 at 1:30 p.m., the resident indicated she had enjoyed the lunch meal, however, she did not eat any of her breakfast because "it looked disgusting." 3. During a random observation on 4/16/24 at 10:00 a.m., a resident's breakfast tray was observed on an over bed table. The fried egg was green and light gray in color, there was 1 piece of bacon that was burned and the other piece was looked like it was raw. At 10:10 a.m., the Dietary Food Manager (DFM) was asked to observe the breakfast meal that had been served to a resident. During an interview on 4/16/24 at 10:20 a.m., the DFM indicated she was going to do an inservice on cooking and preparing breakfast food. 4. During an interview on 4/14/24 at 11:40 a.m., Resident 41 indicated the food was overcooked. He stated "The sausage patties were so hard you could throw it at a wall and it would make a hole." During an interview on 4/18/24 at 10:00 a.m., the Administrator indicated the dietary staff were contracted and not employed by the facility. She indicated it was time for a change.		·All audits will include all meals and weekends. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Dietary manager/designee will complete audit tool to reflect resident satisfaction of meal presentation. ·The Dietary manager/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	155136	A. BUILDING 00 B. WING	04/18/2024

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F 0805 SS=E Bldg. 00	3.1-21(a)(2) 483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation and interview, the facility failed to prepare a pureed (blended smooth) diet designed to meet the needs of the residents. This had the potential to affect 10 of 10 residents who received a pureed diet. Finding includes: On 4/17/24 at 11:12 a.m., Cook 1 was observed preparing a pureed cabbage braised recipe. Cook 1 added 10 scoops of cabbage to the mixer and turned on the mix cycle. Cook 1 then added 2 cups of "sauerkraut juice". The mixer was turned back on and stirred. The mixture was observed to be watery and Cook 1 added a tablespoon of thickener. The mixer was turned back on and then stirred to review consistency. Cook 1 then added another tablespoon of thickener and turned on the mixer. A total of 7 tablespoons of thickener were added to the recipe. Once the mixture was completed, the pureed meal was appropriate consistency and was free of lumps or chunks. During an interview on 4/17/24 at 11:25 a.m., Cook 1 indicated the cabbage was too watery and she had to add more thickener. During an interview on 4/17/24 at 11:29 a.m., Cook 1 indicated the recipe would not make 10 servings and she would have to make more.	F 0805	**F805 Food in Form to Meet Individual Needs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Correct recipe followed for all future meals. No ill effect due to the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents on a puree diet have the potential to be affected by this alleged deficient practice. Full house audits completed for food consistency to ensure the food form is appropriate. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All staff were educated on food form.	05/05/2024

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	During an interview on 4/17/24 at 12:00 p.m., the Director of Nursing (DON) indicated the dietary recipe should have been followed. A recipe titled; "Pureed Cabbage Braised" was provided by the Dietary Manager on 4/17/24 at 11:10 a.m. This current recipe indicated, " ... Add water if product needs thinning..." 3.1-21)(a)(3)		·Dietary manager/designee will audit x5 puree meals each week x 6 months at random to ensure food form is appropriate for residents receiving a puree diet. ·All audits will include all meals and weekends. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Dietary manager/designee will complete audit tool to reflect proper puree consistency/recipe is followed. ·The Dietary manager/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0809 SS=E Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up			

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	155136	A. BUILDING 00 B. WING	04/18/2024

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	to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. Based on observation and interview, the facility failed to ensure meals were served as scheduled for 2 of 2 meal observations. (The lunch meal) Findings include: 1. On 4/16/24 at 12:20 p.m., residents were observed seated at their tables in the main dining room. Staff started passing beverages to the residents at 12:35 p.m. and the first tray served to the residents was at 1:15 p.m. The residents were observed becoming impatient and wanting their food. On 4/17/24 at 1:01 p.m., a food cart was taken to the Memory Lane Unit from the kitchen. At 1:10 p.m., a second cart was sent to Memory Lane. At 1:11 p.m. on 4/17/24, the first tray in the main dining room was served. The posted meal times indicated Memory Lane was to be served lunch at 12:30 p.m. and the Main Dining Room at 1:00 p.m. During an interview on 4/18/24 at 10:00 a.m., the Administrator indicated the dietary staff was a contracted service for the facility and the meals should have been served on time.	F 0809	**F809 Frequency of meals/Snacks at Bedtime** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Timely meals served, mealtimes adjusted within regulatory requirements to accommodate resident's preference and allow more timely service. No ill effect due to the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents receiving meals at this facility have the potential to be affected by this alleged deficient practice. Full house audits completed for food timeliness to ensure the food is being served on time. **What measures will be put into place or what systemic**	05/05/2024

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	155136	A. BUILDING 00 B. WING	04/18/2024

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	2. During the Resident Council interview on 4/16/24 at 1:57 p.m., 10 residents were in attendance. The majority of the residents indicated they ate their meals in the main dining room. The residents in attendance indicated breakfast was served late on Sunday morning (4/14/24) and lunch was late today. They also indicated that dinner was sometimes served late on bingo night. 3.1-21(c)		**changes will you make to ensure that the deficient practice does not recur?** ·All staff were educated on food timeliness. ·Dietary manager/designee will audit x5 meals each week x 6 months at random to ensure food is being served on time. ·All audits will include all meals and weekends. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Dietary manager/designee will complete audit tool to reflect timely food service is rendered. ·The Dietary manager/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
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.			

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	155136	A. BUILDING 00 B. WING	04/18/2024

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	§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 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			

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	(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 record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to sliding scale insulin administration, for 1 of 5 residents reviewed for unnecessary medications. (Resident 107) Finding includes: The record for Resident 107 was reviewed on 4/16/23 at 9:10 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and mild cognitive impairment. The Significant Change Minimum Data Set (MDS) assessment, dated 2/15/24, indicated the resident had short and long term memory problems and she was severely impaired for daily decision making. The resident had also received insulin during the assessment reference period.	F 0842	**F842 Resident Records-Identifiable Information** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident 107 insulin documented, no ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents in the facility that receive insulin have the potential to be affected by this alleged deficient practice. A full house audit was completed to	05/05/2024

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BRICKYARD HEALTHCARE - TERRACE CARE CENTER	1900 ANDREW AVE 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
	A Physician's Order, dated 3/21/24, indicated the resident was to receive Lispro Insulin (a short acting insulin) before meals and at bedtime based on the following sliding scale: 151 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units 351 - 400 = 10 units If blood sugar was greater than 400, give 12 units and call the Physician. Notify the Physician if the resident's blood sugar was less than 60. The March 2024 Medication Administration Record (MAR) indicated the resident's sliding scale insulin was not signed out as being given on 3/26 at 8:00 p.m., and on 3/29/24 at 4:00 p.m. and 8:00 p.m. The April 2024 MAR, indicated the resident's sliding scale insulin was not signed out as being given on 4/12 at 4:00 p.m. and 8:00 p.m., and on 4/17/24 at 11:00 a.m. and 8:00 p.m. During an interview on 4/18/24 at 1:30 p.m., the Director of Nursing indicated a QMA had been scheduled on those dates and the Nurse administered the insulin but did not sign it out. 3.1-50(a)(1) 3.1-50(a)(2)		ensure all resident's insulin orders were addressed as applicable to each specific resident's needs. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** Nursing staff educated on the need to ensure insulin is being signed out. DON/designee will audit all residents with insulin to ensure insulin is being signed out. Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** The DON/designee will complete audit tool to reflect residents' insulin is being signed out. The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	