STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155137	A. BUILDING 00 B. WING	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - VALPARAISO CARE CENTER	251 STURDY RD VALPARAISO, IN 46383

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00393203. Complaint IN00393203 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 13, 14, 15, 16, and 17, 2022. Facility number: 000062 Provider number: 155137 AIM number: 100271400 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 3 Medicaid: 53 Other: 17 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/18/22.	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance preparation, submission, and implementation. This plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care, and to comply with all applicable state and federal regulatory requirements. The facility respectfully requests paper compliance. Thank you for your consideration, Tiffany Sydow, BA, HFA	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable			

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

Tiffany Sydow 12/02/2022

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	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-			

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	(iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to develop and implement a care plan for a resident's skin discolorations for 1 of 20 residents reviewed for care plans. (Resident 12) Finding includes: On 11/13/22 at 1:38 p.m., Resident 12 was observed lying in bed. A dark purple discoloration was observed to the top of the left hand/wrist area. On 11/15/22 at 9:07 a.m., Resident 12 was observed lying in bed. A dark purple discoloration was observed to the top of the left hand/wrist area. Record review for Resident 12 was completed on 11/16/22 at 10:05 a.m. Diagnoses included, but were not limited to, anxiety, depression, psychotic disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/25/22, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist with bed mobility, transfers, dressing, toilet use and personal hygiene. The record lacked any documentation the skin discoloration had been assessed. Interview with the Wound Nurse on 11/16/22 at 11:25 a.m., indicated the resident's discoloration was a birthmark. He indicated she had multiple discolorations on her upper body, including a large purple discoloration to her left index finger	F 0656	Facility requests paper compliance/desk review F656 Develop/Implement Comprehensive Care Plan 1. Resident 12 was assessed and noted to have no adverse reaction related to the deficient practice. Resident 12's care plan was updated to include skin discolorations. 2. All residents have the potential to be affected. A whole-house skin sweep was completed and residents with skin discolorations care plans were reviewed and revised to include the skin discolorations. 3. The Director of Clinical Education/designee educated all licensed nursing staff on the "Comprehensive Care Plans" policy prior to 12/9/22. The Director of Nursing Services/designee will audit weekly skin assessments for five random residents three times a week x 2 months, then five random residents weekly x 4 months. Audits will include all shifts and units and will include weekends. 4. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	12/09/2022

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	and the top left hand/wrist, that family had said were birthmarks. He further indicated they did not have the discolorations documented as birthmarks on a care plan and that he would put one in place. Interview with the Director of Nursing (DON) on 11/16/22 at 11:35 a.m., indicated they should have mapped out her birthmarks on her body and put documentation of the birthmarks in a care plan. 3.1-35(a)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents observed during medication pass. Three errors were observed during 33 opportunities for errors during medication administration. This resulted in a medication error rate of 9%. (Residents 64 and 65) Findings include: 1. On 11/17/22 at 8:40 a.m., LPN 1 was observed preparing medications for Resident 64. She placed all the medications in a cup and indicated there were 10 pills in the cup. There were 10 pills and a medicated patch observed being prepared. She administered the medications to the resident and signed them out on the Medication Administration Record (MAR).	F 0759	Facility requests paper compliance/desk review F759 Free of Medication Error Rates 5% or More 1. Resident 64 and resident 65 were assessed and noted to have no adverse reaction related to the deficient practice. 2. All residents receiving medications have the potential to be affected. LPN 1 was immediately educated on the "Medication Administration" policy. 3. The DCE/designee educated all licensed nursing staff on the "Medication Administration" policy prior to 12/9/22. The Director of Nursing Services/designee will observe/audit two random nurses medication passes three times a	12/09/2022

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	The resident's record was reviewed on 11/17/22 at 11:15 a.m. to reconcile the medications given. A Physician's Order, dated 1/13/22, indicated Rosuvastatin Calcium 5 milligram (mg) capsule daily. The November MAR indicated the Rosuvastatin and the 10 additional pills and patch observed above had been given that day during the observed medication pass. The Rosuvastatin had been omitted per the administration observation. Interview with LPN 1 on 11/17/22 at 11:40 a.m., indicated she thought she had given the medication. 2. On Thursday, 11/17/22 at 9:00 a.m., LPN 1 was observed preparing medications for Resident 65. She placed all the medications in a cup and indicated there were 10 pills in the cup. She administered the medications to the resident and signed them out on the MAR. The resident's record was reviewed on 11/17/22 at 11:20 a.m. to reconcile the medications given. A Physician's Order, dated 4/16/22, indicated Finesteride 5 mg tablet daily and Vitamin D 1.25 mg every Thursday. The November MAR indicated the Finesteride, Vitamin D and the 10 additional pills observed above had been given that day during the observed medication pass. The Finesteride and Vitamin D had been omitted per the administration observation. Interview with LPN 1 on 11/17/22 11:40 a.m., indicated she looked in the medication cart, the		week x 2 months, then two random nurses medication pass weekly x 4 months. Audits will include all shifts and units and will include weekends. 4. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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	medications were not there, and she would contact the pharmacy. 3.1-48(c)(1)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure a sanitary kitchen related to staff not wearing hairnets and dirty shelves and carts. This had the potential to affect the 72 of 73 residents who received meals from the kitchen. Findings include: 1. On 11/13/22 at 9:43 a.m., the kitchen was observed during the initial tour. The Cook and	F 0812	Facility requests paper compliance/desk review F812 Food procurement, Store/Prepare/Serve-Sanitary 1. All residents that receive meals from the kitchen have the potential to be affected by the deficient practice. 2. All residents that receive meals from the kitchen have the potential to be affected	12/09/2022

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	Assistant Dietary Manager (ADM) were present, neither was wearing a hair net. Interview with the Cook and the ADM at that time indicated they should be wearing hair nets. They put them on at that time. 2. On 11/13/22 at 9:43 a.m., the kitchen was observed. The shelves below the work area and serving carts had an accumulation of dust, crumbs and spills. On 11/17/22 at 10:51 a.m., the shelves and serving carts had been cleaned. Interview with the Kitchen Manager at that time indicated she was aware of the accumulation of dirt on the shelves, but it had now been cleaned. The staff was to clean all shelves, carts and floors at the end of every shift. 3.1-21(i)(3)		by the deficient practice. The Cook, Assistant Dietary Manager and Kitchen Manager were immediately educated regarding the “Maintaining a Sanitary Tray Line” policy. 3. All dietary employees were educated on the “Maintaining a Sanitary Tray Line” policies by the Dietary Services Manager/designee prior to 12/9/22. The Dietary Services Manager/Registered Dietician/designee will audit 3 random meal preparations to ensure that proper protocols per policy are occurring. Audits will occur 3 times a week for 4 weeks, then weekly for 5 months. Audits will occur on all shifts and will include weekend audits. The Dietary Services Manager/Registered Dietician/designee will audit both shelves and carts at 3 random times to ensure areas are clean and safe. Audits will occur 3 times a week for 4 weeks, when weekly for 5 months. Audits will occur on all shifts and will include weekend audits. 4. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	