STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 00 B. WING	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00438189 and IN00435892 Complaint IN00438189 - No deficiencies related to the allegations are cited. Complaint IN00435892 - No deficiencies related to the allegations are cited. Survey dates: July 29, 30, 31, and August 1, 2, and 5, 2024 Facility number: 000039 Provider number: 155685 AIM number: 100275130 Census Bed Type: SNF/NF: 111 Total: 111 Census Payor Type: Medicare: 12 Medicaid: 73 Other: 26 Total: 111 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/9/24.	F 0000	The facility requests desk review in lieu of a revisit regarding the alleged deficient practices.	
F 0567 SS=E Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds Based on interview and record review, the facility	F 0567	What corrective action will be	09/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Oliver	VP Regulatory Compliance	09/06/2024

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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	failed to ensure resident funds were available on the same day of the request and for the desired amount for 4 of 4 residents reviewed for facility-managed personal funds. (Residents 18, 5, 31 and 8) Findings include: During an interview on 7/29/24 at 10:15 A.M., Resident 18 indicated he was able to obtain money from his facility account between the hours of 9 A.M. and 4 P.M. weekdays, and not at all on Saturday and Sunday. During an interview on 7/29/24 at 10:54 A.M., Resident 5 indicated he was only able to get five dollars from his facility account on the weekends. During an interview on 7/30/24 at 9:42 A.M., Resident 31 indicated she could only get money from her facility account until 4 P.M. weekdays, and not at all on Saturday and Sunday. During an interview on 7/30/24 at 1:15 P.M., Resident 8 indicated she was unable to get money from her facility account after 4 P.M. During an interview on 7/31/24 at 2:27 P.M., LPN 13 indicated the residents had a five dollar limit that they could take out of their facility accounts. During an interview on 7/31/24 at 2:13 P.M., the Business Office Manager (BOM) indicated the residents should not have a five dollar withdrawal limit for their facility accounts. During an interview on 8/2/24 at 2:14 P.M., the Executive Director (ED) indicated he was unaware that staff was telling the residents they had a 5 dollar limit to withdraw from their facility		accomplished for those residents found to have been affected by the deficient practice? · Residents #18, 5, 31, 8, LPN 13 were informed of where to access their funds on evenings and weekends and that there is no limit as long as they have the funds in their accounts. 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 an account with us have the potential to be affected. All residents were informed of where to access their funds on evenings and weekends and that there is no limit as long as they have the funds in their accounts. What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur? · All staff educated on where residents can access their funds on evenings and weekends and that there is no limit as long as they have the funds in their accounts. · BOM/designee will audit 5 residents 5x weekly for 4 weeks and then once a month for 6 months. to ensure that all residents are aware of where to	

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	accounts. On 8/1/24 at 2:32 P.M., the Director of Nursing provided a policy titled, "Availability of Resident Funds-After Business Office Hours" no date, and indicated the policy was the one currently used by the facility. The policy indicated "...During non-business office hours (e.g., nights, weekends, and holidays), the Business Office Manager, or designee, provides the Nurse Supervisor on duty at the time the business office closes a residents' fund petty cash box...." 3.1-6(a)		access their funds on evenings and weekends and that there is no limit as long as they have the funds in their accounts. 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 BOM/designee will complete audit tool to ensure all residents are aware of where to access their funds on evenings and weekends and that there is no limit as long as they have the funds in their accounts. · The BOM/ 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. DOC: 9/4/24	
F 0570 SS=E Bldg. 00	483.10(f)(10)(vi) Surety Bond-Security of Personal Funds Based on record review and interview, the facility failed to ensure a surety bond sufficiently covered the total monies in the Resident Fund account. This had the potential to affect the 56 residents who had resident fund accounts managed by the facility. Finding includes: During an interview and record review of Resident Fund accounts, with the Business Office Manager	F 0570	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · The BOM received education regarding the need for the Resident Fund to be less than or equal to that of the Surety Bond. No ill effect due to the alleged deficient practice. How will you identify other	09/04/2024

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	(BOM) and the Executive Director, on 8/2/2024 at 8:25 A.M., the total amount in the Resident Fund accounts was $286,128.00. The BOM indicated the amount was higher than usual due to a closed account with funds from a home sale for which she was waiting on verification before sending the funds back to Medicaid. Review of the facility's Surety Bond insurance rider to cover Resident Fund monies, dated April 1, 2020, indicated the covered amount had been increased to $250,000. During an interview with the Executive Director (ED) on 8/5/2024 at 9:40 A.M. he indicated he did not know why the Corporation had not raised the Resident Fund Surety Bond amount higher. He confirmed the total amount noted on 8/2/2024 was unusually high for that account. The current facility policy titled "Surety Bond Requirements" provided by the ED on 8/5/2024 at 9:00 A.M., included the following: "...The surety bond, or alternative to a surety bond, must be equal to or greater than the total amount of residents' funds, as of the most recent quarter..." 3.1-6(j)		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 an account with us have the potential to be affected. The Resident Fund account is now less than or equal to that of the Surety Bond. What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur? · The BOM/designee was educated regarding the need for the Resident Fund to be less than or equal to that of the Surety Bond. · BOM/designee will audit the Resident Fund account 5x weekly for 4 weeks and then once a month for 6 months to ensure that the account does not exceed the Surety Bond. 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 BOM/designee will complete audit tool to ensure that the Resident Fund account does not exceed the Surety Bond. · The BOM/ 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	

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			monitoring is needed, audit will continue. DOC: 9/4/24	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on record review and interview, the facility failed to provide accurate orders for resuscitative wishes for 2 of 3 resident reviewed for advanced directives. (Residents 94 & 36) Findings include: 1. A record review for Resident 94 was completed on 7/31/2024 at 11:19 A.M. Diagnoses included, but were not limited to: cerebral infarction, chronic obstructive pulmonary disease (COPD), congestive heart failure, atrial fibrillation, epilepsy, and diabetes mellitus type 2. An Admission Minimum Data Set (MDS) assessment, dated 6/7/24, indicated Resident 94 had severe cognitive impairment. A Physician Orders for Scope of Treatment (POST) form, dated 6/1/2024, and signed by the nurse practitioner on 6/27/2024, indicated to not attempt resuscitation. A Physician's Order, dated 6/10/2024, indicated Resident 94 was a full code, indicating cardiopulmonary resuscitation to was to be completed. A Care Plan, dated 6/13/2024, indicated Resident 94 had an advanced directive of a full code. The goal, dated 6/13/2024, indicated that Resident 94's wishes would be honored. The interventions include cardiopulmonary resuscitation would be	F 0578	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · Resident #94 and 36 had accurate orders for resuscitation orders placed for advanced directives, care plans updated, 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 have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents have a current POST form, with correct resuscitation order in place and that care plans are 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 POST forms are	09/04/2024

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	honored, and to review code status quarterly. During an interview, on 7/31/2024 at 12:19 P.M., LPN 3 indicated Resident 94 had an order to be a full code. The POST form indicated his wishes to be a do not resuscitate. LPN 3 indicated the physician's order, care plan and the POST form conflicted related to the wishes of Resident 94. 2. The record for Resident 36 was completed on 7/31/2024 at 9:54 A.M. Diagnoses included, but were not limited to: diabetes, hypertension, anxiety, depression, epilepsy, and Schizophrenia. Physician's orders, dated 8/1/2024- 8/31/2024, lacked documentation of physician's orders for code status preferences. During an interview, on 7/31/2024 at 12:10 P.M., LPN 13 indicated the resident should have had an order for his code status. On 28/1/2024 at 12:25 P.M., the Director of Nursing provided the policy titled,"Communication of Code Status", dated 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated"...It is the policy of this facility to adhere to residents' rights to formulate advanced directives...When an order is written pertaining to a resident's presence or absence of an Advanced Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to: a. Full Code. b. Do Not Resuscitate. c. Do Not Intubate. d. Do Not Hospitalize. 3. The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record. 4. The designated sections of the medical record are: Active order, copy of code		accurately filled out, order placed with matching resuscitation orders placed and care plan to updated upon admission and as needs change. · DON/designee will audit 5 residents 5x weekly for 4 weeks and then once a month for 6 months to ensure POST forms are filled out with matching orders, along with any new admissions and that care plans reflect orders. 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 POST forms are filled out with matching orders, and that care plans reflect orders. · 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. DOC: 9/4/24	

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	status uploaded into electronic file. ...8. The resident's code status will be reviewed as least quarterly and documented in the medical record...." 3.1-4(f)(7)			
F 0655 SS=E Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan Based on record review and interview, the facility failed to ensure baseline care plans were initiated for a resident receiving dialysis, a resident with falls and edema, and a resident with a wound, and failed to ensure baseline care plans were completed timely for a resident with an enteral feeding tube, for 4 of 27 residents reviewed for baseline care plans. (Residents 36, 107, 14 and 99) Findings include: 1. The record for Resident 36 was completed on 8/01/2024 at 8:48 A.M. Diagnoses included, but were not limited to, end stage renal disease, neurogenic bladder, viral hepatitis, and diabetes. An Admission Minimum Data Set (MDS) assessment, dated 6/13/2024, indicated Resident 36 was receiving dialysis. A Baseline Care Plan form, dated 6/7/2024, indicated the resident required dialysis. The form lacked any goals, interventions, and any special needs to to address the resident's current needs to properly care for the resident. During an interview, on 8/2/2024 at 2:58 P.M., the Director of Nursing indicated the resident had a baseline care plan, but it did not have all the information in it from the chart. 2. During an	F 0655	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · The baseline care plans for Residents 36, 107, 14 and 99 was updated to include goals, interventions, and any special needs and was completed timely. 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 have the potential to be affected. All residents baseline care plans were audited in order to ensure that they were updated to include goals, interventions, and any special needs and was completed timely. What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur? · The SSD/Designee educated all staff in order to ensure that they	09/04/2024

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	observation of Resident 107, on 7/29/2024 at 10:00 A.M., a bottle of Glucerna 1.5 was infused at 60 milliliters per hour via a tube feeding. A record review for Resident 107 was completed on 7/31/2024 at 1:57 P.M. Diagnoses included, but were not limited to, cerebral infarction, dysphagia, and diabetes mellitus type 2. He was admitted on 7/2/2024. An Admission Minimum Data Set (MDS) assessment, dated 7/9/2024, indicated Resident 107 received tube feeding, and had moderate cognitive impairment. Physician's Orders, dated 7/3/2024, indicated for Glucerna 1.5 to infuse via a gastrostomy tube at 60 milliliters per hour (ml/hr). A Care Plan, dated 7/18/2024, indicated Resident 107 received nutrition/hydration via a gastrostomy tube. All goals and interventions were dated 7/18/2024. During an interview, on 8/1/2024 at 3:13 P.M., LPN 2 indicated the baseline care plan was dated 7/9/2024. 3. A record review for Resident 14 was completed, on 8/2/24 at 9:35 A.M. Diagnoses included included, but were not limited to major depressive disorder, heart disease, edema, type 2 diabetes, hypertension, muscle weakness, chronic pain syndrome and absence of left and right leg below knee. An Admission MDS (Minimum Data Set) assessment, dated 7/12/24, indicated Resident 14 has intact cognition. A baseline care plan, completed on 7/15/24, indicated Resident 14 had a history of falls prior to		understood that all baseline care plans were to include goals, interventions, and any special needs and that they are completed within 48 hours. · SSD/designee will audit all new admissions 5x weekly for 4 weeks and then once a month for 6 months to ensure that all residents baseline care plans include goals, interventions, and any special needs and that they are completed within 48 hours. 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 SSD/designee will complete audit tool to ensure that the baseline care plans include goals, interventions, and any special needs and that they are completed within 48 hours. · The SSD/ 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. DOC: 9/4/24	

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	admission and as ordered psychotropic medication. During an interview on 8/2/24 at 1:34 P.M., the Director of Nursing (DON) indicated a baseline care plan should have been completed within 48 hours of admission, it was late and should have been completed timely. 4. A record review for Resident 99 was completed on 7/30/24 at 2:10 P.M. Diagnoses included, but were not limited to, diabetes, dementia, pressure ulcer, muscle weakness and diabetes. A Significant Change MDS assessment, dated 5/17/24, indicated Resident 99 has moderate cognitive impairment. A baseline care plan, completed on 4/29/24, indicated Resident 99 was admitted with a pressure ulcer. During an interview on 8/1/24 at 2:52 P.M., the DON indicated a baseline care plan should have been completed for her wounds within 48 hours of admission. On 8/2/24 at 1:16 P.M., the Executive Director provided the policy titled, "Baseline Care Plan", dated 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders.			

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	iv. Therapy services. v. Social Services. vi. PASARR recommendation, if applicable...." 3.1-30(a)			
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility failed to ensure comprehensive person-centered plans of care were created related to behaviors, a urinary tract infection, constipation, impaired vision and edema for 5 of 23 residents reviewed for comprehensive care plans. (Residents 28, 10, 14, 66 & 215) Findings include: 1. The record for Resident 28 was reviewed on 7/31/2024, at 9:15 A.M. Diagnoses included but were not limited to: hemiplegia and hemiparesis, cerebral infarction, unspecified dementia, atrial fibrillation, cardiomegaly, hypertension, and anxiety disorder. Resident 28's current medications included Zyprexa (antipsychotic) 10 milligrams (mg) 1 tablet by mouth at bedtime for dementia with agitation. A Care Plan, dated 7/28/2024, indicated the resident had target behaviors of paranoia and agitation. Interventions included, but were not limited to, assess for pain, monitor for side effects of antipsychotics and report to the physician, monthly pharmacy review of the medication regimen, offer to call the resident's wife, offer to sit and talk about the resident's wife, provide medications as ordered and evaluate for effectiveness, psychotropic risk/benefit and	F 0656	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · The comprehensive care plans for Resident 28 were updated to include that the care plan interventions for behaviors were person centered. The comprehensive care plans for Resident 10 were updated to include care plans and interventions related to impaired vision and the need for eye glasses. · The comprehensive care plans for Resident 14 were updated to include a care plan to monitor their edema. · The comprehensive care plans for Resident 66 were updated to include a care plan for their urinary tract infection. · The comprehensive care plans for Resident 66 were updated to include a care plan for their urinary tract infection. · The comprehensive care plans for Resident 215 were updated to include a person centered care plan for their constipation.	09/04/2024

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	reduction plan as recommended by the physician and pharmacist, and reassure the resident of his safety. Resident 28's record lacked person-centered Care Plan interventions for behaviors. During an interview, on 7/31/2024 at 1:43 P.M., CNA 4 indicated all behaviors exhibited by the residents were charted in the electronic medical record system. The CNA indicated any interventions attempted by the CNA's were charted in electronic medical record system and were not individualized to the specific resident, the interventions were the same for every resident. During an interview, on 8/1/2024, at 2:41 P.M., the Memory Care Director indicated the interventions were individualized for the anxiety portion but not the antipsychotic portion of the care plan. She indicated that all parts of the care plan should be patient-centered.2. The record for Resident 10 was reviewed on 7/30/2024 at 2:20 P.M. Diagnoses included, but were not limited to, Alzheimer's disease, schizoaffective disorder, bipolar disorder, mild cognitive impairment and anxiety. During an interview with Resident 10, on 7/29/2024 at 9:30 A.M., she indicated she could not see very well and her eye glasses were not working. The resident was not wearing her glasses, but a hard covered eyeglass case was noted by the television. The resident indicated she did not think she had seen an eye doctor recently. The Quarterly Minimum Data Set (MDS) assessment, completed 6/19/2024, indicated her vision was adequate without corrective lenses.		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 have the potential to be affected. All residents comprehensive care plans were audited in order to ensure that they included all necessary care plans and that they are person centered. What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur? · The SSD/Designee educated all staff in order to ensure that they understood that all comprehensive care plans were to be completed and accurate and that they are to be person centered. · SSD/designee will audit 5 residents 5x weekly for 4 weeks and then once a month for 6 months to ensure that all residents comprehensive care plans are complete and accurate and that they are person centered. 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 SSD/designee will complete audit tool to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	There was no current care plan for Resident 10 related to impaired vision and the need for eye glasses and/or any other intervention to address the resident's impaired vision. The most recent LTC (Long Term Care) facility evaluation, completed on 7/14/2024 indicated the resident's vision was adequate and she did not utilize corrective lenses. During an interview, on 7/31/2024 at 1:45 P.M. QMA 13 indicated she had not observed Resident 10 wearing eyeglasses. During an observation and interview, on 7/31/24 at 1:45 P.M., Resident 10's eyeglass case, located on the dresser in front of her television, was opened and a pair of prescription eyeglasses that looked like bifocals was observed. The resident indicated she was not wearing the glasses because they were not working for her. During an interview with the MDS coordinator, on 7/31/2024 at 2:00 P.M. she indicated the Social Service Director had completed the section of the MDS pertaining to vision and had inaccurately marked no corrective lenses. The MDS coordinator confirmed Resident 10 did have eyeglasses and the resident had been seen by the in-house eye doctor in March of 2024 and was prescribed bifocal eye glasses. The resident was not due to be seen again for 12 - 15 months from that time. 3. During an observation and interview on 7/29/2024 at 11:34 A.M., alert and oriented Resident 14 indicated he was admitted to the facility with edema to his bilateral below the knee amputation stumps. His prosthetic leg appliances		comprehensive care plans are complete and accurate and that they are person centered. · The SSD/ 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. DOC: 9/4/24	

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	were observed leaning against the wall in his room. He indicated his legs were too swollen to wear the prosthetic legs. The resident's lower thighs, knees and stump areas were observed to be swollen and looked similar in circumference to his upper thighs. A bandage was noted on the bottom of the left stump. The record for Resident 14 was reviewed on 7/31/2024 at 11:31 A.M. He was admitted to the facility on 7/5/2024 with diagnoses including but not limited to, major depressive disorder, recurrent severe, pressure ulcer stage 3 right lateral hip, chronic pain syndrome, lack of coordination, muscle weakness, type 2 diabetes, insomnia, obsessive-compulsive disorder, history of acquired absence of the left leg and right leg below knee. The physician's orders for medication included an order, dated 7/29/2024 to administer Lasix (a diuretic medication) 40 mg tablet at bedtime for Inflammation for 3 days. A subsequent order, dated 8/1/2024, indicated the resident had received Lasix 40 mg one tablet at bedtime for Edema. The Admission MDS assessment, completed on 7/12/2024, indicated the resident was alert and oriented, utilized a wheelchair independently for mobility and required moderate assistance for lower body dressing. The current care plans for Resident 14 did not include a care plan to monitor the resident's edema to his bilateral lower extremity edema. A care plan to address the resident's coronary artery disease diagnosis included an intervention to monitor the resident for edema and other potential complications of the disease.4. During an			

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	interview, on 7/30/2024 at 9:07 A.M., Resident 66 indicated he had a urinary tract infection. A record review was completed on 8/1/2024 at 8:48 A.M. Diagnoses included, but were not limited to, hypertension, end stage renal disease, neurogenic bladder, Viral hepatitis, and diabetes. Resident 66's current Physician Orders, dated 7/29/2024, included Cephalexin (antibiotic) 500 mg (milligram) - Give 1 capsule orally every 12 hours for UTI (urinary tract infection) for 5 days. The record lacked a care plan for the urinary tract infection. During an interview, on 8/2/2024 at 2:48 P.M., the Director of Nursing indicated there should have been a UTI Care Plan on the chart. 5. During an interview, on 7/29/2024 at 3:03 P.M., Resident 215 indicated he had not had a bowel movement (BM) in 14 days. The record for Resident 215 was completed on 7/30/2024 at 11:00 A.M. Diagnoses included, but were not limited to: Neurogenic bladder, anxiety, and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 4/29/24, indicated the resident received opioid medications and received scheduled pain medications. The documentation for bowel continence, dated July 2024, indicated Resident 215 had no bowel movement documented from July 16 on the night shift to July 22 on the night shift. The clinical record lacked a person centered care			

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	plan for constipation. During an interview, on 8/5/2024 at 10 :11 A.M., the Director of Nursing indicated there should have been a care plan for constipation. On 8/2/2024 at 1:11 P.M., the Director of Nursing provided the policy titled,"Comprehensive Care Plans", dated 2023, and indicated the policy was the one currently used by the facility The policy indicated"... It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident right's, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment... 1. The care planning process will include and assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally-competent and trauma-informed...3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being... 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress...." 3.1-35(a)			
F 0679 SS=D	483.24(c)(1) Activities Meet Interest/Needs Each Resident			

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Bldg. 00	Based on observation, record review, and interview, the facility failed to provide resident-centered activities for 1 of 3 residents reviewed for activities. (Resident 93) Finding includes: During an observation on 7/29/2024 at 3:08 P.M., Resident 93 was lying in bed. There was no radio or television on in the room. On 7/30/3034 at 11:22 A.M., Resident 93 was observed in bed, with a loud hum of the oxygen concentrator and no radio or television playing. A record review was completed on 7/31/2024 at 8:57 A.M. Diagnoses included, but were not limited to: unspecified sequelae of cerebral infarction, anoxic brain, and tracheostomy. A Quarterly Minimum Data Set (MDS) assessment, dated 6/23/2024, indicated cognitive function could not be assessed due to unresponsiveness. An Admission MDS, dated 4/1/2024, indicated activity interview responses had no answers due to non-responsiveness. During observations on 7/31/2024 at 9:12 A.M. and 2:56 P.M., no music or television was observed to be on in the resident's room. An Activity Participation Review, dated 3/27/2024 at 10:11 A.M., indicated Resident 93 liked to listen to easy listening music, liked to watch cartoons, talk shows, and Hallmark type of movies. A Care Plan, dated 3/27/2024, indicated Resident 93 was unresponsive, and her mother would visit weekly. An intervention, dated 4/9/2024, indicated	F 0679	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · The activity care plan for Resident 93 were updated to include that the resident will receive 1 on 1 activities to include music. A radio was placed in Resident 93's room. 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 have the potential to be affected. All residents activity care plans were audited in order to ensure that they included all of their preferred activities and the activity program was meeting those preferred activity needs. What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur? · The Activity Director/Designee educated all staff in order to ensure that they understood that all activity care plans were to list each residents preferred activities and that the activity program met those activity needs. · Activity Director/designee will audit 5 residents 5x weekly for 4 weeks and then once a month for	09/04/2024

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	per Resident 93 mother's request, a television or music should be on in the room. A Progress Note, dated 5/28/2024 at 1:52 P.M., indicated Resident 93's activities preferences from the family as the following: - It is somewhat important to Resident to listen to music they like. Preferred music genre: Easy listening. - It is somewhat important for Resident to do their favorite activities. Favorite activities include: Watch television A Physician's Order, dated 7/6/2024, indicated Resident 93 may participate in activities per her individual plan of care. The Activity Tasks for the month of July 2024 indicated television was the activity provided for Resident 93 twice daily. On 8/1/24 at 9:54 A.M., the Activity Director (AD) observed Resident 93's room, and indicated, "Oh, there's no television in here. They must have taken it out when she was at the hospital." The AD indicated Resident 93 liked easy listening music and had not received any one-on-one visits since she came back from her hospitalization in July. A policy was provided by the Director of Nursing, on 8/1/2024 at 12:18 P.M. The policy titled, "Activities", indicated, " ... It is the policy of this facility to provide ongoing program to support in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interest of each resident, as well as support their physical, mental, and psychosocial		6 months to ensure that all residents activity care plans listed each residents preferred activities and that the activity program met those activity needs. ED/designee to randomly observe residents to ensure they are receiving resident centered activities per their preference as listed on their care plan. These observations to be conducted 5 residents weekly x 4 weeks, then 3 residents weekly x 4 weeks, then 2 residents weekly x 4 months. 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 Activity Director/ED/designee will complete audit tools to ensure that the activity care plans list each residents preferred activities and that the activity program is observed meeting those activity needs. · The Activity Director/ 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. DOC: 9/4/24	

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	well-being. Activities will encourage both independence and interaction within the community ...." 3.1-33(b)(6)(C) 3.1-33(b(8)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review and interview, the facility failed to ensure edema was monitored for 1 of 1 residents reviewed for edema. (Resident 14) and failed to ensure antibiotic medication was administered timely for 1 of 2 residents reviewed for antibiotic use. (Resident 99) Findings include: 1. During an observation and interview on 7/29/2024 at 11:34 A.M., alert and oriented Resident 14 indicated he was admitted to the facility with edema to his bilateral below the knee amputation stumps. His prosthetic leg appliances were noted leaning against the wall in his room. He indicated his legs were too swollen to wear the prosthetic legs. The resident's lower thighs, knees and stump areas were noted to be swollen and looked similar in circumference to his upper thighs. A bandage was noted on the bottom of the left stump. The record for Resident 14 was reviewed on 7/31/2024 at 11:31 A.M. He was admitted to the facility on 7/5/2024 with diagnoses including, but not limited to, major depressive disorder, recurrent severe, pressure ulcer stage 3 right lateral hip, chronic pain syndrome, lack of coordination, muscle weakness, type 2 diabetes, insomnia,	F 0684	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · Resident 14 edema currently being monitored and treated, no ill effect due to the alleged deficient practice. · Resident 99, received full course of antibiotics, 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 edema will have monitoring orders put in place to ensure to ensure nurses are assessing it daily. · All antibiotic orders will be reviewed daily. What measures will be put into place or what systematic changes	09/04/2024

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	obsessive-compulsive disorder, history of acquired absence of the left leg and right leg below knee. The Admission Minimum Data Set (MDS) assessment, completed on 7/12/2024, indicated the resident was alert and oriented, utilized a wheelchair independently for mobility and required moderate assistance for lower body dressing. The current care plans for Resident 14 did not include a care plan to monitor the resident's edema to his bilateral lower extremity edema. A care plan to address the resident's coronary artery disease diagnosis included an intervention to monitor the resident for edema and other potential complications of the disease. The Nursing Clinical Admission Assessment, completed on 7/6/2024, indicated the resident had no edema. The most recent weekly Skin and Wound assessment and the most recent weekly skin assessments, dated 8/1/2024, indicated the resident's edema was not assessed. During an interview, on 8/1/2024 at 2:11 P.M., the Rehab (Rehabilitation) Director indicated Resident 14 had been admitted to the facility with significant bilateral edema to his legs and stumps. The edema was present in the resident's thighs and down to his stumps. He indicated the resident was not tolerating the stump shrinker in therapy and due to his edema, he thought the resident had been prescribed a diuretic medication about a week and a half ago. The physician's orders for medication included an		will you make to ensure that the deficient practices do not recur? · Nursing staff educated on the need to monitor edema and the need to start antibiotics immediately after order is given and available. · DON/designee will audit 5 residents 5x weekly for 4 weeks and then once a month for 6 months to ensure residents with edema have monitoring orders and will review all antibiotic orders received were started timely. 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 residents with edema have monitoring orders and will review all antibiotic orders received and ensure they were started 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.	

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	order, dated 7/29/2024, to administer Lasix (a diuretic medication) 40 mg tablet at bedtime for edema for 3 days. A subsequent physician's order, dated 8/1/2024, indicated the resident had received Lasix 40 mg one tablet at bedtime for Inflammation of his stumps. . During an interview with the Medical Record Nurse, on 8/1/2024 at 1:30 P.M. she indicated she was providing nursing coverage for the nursing unit on which Resident 14 resided. If edema was assessed, it would be documented in nursing progress notes, weekly skin assessments and weekly skin and wound assessments, and possibly on shower record sheets. She indicated the shower record sheets were not a part of the clinical record and if edema was noted on the shower record, the nurse should assess the edema and note it on the weekly skin assessments. During an interview, on 8/5/2024 at 9:00 A.M., the Director of Nursing (DON) indicated the physician and the Nurse Practitioner had assessed the resident's edema. The facility did not have a policy and procedure specific to monitoring for edema. 2. The record for Resident 99 was reviewed on 7/31/2024 at 2:01 P.M. Diagnoses included but were not limited to, diabetes mellitus with hyperglycemia, delusional disorder, unspecified psychosis, dementia, encephalopathy, chronic pain syndrome, insomnia, old myocardial infarction, unsteadiness and lack of coordination. During an observation and interview with Resident 99, on 7/29/2024 at 10:08 A.M., Resident 99 indicated she was receiving an antibiotic for her infected toe and it was very painful. The resident's right foot was noted to a scabbed area		DOC: 9/4/24	

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	on the top of the toes. During an observation of wound care on 8/1/2024 at 8:40 A.M. with the Wound Nurse, Resident 99's third toe was noted to have an open area and her toe was red and swollen. A Nursing Progress Note, dated 7/20/2024, indicated the resident had a blister noted to the right foot middle/3rd toes, the physician had observed the blister and did not want a treatment. A Nursing Progress Wound Note, dated 7/25/2024, indicated the right foot toe wound was covered with eschar (dead tissue that sheds or falls off from the skin), the periwound was edematous and red, and she recommended an antibiotic. The physician was notified and an order received on 7/25/2024 for Doxycycline Hyclate (an antibiotic) 100 mg one capsule two times a day for cellulitis of the right third toe. The order was entered and discontinued in the electronic computer system on 7/25/2024. The order was then put in again on 7/26/2024 and discontinued. The current order was then entered in the electronic medical system for the antibiotic on 7/26/2024 at 8:00 P.M. Review of the Medication Administration Record for Resident 99 indicated the scheduled evening dose of Doxycycline for 7/26/2024 was not administered and the resident did not receive the first dose of antibiotic until 7/27/2024 in the morning. During an interview with the Director of Nursing, on 8/5/2024 at 9:00 A.M., she indicated the facility did not have a policy specific to timeliness of following antibiotic orders. A copy of medications included in the facility's Emergency			

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	Drug Kit was requested on 8/4/2024 and 8/5/2024 and not provided prior to the survey exit. 3.1-37			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, record review, and interview, the facility failed to provide a range of motion program to prevent further contractures for 1 of 2 residents reviewed for range of motion. (Resident 93) Finding includes: During an observation on 7/29/2024 at 3:11 P.M., Resident 93 was observed to have her hands in a fist-like position and her knees bent. On 7/31/2024 at 9:19 A.M., a straight legged, cushioned boot was observed sitting on a table at the end of the resident's bed. A record review was completed on 7/31/2024 at 8:57 A.M. Diagnoses included, but were not limited to, unspecified sequelae of cerebral infarction, anoxic brain, and tracheostomy. Past Physician's Orders included the following: - 3/28/2024-6/24/2024 Resting hand splint to right hand in the morning, and remove at night for skin integrity. - 3/27/2024-6/24/2024 Foot brace to left lower extremity drop foot. - 3/27/2024-6/24/2024 Passive range of motion to residents upper and lower extremities every shift and can be completed per Qualified Medication Assistant of Certified Nursing Assistant.	F 0688	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 93 received a physicians order for passive range of motion. 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 and/or splints have the potential to be affected by this alleged deficient practice. Full house audit completed of all residents in house with orders for braces and/or splints to ensure application of such devices are completed and/or that they were receiving passive range of motion. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? · DNS/Designee educated Clinical on applying braces and/or splints that the physician prescribes to residents and on passive range of	09/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 00 B. WING	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

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	A Physician's Order, dated 7/6/2024, indicated physical therapy, occupational therapy, and speech therapy, if indicated. A Care Plan, dated 3/26/2024, indicated Resident 93 had a physical functioning deficit related to impaired mobility, impaired cognition, incontinence, and required assistance with her activities of daily living. Resident 93 was in a persistent vegetative state. The goal, dated 3/26/2024 and revised on 7/28/2024, indicated Resident 93 would maintain the current level of physical functioning through the next review date of 9/23/2024. Interventions included, monitor and report changes in range of motion ability, and to provide passive range of motion as ordered. During an interview, on 8/1/2024 at 9:24 A.M., LPN 2 indicated Resident 93 had a passive range of motion program prior to her hospitalization on 6/23/2024 with a return date of 7/6/2024. LPN 2 indicated Resident 93 should be receiving a passive range of motion program, and that her hands and knees were tight. LPN 2 could not provide documentation that a passive range of motion program was being completed. She indicated Resident 93's splints were discontinued due to causing anxiety. A policy was provided by the Director of Nursing, on 8/1/2024 at 12:18 P.M. The policy titled, "Prevention of Decline in Range of Motion", indicated, " ...Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable ...Policy Explanation and Compliance Guidelines: 1. The facility in collaboration with the medical director, director of nurses, and as appropriate,		motion. · Director of nursing/designee will audit 5 residents per week for 4 weeks and then once monthly for 6 months to ensure prescribed braces and/or splints are applied as ordered and that, when applicable, residents are receiving passive range of motion. 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 braces and/or splints and that residents whom meet the criteria are receiving passive range of motion. · 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. Date of Compliance: 9/4/2024	

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	physical/occupational consultant shall establish and utilize a systemic approach for prevention of decline in range of motion, including assessment, appropriate care planning, and preventative care ...." 3-1-42(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on observation, record review, and interview, the facility failed to provide a peripherally inserted central catheter care for 1 of 5 residents reviewed for infection control (Resident 266) Finding includes: On 7/29/2024 at 9:32 A.M., Resident 266 was observed to have vancomycin and piperacillin hanging from an intravenous pole. He had a peripherally inserted central catheter (PICC) to his left antecubital space (the crook of the elbow), the transparent dressing, dated 7/24/2024, was folded in half with the insertion point site of the PICC line exposed. On 7/29/2024 at 2:37 P.M., the PICC line transparent dressing remained folded in half with the insertion point site of the PICC line exposed. During an observation, on 8/1/2024 at 9:45 A.M., the transparent dressing was observed to not be adhered along the lateral edges of the dressing. Resident 266 indicated he had received a shower the previous evening, and the dressing became wet. A record review was completed on 8/1/2024 at	F 0694	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · Resident #266 PICC line dressing changed at time of concern, 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 a PICC line have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents that have a PICC line have an intact dressing. 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	09/04/2024

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	10:14 A.M. Diagnoses included, but were not limited to, osteomyelitis, methicillin-susceptible staphylococcus aureus, and diabetes mellitus type 1. A Physician's Order, dated 7/26/2024, indicated to complete a PICC line dressing change weekly and as needed every night shift. During an interview, on 8/1/2024 at 3:06 P.M., LPN 2 indicated the PICC line dressing are changed weekly and as needed if the dressing was peeling or soiled. She indicated she had seen the dressing on 7/29/2024, and the dressing was changed during night shift the next day. A policy was provided as current on 8/2/2024 at 11:43 A.M. by the Director of Nursing. The policy, titled, "PICC/Midline/CVAD [central venous access device] Dressing Change", indicated, " ...It is the policy of this facility to change peripherally inserted central catheter [PICC], midline or central venous access devices [CVAD] dressing weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of change ...." 3.1-47(a)(2)		importance of an intact PICC line dressing and to change as needed. · DON/designee will audit 5 residents 5x weekly for 4 weeks and then once a month for 6 months to ensure PICC line dressings are intact along with any new admissions. 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 PICC line dressings are intact. · 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. DOC: 9/4/24	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to provide adequate	F 0695	What corrective action will be accomplished for those residents	09/04/2024

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	tracheostomy care for 1 of 1 resident reviewed for tracheostomy/ventilation. (Resident 93) Finding includes: During an observation on 7/29/2024 at 9:39 A.M., Resident 93's oxygen collar was observed to be to the left of her tracheostomy stoma site. On 7/29/2024 at 10:44 A.M., Resident 93's oxygen collar was observed to be at left of the tracheostomy stoma site. At 10:49 A.M., Qualified Medication Assistant (QMA) 19 was requested to obtain an oxygen saturation. The saturation level read 85-86 percent. QMA 19 indicated it was due to the way Resident 93 slept, and many interventions had been attempted. A rolled towel was observed on the right side of the neck. At 10:51 A.M., Resident 93's oxygen saturations were observed to be at 89 percent. Resident 93 was repositioned in bed, and at 10:53 A.M., her oxygen saturations were 92 percent. A record review was completed on 7/31/2024 at 8:57 A.M. Diagnoses included, but were not limited to, unspecified sequelae of cerebral infarction, anoxic brain, and tracheostomy. A Quarterly Minimum Data Set (MDS) assessment, dated 6/23/2024, indicated cognitive function could not be assessed due to unresponsiveness. The assessment indicated Resident 93 received treatments of oxygen therapy, suctioning, and tracheostomy care. Current Physician's Orders for tracheostomy care included the following: - 6/24/2024 Disposable Ambu bag (a positive pressure ventilation for a person with insufficient or ineffective breathing, a complete back-up		found to have been affected by the deficient practice? · Resident #93 was positioned properly so that trach collar would allow adequate gas exchange at the time of finding, along with an order placed for changing suction canister and tubing weekly and as needed, routine tracheostomy care and suctioning every shift and as needed, and changing the trachestomy ties weekly and as needed, 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 a tracheostomy have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents who have a trachestomy are receiving the correct trach care and that proper orders are in place, along with proper positioning of tracheostomy collar to allow adequate gas exchange. 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 tracheostomy care and postioning of the tracheostomy collar. · DON/designee will audit 5	

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	tracheostomy set, and a suction machine set up at bedside. - 7/7/2024 Continuous humidified oxygen via tracheostomy collar at 5 liter per minute to the stoma, and to call the physician if oxygen saturations were below 90 percent. - 7/7/2024 Suction as needed for tracheostomy care. The physician's orders did not include changing the suction canister and tubing weekly and as needed, changing the tracheostomy ties weekly and as needed, routine tracheostomy care and suctioning every shift and as needed, and the tracheostomy tube needed should it be expelled. A review of the Medication and Treatment Administration Record for July 2024 indicated no entries for tracheostomy care. A Care Plan, dated 3/26/2024, indicated Resident 93 had a tracheostomy secondary to cerebral vascular accident (CVA), encephalopathy/anoxic brain injury, chronic hypoxic respiratory failure, and a history of traumatic brain injury. The goal, dated 3/36/3034 and updated 7/28/2024, indicated Resident 93 would have adequate gas exchange as evidenced by no adventitious breath sounds, and absence of respiratory distress. The interventions included to administer humidified oxygen as ordered, check oxygen saturations as needed, observe tracheostomy site daily for signs and symptoms of infection, provide tracheostomy care daily as ordered and as needed, suction tracheostomy as ordered and as needed, and to place the tracheostomy tube size above the bedside for emergency use. During an interview, on 8/1/2024 at 9:12 A.M., LPN 2 indicated tracheostomy care included		residents 5x weekly for 4 weeks and then once a month for 6 months to ensure tracheostomy collars are positioned correctly and the proper orders are in place to provide trachestomy care and will audit all new admissions with a tracheostomy. 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 tracheostomy collars are positioned correctly and the proper orders are in place to provide trachestomy care and will audit all new admissions with a tracheostomy. · 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. DOC: 9/4/24	

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	cleaning it daily and as needed, suctioning as needed, changing the gauze around the tracheostomy daily and as needed, and changing the oxygen collar weekly or as needed. She indicated the tracheostomy did not have an inner cannula to change. All oxygen humidification tubing was changed by an outside vendor. LPN 2 indicated Resident 93 should have had orders for all the care needed for the tracheostomy. A policy was provided by the Director of Nursing, on 8/1/2024 at 12:18 P.M. The policy titled, "Tracheostomy Care", indicated, " ...The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences ...." 3.1-4(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview and record review, the facility failed to verify controlled substance counts for 1 of 1 medication cart observed. (SW Unit) Finding includes: During a medication storage observation of the SW Unit medication cart, on 8/2/24 at 9:43 A.M. with RN 11, the controlled medication log book had missing signatures for the count sheets on July 1, 5, 6, 11, 13, 14, 17, 18 and 27, 202.4 During an interview on 8/2/24 at 11:14 P.M., the	F 0755	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Narcotic reconciliation sheets updated per policy 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 have the potential to be	09/04/2024

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	Director of Nursing indicated all narcotic count sheets were to be signed by the oncoming and offgoing nurse/QMA for verification of residents' medications. A current policy was provided on 8/2/24 at 1:10 P.M. by the Director of Nursing. The policy, titled, "Controlled Substance Administration and Accountability", indicated "...for areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift...." 3.1-25(e)(2)		affected by this alleged deficient practice. All narcotic reconciliation sheets reviewed and updated per policy. 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 controlled substance sheets and accountability. · DON/designee will audit each narcotic count sheet 5 times per week for 4 weeks and then once a month for 6 months to ensure signatures are present. 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 signatures are present · 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	

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			continue. DOC: 9/4/24	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to ensure an appropriate diagnosis for a resident who received an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 28) Finding includes: The record for Resident 28 was reviewed on 7/31/2024 at 9:15 A.M. Diagnoses included, but were not limited to, hemiplegia and hemiparesis, cerebral infarction, unspecified dementia, atrial fibrillation, cardiomegaly, hypertension, and anxiety disorder. Current medications for Resident 28 included Zyprexa (Olanzapine - an antipsychotic) 10 mg (milligram) 1 tablet by mouth at bedtime for dementia with agitation. A Psychiatric Note, dated 7/24/2024 at 8:09 P.M., lacked an approved diagnosis and documented a plan by the psychiatric provider to continue Zyprexa despite being clinically contraindicated, as benefits outweighed risks. A professional resource, https://medlineplus.gov/druginfo/meds, indicated the following: "Olanzapine is used to treat the symptoms of schizophrenia (a mental illness that causes	F 0758	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · Resident 28's diagnosis was updated by the psych provider and the medication is no longer contraindicated. 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 are taking prescribed antipsychotics have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents that are taking prescribed antipsychotics have the appropriate diagnosis. What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur? · SSD/designee educated all	09/04/2024

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	disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers 13 years of age and older. It is also used to treat bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) in adults and teenagers 13 years of age and older. Olanzapine is in a class of medications called atypical antipsychotics ... IMPORTANT WARNING: Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as olanzapine have an increased chance of death during treatment. Older adults with dementia may also have a greater chance of having a stroke or mini-stroke during treatment. Olanzapine is not approved by the Food and Drug Administration (FDA) for the treatment of behavior disorders in older adults with dementia. Talk to the doctor who prescribed this medication if you, a family member, or someone you care for has dementia and is taking olanzapine. For more information visit the FDA website: http://www.fda.gov/Drugs." During an interview on 8/2/2024, at 1:32 P.M., the DON indicated that the resident did not have an appropriate diagnosis for taking the antipsychotic. On 8/5/2024, at 12:34 P.M., the Director of Nursing provided a policy titled, "Unnecessary Drugs - Without Adequate Indication for Use," dated February 2023, and indicated the policy was the one currently used by the facility. The policy indicated "...documentation will be provided in the resident's medical record to show adequate		nursing staff on the importance of ensuring that residents whom take prescribed antipsychotics have the appropriate diagnosis. · SSD/designee will audit 5 residents 5x weekly for 4 weeks and then once a month for 6 months to ensure that residents whom take prescribed antipsychotics have the appropriate diagnosis along with any new admissions. 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 SSD/designee will complete audit tool to ensure that residents whom take prescribed antipsychotics have the appropriate diagnosis along with any new admissions.. · 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. DOC: 9/4/24	

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	indications for the medication's use and the diagnosed condition for which it was prescribed..." 3.1-48(a)(4)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was handled appropriately, foods were sealed appropriately, and failed to date foods when opened. This had the potential to affect 114 residents of 115 residents who received meals from the kitchen. Findings include: 1. An initial walk through of the kitchen with the Dietary Manager was completed on 7/29/2024 at 9:35 A.M. The following were observed: in the dry storage area was an opened/undated box of lasagna noodles not sealed, a gallon of vanilla with an opened date of 4/15/2023. In the walk-in cooler was an undated container of gravy and 3 health shakes with an expiration date of 7/23/2024, and an opened and undated box of Cream of Wheat cereal. 2. During a meal observation, on 7/29/2024 at 12:35 P.M., CNA 17 was observed to have her thumb extending over the plates' rim onto the food surface of the plate when serving 2 different residents. During an interview, on 7/29/2024 at 12:50 P.M., CNA 17 indicated her thumb should be underneath the plate.	F 0812	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · The box of lasagna noodles, the gallon of vanilla, the gravy, the 3 health shakes and the box of cream of wheat were all disposed of immediately. · C.N.A. 17 was redirected immediately to not place her thumb over the plates rim and onto the food surface. · C.N.A. 18 was redirected immediately to dispose of the food on the tray prior to serving the food to the resident. 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 have the potential to be affected by this alleged deficient practice. · All undated/outdated food was accounted for and disposed of immediately. · All staff were educated immediately on infection control practices including not placing their thumbs on the food surface of the plates and the need to have their hair pulled back while	09/04/2024

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	155685	A. BUILDING 00 B. WING	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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. During an observation, on 7/29/2024, CNA 18 was observed to hold the meal tray on her shoulder with one hand underneath the tray. While she was moving and walking, her hair was observed touching the top of the tray. During an interview, on 7/29/2024 at 12:58 P.M., CNA 18 indicated she should not put the tray on her shoulders. On 8/2/2024 at 12:18 P.M., the Director of Nursing provided the policy titled, "Date Marking for Food Safety", dated 2024, and indicated the policy was the one currently used by the facility. The policy indicated"...2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consists of the day/date of opening, and the day/date the item must be consumed or discarded...6. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly...." A policy was requested on meal tray delivery, but one was not provided prior to the survey exit. 3.1-21(i)(3)		serving residents their food. What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur? · Dietary Director/designee educated all staff on proper labeling and dating of food and proper handling of food while serving. · Dietary Director/designee will audit labeling and dating and proper handling of food 5x weekly for 4 weeks and then once a month for 6 months to ensure that there are no deficient practices. 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 Dietary Director/designee will complete audit tool to ensure proper labeling and dating of food and proper food handling. -The Dietary Director/designee will audit dining service for infection control practices including not placing their thumbs on the food surface of the plates and the need to have their hair pulled back while serving residents their food at various meals 5 times weekly x 4 weeks then 3 times weekly times 8 weeks then 2 times weekly x 3 months. Audits will be reviewed monthly by the QAPI committee to determine compliance and need for further auditing..	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			· The Dietary Director/ 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. DOC: 9/4/24	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure staff change gloves and complete hand hygiene when providing perineal care for 1 of 1 resident reviewed for personal care. (Resident 47) Finding includes: During a random observation, on 7/29/2024 at 3:20 P.M., Resident 47 was observed lying on wet bed linens. Resident 47 indicated, "they don't clean me up like they should." During a random observation, on 7/31/2024 at 1:23 P.M., Resident 47's call light was on. CNA 15 was observed answering the light. After the aide exited the residents' room, she indicated the room had a strong urine smell. CNA 15 indicated she smelled the urine and was not sure when he was checked or changed last. On 7/31/2024 at 1:38 P.M., CNA was observed to provide perineal care to Resident 46. CNA 16 applied gloves and obtained a wash basin and washcloth and a towel. He removed the brief, and with the same area of the washcloth wiped both sides of the residents groin, then washed the penis. He then rinsed the areas with another	F 0880	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · No resident was affected by deficient practice, employee washed hands immediately after alerted. 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 have the potential to be affected by this alleged deficient practice. No resident was affected as staff member was alerted immediately and educated on proper perineal care. What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?	09/04/2024

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	washcloth. With the same gloves still on, CNA 16 then put the wet brief in the trash bag and moved the covers on the bed. CNA 16 then washed the buttocks and dried the area. He placed the dirty linens along with a rolled up bed sheet that was wet with a large yellow stain on the night stand. CNA 16 obtained a new clean sheet and placed it on the bed. With the same gloves on, the aide then placed a clean brief on the resident. CNA 16 then put the resident's pants on him. He then touched the clean towel and then emptied the basin. The CNA removed the dirty bed linens from the night stand and then placed them in a bag. CNA 16, still with the same gloves on, touched the bedside table placed everything in another bag and left the room without washing his hands. During an interview, on 7/31/2024 at 1:46 P.M., the CNA indicated he should have changed his gloves and washed his hands. On 8/1/2024 at 12:25 P.M., the Director of Nursing provided the policy titled,"Hand Hygiene", dated 2002, and indicated the policy was the one currently used by the facility. The policy indicated"... All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors... a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hygiene prior to donning gloves, and immediately after removing gloves.... 3.1-18(b)		· Nursing staff educated on perineal care and handwashing procedures and techniques. · DON/designee will audit 5 employees 5x weekly for 4 weeks and then once a month for 6 months to ensure proper perineal care and handwashing occurs. 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 proper perineal care and handwashing techniques are completed afterwards. · 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. DOC: 9/4/24	