STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	01/18/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00418853, IN00421493, IN00421983 and IN00423695. Complaint IN00418853 - No deficiencies related to the allegations are cited. Complaint IN00421493 - No deficiencies related to the allegations are cited. Complaint IN00421983 - Federal/state deficiencies related to the allegations are cited at F842. Complaint IN00423695 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: January 17 and 18, 2024 Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census Bed Type: SNF/NF: 134 Total: 134 Census Payor Type: Medicare: 18 Medicaid: 94 Other: 22 Total: 134 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	This plan of correction shall serve as this facilities credible allegation of compliance. Preparation, submission and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The facility respectfully request paper compliance. Thank you for your consideration.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Latoya Haggard	Executive Director	02/08/2024

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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	Quality review completed on 1/26/24.			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in 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,			

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	organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to ensure resident records were complete and accurate related to a lack of documentation regarding edema and laboratory testing for 1 of 3 residents reviewed for edema. (Resident D) Findings include:	F 0842	/p> A 30-day look back was completed on all residents with lab orders and a change in condition to check for completion and accuracy of resident's records and all residents identified have been corrected. 3. The Director of Clinical	02/16/2024

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	Resident D's record was reviewed on 1/17/24 at 10:00 a.m. Diagnoses included, but were not limited to, muscle wasting and atrophy, schizophrenia, bipolar disorder, autistic disorder and deaf non speaking. The Admission Minimum Data Set assessment, dated 9/6/23, indicated the resident required substantial/ maximum assistance for bed mobility and transfers, and was dependent on staff for toileting. A General Note, dated 10/4/23, indicated the resident had completed the Brief Interview for Mental Screening and was cognitively intact. A General Note, dated 10/4/23, indicated a verbal order had been received from the Physician's nurse for Lasix (a diuretic) 40 milligrams daily for 5 days for lower extremity swelling and to obtain a uric acid lab test to rule out the medical diagnosis of gout. The record lacked results of the uric acid lab test. There was no documentation the lab test had been completed or was refused. There were no orders for the uric acid test in Physician Orders in the electronic record. The Skilled Nursing Assessments, dated 10/4, 10/5, 10/6 and 10/7/23, indicated there was no edema and no labs ordered. Progress notes after 10/4/23, lacked any documentation related to lower extremity edema, labs completed or refused, or family or Physician notification. The AIT (Administrator in Training) provided a lab requisition dated 10/4/23 for a uric acid test. A		Service/designee in-serviced all clinical staff regarding accurate and complete documentation for residents with lab orders and/or change in condition. DNS/designee will monitor all residents with lab orders and/or change in condition for accuracy and complete documentation. Audits will occur five times per week x 4 weeks, then three times per week x 2 months, then weekly x 3 months. Audits will include all shifts and units and will include weekends. Audits will be reviewed by QAPI committee until consistent substantial compliance is achieved as determined by the committee. ="" p=""> ="" p="">	

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	refusal had been circled, it was signed by a nurse and undated. During a telephone interview with a laboratory employee on 1/18/24 at 8:55 a.m., she indicated if a resident refused to have a lab obtained, they would have a record in their system. She indicated there was no order received for Resident D for a uric acid test around 10/4/23 or a refusal of the test. During an interview with RN 1 on 1/18/24 at 8:50 a.m., she indicated when a lab order was received the procedure was to enter the order into the computer, fill out a lab requisition, and call the lab to let them know if it was something unusual. The lab came to the facility 5 days a week. If the resident refused, they would notify the Physician and family and document in a progress note. During an interview with the Physician on 1/18/24, he indicated he was aware the resident had refused the lab test three months ago, but had not documented in the record. This citation relates to Complaint IN00421983. 3.1-50(a)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control			

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

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	lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to not having current outbreak status information visibly posted or passive screening completed for visitors during an outbreak. This had the potential to affect all 134 residents in the facility. Findings include: On 1/17/24 at 8:45 a.m., the facility entrance was observed. There were no visible postings in the entrance way that indicated the facility was in COVID-19 outbreak status. There was a reception desk with an employee present. There was a sign-in book that required name, date, time of visit and reason for visit, there were no health	F 0880	*The facility respectfully request paper compliance* Infection Preventionist made sure that everyone entering the facility was aware of the covid outbreak and the recommended action to prevent the transmission to others by placing posting to both entrances into the facility. An audit was performed to screen all residents and no residents were identified as being affected. IP was in serviced on the current CDC guidelines and recommendations related to covid-19. All staff were educated regarding appropriate use of PPE r/t type of isolation. IP/Designee will audit both entrances to make	02/16/2024

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	screening questions, nor did the receptionist ask any. There was a stand with hand sanitizer and face masks with a sign that indicated to cover your cough, and clean your hands. During tour of the facility on 1/17/24, there were rooms noted to have isolation bins and contact/ droplet isolation signs on the door. A staff member indicated they were for residents with COVID-19 or RSV (Respiratory Syncytial Virus). Staff were not observed to be wearing face masks. During an interview with the AIT (Administrator in Training) on 1/18/24 at 8:58 a.m., she indicated there were currently two residents with COVID-19 in the facility. During an interview with the IP (Infection Prevention) Nurse, on 1/18/24 at 11:05 a.m., she provided a letter she indicated was on the reception desk. The letter was dated 10/24/23 and indicated, "Attention all visitors, vendors, and contractors: Due to a COVID-19 outbreak we are back to wearing masks. If you're here to visit a COVID positive resident, please check in at the nurses' station prior to entering for instructions. Thank You." She indicated the facility had been in outbreak status off and on since October 24, and that masks were not required any more. When advised the State Agency staff had not seen the letter, she indicated maybe it had been taken down. She would update the letter to reflect current recommendations. During an interview with the AIT on 1/18/24, she indicated the receptionist would ask visitors if they were having any symptoms when visiting, that was their passive screening. The current Center for Disease Control document,		sure posting is up for passive screening and current outbreak if necessary. IP/designee will also audit 5 random staff for appropriate PPE usage for type of isolation. Audits will occur five times per week x 4 weeks, then three times per week x 2 months, then weekly x 3 months. Audits will include all shifts and units and will include weekends. Audits will be reviewed by QAPI committee until consistent substantial compliance is achieved as determined by the committee	

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	"Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease Pandemic", indicated, "...Ensure everyone is aware of recommended IPC practices in the facility. Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations. Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria: 1) a positive viral test for SARS-CoV-2 2) symptoms of COVID-19, or 3) close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for healthcare personnel (HCP)...." 3.1-18(b)			