DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	09/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00413741, IN00416058, and IN00416991. Complaint IN00413741 - No deficiencies related to the allegations are cited. Complaint IN00416058 - No deficiencies related to the allegations are cited. Complaint IN00416991 - No deficiencies related to the allegations are cited. Survey dates: September 18, 19, 20, 21, and 22, 2023 Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census Bed Type: SNF/NF: 130 Total: 130 Census Payor Type: Medicare: 7 Medicaid: 95 Other: 28 Total: 130 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/26/23.	F 0000	The facility respectfully requests paper compliance/desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marsha Fulton	Executive Director	10/09/2023

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

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	09/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure a self-medication administration assessment was completed for a resident with medication at the bedside for 1 of 1 residents reviewed for self-administration of medication. (Resident 45) Finding includes: On 9/18/23 at 10:33 a.m., Resident 45 was observed lying in her bed. There was a bottle of Deep-Sea Nasal Spray on top of the bedside table. On 9/20/23 at 10:02 a.m., the bottle of nasal spray was still observed on the bedside table. The record for Resident 45 was reviewed on 9/19/23 at 2:09 p.m. Diagnoses included, but were not limited to, anemia, heart failure, diabetes, anxiety, depression, weakness and cellulitis. The Quarterly Minimum Data Set (MDS) assessment, dated 7/12/23, indicated the resident was cognitively intact and required extensive assistance with 2 staff physical assist for bed mobility, dressing, toileting, personal hygiene, and transfers. A Physician's Order, dated 7/5/23, indicated to give Ocean Nasal Spray (Saline spray), 1 spray in both nostrils every 8 hours as needed. There was no self-medication administration assessment.	F 0554	1.p paraid="635493503" paraeid="{24b9bd57-9baa-472f-bdc0-5097c6823bb1}{123}" >Immediate action(s) taken for the resident(s) found to have been affected include: Resident 45 was found to have a nasal spray at bedside. Nasal spray was removed. Resident was assessed and resident did not meet criteria for self administration of medications. Identification of other residents having the potential to be affected was accomplished by: · All residents have the potential to be affected, an audit was performed and no other residents were identified as being affected. Actions taken/systems put into place to reduce the risk of future occurrence include: ·The Director of Clinical Education in-serviced all nurses and QMAs regarding the “Resident Self-Administration of	10/24/2023

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	09/22/2023

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

(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
	There was no Physician order to self-administer medications. Interview with the Nurse Consultant and Administrator in Training (AIT) on 9/20/23 at 3:06 p.m., indicated they were unaware the resident had nasal spray at the bedside. Interview with the AIT on 9/20/23 at 5:20 p.m., indicated she was aware the resident should not have had medication at the beside and the nasal spray order was discontinued. There was no additional information provided. 3.1-7(a)(2)		Medication" policy prior to the date of alleged compliance. How the corrective action(s) will be monitored to ensure the practice will not recur The Director of Nursing Services/designee will audit 5 random residents to for any medications noted at the bedside the resident is appropriate for self-administration and has an assessment in place and an order for self-administration is completed. Audits will be completed 5 times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly 4 months. Audits will include all shifts and units and weekends. Results of audits will be reviewed at the monthly QAPI (Quality Assurance and Performance Improvement) meeting for a minimum of six months and until 95% compliance is achieved.	

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	09/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			
	Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to nail care for 1 of 7 residents reviewed for ADL's. (Resident 118) Finding includes: On 9/18/23 at 11:30 a.m. and 1:52 p.m., on 9/19/23 at 10:30 a.m. and 3:17 p.m., and on 9/20/23 at 10:40 a.m. and 2:14 p.m., Resident 118 was observed with long fingernails to both hands. The record for Resident 118 was reviewed on 9/19/23 at 2:50 p.m. The resident was admitted to the facility on 8/3/23. Diagnoses included, but were not limited to, stroke, dysphagia, peg tube, high blood pressure, dementia, altered mental status and neuromuscular dysfunction of the bladder. The Admission Minimum Data Set (MDS) assessment, dated 8/10/23, indicated the resident was severely impaired for decision making. The resident had no mood or behavior problems and was totally dependent on staff with a 2 person physical assist needed for personal hygiene. The resident had an indwelling foley (urinary) catheter and received an enteral feeding of 51% or more a day. A Care Plan, dated 8/16/23, indicated the resident had an ADL self care deficit related to a stroke.	F 0677	ol="" role="list" start="1" Immediate action(s) taken for the resident(s) found to have been affected include: Nail care was provided and documented for resident #118 on 9/20/23. Identification of other residents having the potential to be affected was accomplished by: p="" paraid="701846114" paraeid="{7e95606e-8ac4-4f15-ad12-9b63ba933dda}{136}">All residents have the potential to be affected. The Patient Advocates conducted an assessment of each residents' nails on 9/20/23 and nail care was provided to all identified residents. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Clinical Education/designee educated all direct care staff regarding the "Nail Care" policy prior to the date of alleged compliance.How the corrective action(s) will be monitored to ensure the practice will not recur: The ADNS/designee will conduct a random audit of 10 residents per week for 4 weeks, then 5 residents weekly x 4 weeks, then 5 residents monthly x 4 months.	10/24/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	09/22/2023

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

(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
	The CNA task section indicated there was no documentation the resident's nails were clipped. Interview with the Administrator in Training (AIT) on 9/20/23 at 5:20 p.m., indicated the resident's nails were clipped this evening. 3.1-38(a)(3)(E)		Audits will include all shifts and units and weekends. Results of audits will be reviewed at the monthly QAPI (Quality Assurance and Performance Improvement) meeting for a minimum of six months and until 95% compliance is achieved.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure palm protectors were in place as ordered for 1 of 1 residents reviewed for limited range of motion (ROM). (Resident 231) Finding includes:	F 0688	ol="" role="list" start="1" Immediate action(s) taken for the resident(s) found to have been affected include: Resident 231 was assessed by Physical Therapy on 9/20/23, and it was determined that resident no longer required a need for palm	10/24/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	09/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 9/18/23 at 11:15 a.m., 1:20 p.m., and 2:24 p.m., on 9/19/23 at 10:30 a.m., 1:52 p.m., and 3:15 p.m., and on 9/20/23 at 9:40 a.m., Resident 231 was observed in bed. At those times, there were no palm protectors to either one of his hands. The record for Resident 231 was reviewed on 9/19/23 at 2:15 p.m. The resident was admitted to the facility on 9/12/23. Diagnoses included, but were not limited to, traumatic subdural hemorrhage, stroke, hemiplegia, dysphagia, peg tube, repeated falls, dementia, depression, and anxiety. The Admission Minimum Data Set (MDS) assessment was still in progress. There was no Care Plan for limited range of motion. Physician's Orders, dated 9/12/23, indicated palm protectors to both hands at all times. May remove for bathing and check the placement and skin every shift. The Treatment Administration Record (TAR), dated 9/2023, indicated nursing staff had signed out the palm protectors as being on and in place 9/13-9/20/23. Interview with the Administrator in Training (AIT) on 9/20/23 at 5:20 p.m., indicated the palm protectors were discontinued. 3.1-42(a)(2)		protectors. Identification of other residents having the potential to be affected was accomplished by: All residents who have limited range of motion have the potential to be affected. An audit was completed and no other residents were identified as being affected. ol="" role="list" start="3" Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Clinical Education/designee educated direct care staff regarding the "Prevention of Decline in Range of Motion" policy prior to the date of alleged compliance. How the corrective action(s) will be monitored to ensure the practice will not recur: Unit Managers/designees will perform audits of 5 residents with limited range of motion 5 times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly x's 4 months to ensure devices are in place per orders, care plans are in place and the Treatment Administration Record reflects care accurately. Audits will include all shifts and units and weekends. Results of audits will be reviewed at the monthly QAPI (Quality Assurance and Performance Improvement) meeting for a minimum of six months and until 95% compliance is achieved.	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review, and interview, the facility failed to ensure an indwelling foley (urinary) catheter was placed	F 0690	1.p class="Paragraph SCXW65001587 BCX0" xml:lang="EN-US"	10/24/2023

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	09/22/2023

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

(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
	below the level of the bladder and not on the floor for 3 of 3 residents reviewed for catheters. (Residents 118, 83, and 102) Findings include: 1. On 9/18/23 at 11:30 a.m., 1:35 p.m., and 2:55 p.m., Resident 118 was observed seated in a wheelchair. At those times, her indwelling foley catheter was wrapped around the arm of the wheelchair and above the level of her bladder. On 9/19/23 at 10:30 a.m., 1:52 p.m., and 3:17 p.m., and on 9/20/23 at 9:42 a.m., the resident was observed in bed. At those times, the bed was very low to the ground and the indwelling foley catheter bag was resting directly on the floor. The record for Resident 118 was reviewed on 9/19/23 at 2:50 p.m. The resident was admitted to the facility on 8/3/23. Diagnoses included, but were not limited to, stroke, dysphagia, peg tube, high blood pressure, dementia, altered mental status and neuromuscular dysfunction of the bladder. The Admission Minimum Data Set (MDS) assessment, dated 8/10/23, indicated the resident was severely impaired for decision making. The resident had no mood or behavior problems and was totally dependent on staff with a 2 person physical assist for personal hygiene. The resident had an indwelling foley catheter and received an enteral feeding of 51% or more a day. A Care Plan, dated 8/16/23, indicated the resident had an indwelling urinary catheter. The approaches were to check the catheter tubing for proper drainage and positioning and to keep the drainage bag of the catheter below the level of the		paraid="1350107634" paraeid="{c73ceb27-d72a-4a06-ab0f-9bcb4791aae1}{119}" >Immediate action(s) taken for the resident(s) found to have been affected include: On 9/20/23, residents 118, 83 and 102 catheters were all corrected and placed below the level of their bladders. Resident 118 also received a basin to place catheter in when resident in bed d/t resident bed lowered to the floor. Identification of other residents having the potential to be affected was accomplished by: . All residents with a catheter have the potential to be affected. An audit was and no other residents were identified as being affected. Actions taken/systems put into place to reduce the risk of future occurrence include: ·The Director of Clinical Education/designee in-serviced all clinical staff regarding the	

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	09/22/2023

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

(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
	bladder at all times and off the floor. Physician's Orders, dated 8/3/23, indicated foley catheter 16 French related to bladder dysfunction. Interview with Vice President of Regulatory Compliance on 9/21/23 at 8:45 a.m., indicated the catheter bag should not have been on the floor and it should have been below the level of the resident's bladder.2. On 9/18/23 at 10:25 a.m. Resident 83 was seated in his wheelchair in his room. His urinary catheter bag was inside a blue cloth bag hanging from the arm rest of his wheelchair. The bag was at waist level and was not below the level of the bladder. On 9/20/23 at 9:06 a.m. the resident was seated in his wheelchair near the Nurse's Station. His urinary catheter bag was inside a blue cloth bag hanging from the arm rest of his wheelchair. The bag was at waist level and was not below the level of the bladder. On 9/20/23 at 12:15 p.m. the resident was seated in his wheelchair in the Main Dining Room. His urinary catheter bag was inside a blue cloth bag hanging from the arm rest of his wheelchair. The bag was at waist level and was not below the level of the bladder. The record for Resident 83 was reviewed on 9/19/23 at 3:03 p.m. Diagnoses included, but were not limited to, chronic kidney disease, hypertension, and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 8/26/23, indicated the resident had an indwelling urinary catheter. A Care Plan, dated 6/20/23, indicated the resident		"Indwelling Catheter Use and Removal" policy prior to the date of alleged compliance. How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS/designee will audit 5 random residents with catheters to ensure that catheters are hanging below the level of the bladder and are not touching the floor. Audits will be completed 5 times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly 4 months. Audits will include all shifts and units and weekends. Results of audits will be reviewed at the monthly QAPI (Quality Assurance and Performance Improvement) meeting for a minimum of six months and until 95% compliance is achieved.	

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	09/22/2023

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

(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
	had an indwelling urinary catheter. The interventions included, "...check catheter tubing for proper drainage and positioning...keep drainage bag of catheter below the level of the bladder at all times and off floor..." A Physician's Order, dated 8/2/23, indicated the resident had a suprapubic catheter 16 french with 10 cc (cubic centimeters) balloon for the diagnosis of neuromuscular dysfunction of the bladder. A Progress Note, dated 7/31/23, indicated the resident had a urinalysis completed and was diagnosed with a UTI (urinary tract infection). He was started on Bactrim (an antibiotic) 800-160 mg (milligrams) by mouth twice a day for 10 days. A Physician's Note, dated 7/6/23, indicated the resident had frequent urinary tract infections. Interview with the Administrator in Training and the Vice President of Regulatory Compliance on 9/20/23 at 2:49 p.m., indicated the catheter bag should be placed below the level of the bladder. 3. On 9/19/23 at 10:22 a.m. Resident 102 was seated in his wheelchair in his room. His urinary catheter bag was inside a blue cloth bag hanging from the arm rest of his wheelchair. The bag was at waist level and was not below the level of the bladder. The catheter tubing was lying across his lap, and he was holding it in his hands. On 9/20/23 at 9:04 a.m. the resident was seated in his wheelchair in his room. His urinary catheter bag was inside a blue cloth bag hanging from the arm rest of his wheelchair. The bag was at waist level and was not below the level of the bladder. On 9/20/23 at 11:38 a.m. the resident was seated in			

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	09/22/2023

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

(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
	his wheelchair in his room. His urinary catheter bag was inside a blue cloth bag hanging from the arm rest of his wheelchair. The bag was at waist level and was not below the level of the bladder. The record for Resident 102 was reviewed on 9/21/23 at 2:48 p.m. Diagnoses included, but were not limited to, acute kidney failure, retention of urine, and neuromuscular dysfunction of the bladder. The Quarterly Minimum Data Set (MDS) assessment, dated 8/15/23, indicated the resident had an indwelling urinary catheter. A Care Plan, dated 8/23/23, indicated the resident had a suprapubic urinary catheter. The interventions included, "...check catheter tubing for proper drainage and positioning...keep drainage bag of catheter below the level of the bladder at all times and off floor..." A Care Plan, dated 9/11/23, indicate the resident was currently being treated for a UTI. A Physician's Order, updated 2/10/23, indicated the resident had a suprapubic catheter 16 french with 10 cc (cubic centimeters) balloon for the diagnosis of neurogenic bladder. A Physician's Order, updated 9/13/23, indicated gentamicin (an antibiotic) 480 mg intravenously for 14 days for UTI. Interview with the Administrator in Training and the Vice President of Regulatory Compliance on 9/20/23 at 2:49 p.m., indicated the catheter bag should be placed below the level of the bladder. 3.1-41(a)(2)			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	09/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, record review, and interview, the facility failed to ensure residents received the correct diet for double portions and a fluid restriction was monitored for 2 of 3 residents reviewed for nutrition. (Residents 87 and 83) Findings include: 1. An interview with Resident 87's spouse on 9/18/23 at 2:01 p.m., indicated she visited her husband every day and was there during the lunch meal. He was supposed to receive double portions for all meals but had not been getting them. On 9/20/23 at 12:12 p.m. the resident was seated in	F 0692	p="" xml: paraid="728043344" paraeid="{25710322-40a4-4fe1-9669-f62cf06516f2}{12}">Immediate action(s) taken for the resident(s) found to have been affected include: On 9/21/23, dietary and clinical team ensured resident 87 received a tray with double portion. On 9/21/23, Nursing leadership documented resident #83's dietary and nursing fluids were documented and resident was made aware. Assessments were completed, Registered dietician to monitor. MD aware. Identification	10/24/2023

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	09/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a broda chair in the lounge next to his wife. At that time, lunch was served to him and he received 1 tuna fish sandwich, 1 can of tomato juice, 1 small piece of cake and 1 bowl of creamed soup. The meal ticket on his tray indicated double portions. On 9/21/23 at 12:00 p.m., the resident was seated in a broda chair in the lounge next to his wife. At that time, lunch was served to him and he received single portions of carrots, potato salad, cake and chopped meat. The record for Resident 87 was reviewed on 9/20/23 at 10:55 a.m. Diagnoses included but were not limited to, adult failure to thrive, repeated falls, major depressive disorder, high blood pressure, Alzheimer's disease, psychosis, anxiety disorder, insomnia The 7/31/23 Significant change Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact. The resident had no significant weight loss and received a mechanically altered diet. A Care Plan, revised on 8/12/23, indicated the resident received a mechanically altered diet with additional portions for appetite. The approaches were to provide the diet as ordered. Physician's Orders, dated 10/28/22, indicated serve a regular mechanical soft/east to chew diet with double portions. The last Registered Dietitian's (RD) Progress Note was dated 6/12/23. The RD indicated the resident received double portions at meals for appetite. Interview with the Director of Nursing on 9/21/23 at 1:45 p.m., indicated she was unaware the		of other residents having the potential to be affected was accomplished by: All residents have the potential affected. An audit was completed and no other residents were identified as being affected. Actions taken/systems put into place to reduce the risk of future occurrence include: All Clinical and dietary staff were educated by the Director of Clinical Education/designee and the Registered Dietician regarding the "Nutritional and Dietary Supplements" policy and the "Fluid Restriction" policy prior to the date of alleged compliance. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/Dietary Manager/designeewill complete audits of 5 random residents receiving fluid restrictions and 5 random residents receiving dietary nutritional interventions 5 times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly times 4 months. Audits will include all shifts and units and weekends. Results of audits will be reviewed at the monthly QAPI (Quality Assurance and Performance Improvement) meeting for a minimum of six months and until 95% compliance is achieved.	

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	09/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

resident should receive double portions for meals.2. On 9/18/23 at 10:25 a.m., Resident 83 was seated in his wheelchair in his room. He indicated he was sleepy because he hadn't slept well the night before. He was not sure about any fluid restrictions he had.

The record for Resident 83 was reviewed on 9/19/23 at 3:03 p.m. Diagnoses included, but were not limited to, chronic kidney disease, hypertension, and heart failure.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/26/23, indicated the resident was cognitively intact.

A current Care Plan indicated the resident was on a therapeutic diet and a fluid restriction per physician's order.

A Physician's Order, dated 6/30/23, indicated the resident had a fluid restriction of 1500 ml (milliliters) daily. He was to have 360 ml per meal from dietary and 140 ml per shift from nursing.

The Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 8/2023 and 9/2023, lacked any documentation of the resident's fluid intakes or daily fluid intake totals.

The Activities of Daily Living (ADL) Task documentation, dated 8/2023 and 9/2023, lacked any documentation for fluid intakes or daily fluid intake totals.

The Fluid Restriction Log Book, dated 9/2023, had intake/output record sheets for each day. The intake/output sheets only kept track of the fluid intakes and daily fluid intake totals provided by

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	09/22/2023

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

(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
	nursing. There was lack of any documentation of the fluid intakes provided by dietary. Interview with the Administrator in Training (AIT) and the Vice President of Regulatory Compliance on 9/20/23 at 2:49 p.m., indicated they were unsure where the fluid intakes were documented but they would look into it. Interview with an Administrator from a Sister Facility on 9/21/23 at 2:31 p.m., indicated nursing had only documented the fluid intakes provided by nursing. Dietary provided the amount of fluids designated per the fluid restriction Physician's Order but had not documented any fluids intakes. She was unable to provide documentation of any daily fluid intake totals for the resident. A facility policy, titled "Fluid Restriction," received as current, indicated, "...1. The nurse will obtain and verify the Physician's Order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department, and will be recorded on the medication record or other format as per facility protocol..." 3.1-46(a)(1) 3.1-46(b)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-			

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	09/22/2023

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

(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
	§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			
	Based on observation, record review, and interview, the facility failed to ensure gastrostomy tube feedings were infusing at the correct time and rate for 2 of 3 residents reviewed for tube feedings and water flushes were administered during medication pass as ordered for 1 of 7 residents observed during medication pass. (Residents 118, 231, and 57) Findings include: 1. On 9/18/23 at 2:55 p.m., Resident 118 was observed seated in a wheelchair in the dining room. At that time, she was not connected to an enteral tube feeding. On 9/19/23 at 1:52 p.m. and on 9/20/23 at 9:42 a.m., the resident was observed in bed and the enteral tube feed was infusing at 55 cubic centimeters (cc) per hour. The record for Resident 118 was reviewed on 9/19/23 at 2:50 p.m. The resident was admitted to the facility on 8/3/23. Diagnoses included, but	F 0693	p="" xml: paraid="1613862806" paraeid="{524c800d-677d-41e4-9314-4b5ca073b44d}{101}">Immediate action(s) taken for the resident(s) found to have been affected include: Residents 118, 231 and 57 were assessed and no concerns were noted. Physicians were updated. Identification of other residents having the potential to be affected was accomplished by: All residents receiving enteral feeding have the potential to be affected. An audit was conducted and no other residents were noted to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Clinical Education/designee educated all nurses and QMAs on the "Medication Administration via Enteral Tube" and "Flushing a	10/24/2023

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	09/22/2023

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

(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
	were not limited to, stroke, dysphagia, peg tube, high blood pressure, dementia, altered mental status and neuromuscular dysfunction of the bladder. The Admission Minimum Data Set (MDS) assessment, dated 8/10/23, indicated the resident was severely impaired for decision making. The resident had no mood or behavior problems and was totally dependent on staff with a 2 person physical assist for personal hygiene. The resident had an indwelling foley catheter and received an enteral feeding of 51% or more a day. A Care Plan, dated 8/24/23, indicated the resident was dependent on tube feeding. The approaches were to provide enteral formula and feedings as ordered. Physician's Orders, dated 8/8/23, indicated enteral feed two times a day of Jevity 1.5 at 55 cc per hour times 18 hours, on at 2:00 p.m. and off at 8:00 a.m. Interview with the Vice President of Regulatory Compliance on 9/21/23 at 8:45 a.m., indicated the enteral tube feeding should have been infusing as ordered by the Physician. 2. On 9/18/23 at 11:15 a.m., 1:20 p.m., and 2:24 p.m., Resident 231 was observed in bed. At those times, an enteral tube feeding was infusing at 55 cubic centimeters (cc) per hour. On 9/19/23 at 10:30 a.m. and 1:52 p.m., the resident was observed in bed and the enteral tube feeding was infusing at 65 cc per hour. At 3:15 p.m., the tube feeding was turned off. On 9/20/23 at 9:40 a.m., the resident was observed		Feeding Tube" policies prior to the date of alleged compliance. 4. How the corrective action(s) will be monitored to ensure the practice will not recur The DNS/designee will complete audits for 5 random residents with tube feedings to ensure they are starting and stopping according to the physician order as well as monitoring the flushes to ensure they are being carried out per the physician order. Audits will be done 5 times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly 4 months. Audits will include all shifts and units and weekends. Results of audits will be reviewed at the monthly QAPI (Quality Assurance and Performance Improvement) meeting for a minimum of six months and until 95% compliance is achieved.	

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	09/22/2023

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

(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

in bed and the enteral tube feeding was infusing at 65 cc per hour.

The record for Resident 231 was reviewed on 9/19/23 at 2:15 p.m. The resident was admitted to the facility on 9/12/23. Diagnoses included, but were not limited to, traumatic subdural hemorrhage, stroke, hemiplegia, dysphagia, peg tube, repeated falls, dementia, depression, and anxiety.

The Admission Minimum Data Set (MDS) assessment was still in progress.

A Care Plan, dated 9/15/23, indicated the resident was dependent on enteral tube feeding for food and beverage. The approach was to provide the enteral feeding as ordered by the Physician.

Physician's Orders, dated 9/15/23, indicated enteral tube feeding in the afternoon, start Jevity 1.5 at 65 cc per hour times 20 hours. The enteral tube feeding to come down at 8:00 a.m. or when the total volume was infused.

Interview with the Vice President of Regulatory Compliance on 9/20/23 at 8:45 a.m., indicated the enteral tube feeding was to be infusing as ordered by the Physician.
3. On 9/20/23 at 2:22 p.m., QMA 1 was observed preparing to administer a medication through Resident 57's peg tube. QMA 1 washed her hands with soap and water and donned clean gloves to both hands. She checked for placement of the peg tube and for any residual. She attached a piston syringe to the peg tube and administered 15 ml (milliliters) of water. She then opened a package of duloxetine (antidepressant medication) and emptied it with 5 ml of water into a medicine cup. She stirred the mixture with the piston

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	09/22/2023

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

(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
	syringe and administered the medication through the peg tub. After administering the medication, she flushed the tubing with 15 ml of water. Interview with LPN 1 on 9/20/23 at 3:30 p.m., indicated QMA 1 was busy remembering the policy and didn't read the flush order correctly. The record for Resident 57 was reviewed on 9/21/23 at 10:45 a.m. A Physician's Order, dated 12/21/22, indicated to flush the peg tube with 30 ml (milliliters) of water before and after medication administration. Interview with the Nurse Consultant on 9/21/23 at 1:42 p.m., indicated she would speak with the QMA about the flush order. Interview with the Nurse Consultant on 9/21/23 at 2:23 p.m., indicated QMA 1 was nervous and had the procedure in front of her and gave the amount that was on the policy rather then what was ordered by the Physician 3.1-47(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			

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	09/22/2023

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

(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
	Based on observation, record review, and interview, the facility failed to provide proper respiratory care and services related to oxygen at the correct flow rate for 1 of 2 residents reviewed for oxygen. (Resident 69) Finding includes: On 9/18/23 at 11:15 a.m. and 2:25 p.m., on 9/19/23 at 10:35 a.m., 1:52 p.m., and 3:15 p.m., and on 9/20/23 at 9:40 a.m., Resident 69 was observed in bed. At those times he was wearing oxygen per nasal cannula. The flow rate on the concentrator was less than 2 liters per minute but greater than 1.5 liters per minute. The record for Resident 69 was reviewed on 9/20/23 at 10:00 a.m.. Diagnoses included, but were not limited to, peg tube, diabetes, acute kidney failure, stoke, major depressive disorder, and dementia. The resident had just returned from a hospital admission from 8/24/23 to 8/29/23 for sepsis. The 9/5/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact. The resident was not using oxygen while a resident. A 9/18/23 Significant Change MDS assessment was in progress due to a change in the resident's condition. There was no Care Plan for the oxygen. A Nurses' Note, dated 9/9/23 at 10:18 p.m., indicated the resident was in bed and under the care of Hospice and oxygen was in place per nasal cannula at 2 liters per minute.	F 0695	p="" xml: paraid="234349770" paraeid="{7db1766f-f969-4022-8aff-62a3e9818b29}{149}">Immediate action(s) taken for the resident(s) found to have been affected include: On 9/20/23, resident #69's orders and care plan were updated to include oxygen at 2L/NC and oxygen tank replaced with concentrator set on 2L/NC. Assessment was completed, no concerns noted. MD was made aware. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with oxygen have the potential to be affected. An audit was conducted and no other residents were identified as being affected. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Clinical Education/designee in-serviced all clinical staff regarding the "Oxygen Administration" policy prior to the date of alleged compliance. How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS/designee will complete audits for 5 random residents who receive oxygen to ensure they have a physician's order in place, oxygen is set at ordered flow rate and a care plan is in place. Audits will be done 5	10/24/2023

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	09/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Nurses' Note, dated 9/10/23 at 10:05 p.m., indicated the resident remained in bed this afternoon with oxygen in place at 2 liters per minute. A Nurses' Note, dated 9/14/23 at 7:55 p.m., indicated the resident remained in bed wearing oxygen at 2 liters per minute. Physician's Orders, dated 9/19/23, indicated continuous oxygen at 2 liters per minute via nasal cannula. There were no Physician's Orders prior to 9/19/23 for the oxygen. Interview with the Vice President of Regulatory Compliance on 9/20/23 at 3:45 p.m., indicated the oxygen concentrator was from Hospice and it was not working correctly, so they switched it out today. The rate was supposed to be set at 2 liters per minute and there were no orders for the oxygen prior to 9/19/23. 3.1-47(a)(6)		times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly 4 months. Audits will include all shifts and units and weekends. Results of audits will be reviewed at the monthly QAPI (Quality Assurance and Performance Improvement) meeting for a minimum of six months and until 95% compliance is achieved.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a sanitary and safe environment related to marred and gouged walls, rusted ceiling vents, and a broken heat register control on 1 of 3 units observed. (100 unit) Findings include:	F 0921	ol class="NumberListStyle1 SCXW145327105 BCX0" role="list" start="1" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor:	10/24/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	09/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

During the Environment Tour on 9/21/23 at 3:33 p.m. with the Maintenance Director, the following was observed:

100 Unit

a. The ceiling vent in Room 123 was rusted. The heat register was rusted, and pieces were broken. There was one resident who resided in the room.

b. The floor tile was discolored in Room 132 under the television. The wall near bed one was gouged and marred. The cover for the heat register was broken. There were two residents who resided in the room.

Interview with the Maintenance Director on 9/21/23 at 3:33 p.m., indicated he wasn't aware of the issues and he will fix everything next week.

3.1-19(f)

text; overflow: visible;"
Immediate action(s) taken for the resident(s) found to have been affected include:
Rooms repairs to rooms 123 and 132 were completed on 9/25/23.

ol class="NumberListStyle1 SCXW145327105 BCX0" role="list" start="2" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;"
Identification of other residents having the potential to be affected was accomplished by:
All residents have the potential to be affected, an audit was performed and no other residents were affected.

Actions taken/systems put into place to reduce the risk of future occurrence include:

·The Executive Director in-serviced the Director of Maintenance/designee regarding the “Environmental Services Inspection” policy prior to the date of alleged compliance.

How the corrective action(s) will be monitored to ensure the practice

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	09/22/2023

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

(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
			will not recur: The Maintenance Director/designee will conduct a random audit of resident room environment for 10 random residents 5 times a week for four weeks. Then 10 resident rooms 3 times a week for 4 weeks, then 5 random resident rooms 3 times a week for 4 months. Audits will include all shifts and units and weekends. Results of audits will be reviewed at the monthly QAPI (Quality Assurance and Performance Improvement) meeting for a minimum of six months and until 95% compliance is achieved.	