| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155384 | A. BUILDING 00<br>B. WING | 09/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER | 402 19TH STREET<br>TELL CITY, IN 47586 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: September 25, 26, 27, and 28, 2022<br><br>Facility number: 000411<br>Provider number: 155384<br>AIM number: 100275100<br><br>Census Bed Type:<br>SNF/NF: 65<br>Total: 65<br><br>Census Payor Type:<br>Medicare: 1<br>Medicaid: 51<br>Other: 13<br>Total: 65<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed October 4, 2022. | F 0000 | Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.<br><br>We would like to respectfully request a desk review. | |
| F 0657<br>SS=E<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the | | | |

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

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| | resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. | | | |
| | Based on interview and record review, the facility failed to ensure care plan conferences were completed and plans of care were revised for 4 of 5 residents reviewed for care plan conferences and 2 of 5 residents reviewed for unnecessary medications. (Resident 28, Resident 34, Resident 37, Resident 5, Resident 20, Resident 45)<br><br>Findings include:<br><br>1. During an interview on 9/25/22 at 12:58 P.M., Resident 28 indicated she was unaware if she had been invited to a care plan conference.<br><br>On 9/27/22 at 10:08 A.M., Resident 28's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and diabetic neuropathy.<br><br>The most recent quarterly MDS (Minimum Data Set) assessment, dated 8/1/22, indicated Resident 28 was cognitively intact. | F 0657 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents #28, #34, $37, #5, will be notified timely of their care plan conferences schedules. Care plans for resident #45 was revised to include diabetes and treatment including medications as ordered.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Social Services will review care plan schedule to ensure all residents are notified of their scheduled care plan | 10/28/2022 |

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| | Resident 28's clinical record lacked documentation of care plan conferences.<br><br>During an interview on 9/28/22 at 10:00 A.M., the Social Services Director indicated Resident 28's most recent care plan conference was completed on 4/8/22. The resident nor family attended.<br><br>2. During an interview on 9/26/22 at 8:45 A.M., Resident 34 indicated she was not aware if she had care plan conferences.<br><br>On 9/27/22 at 1:57 P.M., Resident 34's clinical record was reviewed. The diagnoses included, but was not limited to, COPD (chronic obstructive pulmonary disease).<br><br>The most recent quarterly MDS assessment, dated 8/20/22, indicated Resident 34 was cognitively intact.<br><br>A care plan conference was completed 5/26/22.<br><br>During an interview on 9/28/22 at 10:00 A.M., the Social Services Director indicated the last care conference for Resident 34 was completed 5/26/22. She further indicated care plan conferences were supposed to be completed quarterly.3. During an interview on 9/26/22 at 10:02 A.M., Resident 37 indicated they had not been to nor been invited to any care plan conferences.<br><br>On 9/27/22 at 10:48 A.M., Resident 37's clinical record was reviewed. The diagnoses included, but were not limited to, COPD and diabetes mellitus type II.<br><br>The most recent quarterly MDS assessment, dated 8/12/22, indicated a moderate cognitive | | meeting. Care plans for residents with diabetes care will be reviewed and ensured that care plans are revised as needed.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Social Services Director will use the monthly calendar prepared by the MDS Coordinator to schedule care plan meetings with residents and families timely. Audits will be conducted 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month and 1x weekly for two months for timely notification of care plans meeting to residents/families and care plans for residents with diabetes care to ensure care plans are up to date and accurate..<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur. Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed. | |

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| | impairment.<br><br>The most recent care plan conference was documented on 10/21/21.<br><br>During an interview on 9/28/22 at 9:33 A.M.,the Social Services Director indicated that care plan conferences should be done quarterly and Resident 37's last care plan conference was 10/21/21.<br><br>4. During an interview on 9/26/22 at 9:22 A.M., Resident 5 indicated they had not been to nor been invited to care plan conferences.<br><br>On 9/27/22 at 8:54 A.M., Resident 5's clinical record was reviewed. The diagnoses included, but were not limited to, heart disease and chronic kidney disease.<br><br>The most recent quarterly MDS assessment, dated 6/17/22, indicated resident 5 had a moderate cognitive impairment.<br><br>The clinical record lacked documentation of a care plan conference being completed.<br><br>During an interview on 9/28/22 at 9:33 A.M., the Social Services Director indicated Resident 5 had not had a care plan conference. 5. On 9/27/22 at 1:00 P.M., Resident 20's clinical record was reviewed. The diagnoses included, but was not limited to, COPD (chronic obstructive pulmonary disease).<br><br>The most recent quarterly MDS assessment, dated 7/20/22, indicated Resident 20 did not receive anticoagulants during the 7 (seven) day look-back period. | | | |

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| | Current physician orders included, but were not limited to,"Nursing Alert: resident is on anticoagulant, monitor for s/s [signs and symptoms]", dated 4/12/22. The current orders lacked an order for an anticoagulant.<br><br>During an interview on 9/28/22 at 11:07 A.M., LPN (licensed practical nurse) 6 indicated Resident 20 was not currently taking an anticoagulant.6. On 9/27/22 at 1:00 P.M., Resident 45's clinical record was reviewed. The diagnosis included, but was not limited to, Diabetes Mellitus type II.<br><br>The most recent quarterly MDS assessment, dated 8/24/22, indicated Resident 45 was cognitively intact, and had not received insulin injections for the 7 (seven) day look back period.<br><br>Current physician orders lacked an order for insulin.<br><br>A current care plan, dated 10/14/21, indicated an alteration in blood glucose due to insulin dependent diabetes mellitus, revised 8/4/22.<br><br>During an interview on 9/28/22 at 8:10 A.M., LPN 6 indicated Resident 45 was not currently taking insulin, nor had he ever taken insulin while a resident.<br><br>During an interview on 9/28/22 at 10:18 A.M., the MDS Coordinator indicated the diabetes care plan for Resident 45 should have been revised on 8/4/22 with the last revision of care plans.<br><br>On 9/28/22 at 1:55 P.M., a current care plan revision policy, dated October 2022, indicated "Upon identification of a change in status ... Care plans will be modified as needed by the MDS Coordinator or other designated staff member". | | | |

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| | A current non-dated comprehensive care plan policy, was provided 9/28/22 at 10:50 A.M., and indicated "The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but not limited to ... The resident and the resident's representative, to the extent practicable ... The comprehensive care plan will be reviewed and revise by the interdisciplinary team after each comprehensive and quarterly MDS assessment"<br><br>3.1-35(c)(2)(C)<br>3.1-35(d)(2)(B) | | | |
| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview, and record review, the facility failed to implement interventions and provide supervision to prevent falls for 2 of 5 residents reviewed for accidents. Fall interventions were not in place. (Resident 10, Resident 48)<br><br>Findings include:<br><br>1. On 9/27/22 at 11:08 A.M., Resident 10's room was observed with white non skid strips on the right side of the bed that lacked grip. The room was lacking non skid strips on the left of the bed | F 0689 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Nonskid strips were replaced with new grip to right side of bed and placed nonskid strips to left side of bed and in front of window for Resident #10. Replaced nonskid strips in front of toilet with new grip for Resident #48.<br><br>How will other residents having the | 10/28/2022 |

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| | and in front of the window.<br><br>On 9/27/22 at 9:30 A.M., Resident 10's clinical record was reviewed. The diagnoses included, but were not limited to, hypertension, depression, and a history of falling.<br><br>The most recent quarterly MDS (Minimum Data Set) assessment, dated 9/19/22, indicated Resident 10 had moderate cognitive impairment, and required limited assistance of 1 (one) staff with bed mobility and transfers and extensive assistance of 1 (one) for toileting. Resident 10 required physical help in part of bathing with 1 (one) staff member.<br><br>Resident 10's care plan included, but was not limited to, "[Resident] at risk for falls related to: due to having dementia, weakness, and arthropathy [disease of the joints]" dated 6/22/22. Interventions included, but were not limited to, "nonskid strips to floor by window," dated 7/12/22 and revised 8/5/22, and "non skid strips to bedside, check placement" dated 9/15/22."<br><br>Resident 10's progress notes indicated the following falls:<br><br>Fall 1<br>7/5/22 at 9:00 P.M., Resident was found in restroom on the floor after trying to toilet self.<br><br>Fall 2<br>7/12/22 at 10:30 P.M., Resident fell ambulating in room with staff. Resident 10 received a skin tear to right forearm.<br><br>Fall 3<br>7/14/22 at 8:00 P.M., Resident was found in restroom on the floor after trying to toilet self. | | potential to be affected by the same deficient practice be identified and what corrective action will be taken. The facility recognizes that all residents have the potential to be affected by this deficient practice. Residents with fall interventions of nonskid strips will be checked for proper placement and any nonskid strips that lack grip will be replaced.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Fall education for nursing staff will be conducted. Audits will be conducted to ensure nonskid strips are in place and any nonskid strips that lack grip will be replaced. Audits will be conducted 5x per week for one month, 4x per week for 1 month, 3x per week for 1 month, 2x per week for 1 month and 1x per week for two months.<br><br>How will the corrective be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed. | |

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| | Fall 4<br>8/3/22 at 9:00 P.M., Resident was found on the floor next to air conditioner. Resident received a skin tear to left elbow.<br><br>Fall 5<br>8/25/22 at 11:00 A.M., Resident was found on the floor next to the air conditioner. Resident received an abrasion and bruising to right elbow.<br><br>Fall 6<br>9/23/22 at 11:30 A.M., Resident was found in the room on the floor after losing balance when backing up to the wheelchair with the walker. Resident received bruising to right upper arm.<br><br>Fall 7<br>9/23/22 at 3:00 P.M., Resident was found in the restroom on the floor after attempting to toilet self.<br><br>Fall 8<br>9/23/22 at 10:45 P.M., Resident was found on the floor next to the bed.<br><br>During an interview on 9/27/22 at 12:59 P.M., LPN (Licensed Practical Nurse) 7 indicated the black strips were added at some point throughout that day in front of the window and on the left of the bed.<br><br>During an interview on 9/27/22 at 1:43 P.M., Resident 10 indicated the strips were added by the bed and window earlier that day and indicated the strips were added due to previous falls by the window.<br><br>During an interview on 9/28/22 at 9:04 A.M., CNA (Certified Nursing Assistant) 2 indicated Resident 10 should have had grips on the floor in his room | | | |

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| | and Resident 10 falls frequently due to lack of supervision.<br>2. On 9/27/22 at 12:50 P.M., Resident 48 was observed sitting in a wheelchair in her room. The bathroom lacked non-skid strips on the floor. Resident 48's room was observed with three non-skid strips at the left side of the bed. Those strips lacked non-skid properties and were slick to the touch.<br><br>On 9/28/22 at 11:00 A.M. the same was observed in Resident 48's room.<br><br>On 9/27/22 at 9:25 A.M., Resident 48's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction, cognitive, social, or emotional deficit following cerebrovascular disease, unsteadiness of feet, other abnormalities of gait and mobility, muscle weakness (generalized), and history of falling.<br><br>The most recent quarterly MDS assessment, dated 8/31/22, indicated Resident 48 was cognitively intact, and required extensive assist of two staff with bed mobility, transfers, and toileting. The MDS assessment indicated Resident 48 had not had falls since admission.<br><br>The current physician orders included, but were not limited to,<br>Resident have a reaching stick within her reach at all times, dated 1/20/20.<br>Non-skid strips in front of the night stand, at bedside, in front of the dresser, at the end of the bed, in front of the closet, in front of the toilet, and in front of the window, dated 6/25/22.<br><br>A current risk for falls care plan, dated 2/11/21, included but was not limited to the following interventions, non-skid strips to be placed in front | | | |

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| | of night stand, at bedside, in front of dresser, at the end of the bed, in front of the closet, in front of the toilet, and in front of the window, dated 6/27/22.<br><br>Resident 48's progress notes indicated the following falls:<br><br>Fall 1<br>On 4/29/22 at 10:30 P.M., Resident 48 had an unwitnessed fall in room. The nurse was walking past the resident's room and heard the resident yell for help. The resident was observed to slide onto the floor and sit on her buttocks beside her bed. Resident was attempting to transfer from her wheelchair to her bed. Resident 48 was assisted into bed per facility protocol.<br><br>Fall 2<br>On 6/13/22 at 7:00 P.M., Resident 48 experienced an unwitnessed fall. The resident was heard calling out for help. She was found sitting on her buttocks on the floor of her bathroom. The resident stated she was going to stand up and slid down to the floor. The fall documentation indicated the non-skid strips in front of the toilet had lost most of their grip. The resident received a superficial abrasion to the left buttock.<br><br>Fall 3<br>On 6/16/22 at 5:00 P.M., Resident 48 experienced an unwitnessed fall in her bathroom trying to self-toilet, with her wheelchair unlocked. The resident complained of pain to her right ankle, but was not sent to the hospital.<br><br>Fall 4<br>On 7/4/22 at 1:00 P.M., Resident 48 experienced a witnessed fall. The resident was standing in her room trying to transfer from her wheelchair to her | | | |

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| | bed and lost her balance. The nurse was unable to reach the resident and she slid to the floor onto her buttocks.<br><br>Fall 5<br>On 7/22/22 at 9:00 A.M., Resident 48 experienced an unwitnessed fall in room. The resident was leaning over in wheelchair trying to wipe up a spilled drink, lost her balance, and fell to floor. The fall resulted in a laceration to the resident's forehead. The resident was sent to the emergency room.<br><br>Fall 6<br>On 8/14/22 at 7:15 A.M., the resident experienced a fall in her room while attempting to self-toilet.<br><br>On 9/28/22 at 10:50 A.M., a current Accidents and Supervision policy, dated 2021, was provided and indicated "The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:...Implementing interventions to reduce hazard(s) and risk(s)...The facility will provide adequate supervision to prevent accidents..."<br><br>3.1-45(a)(2) | | | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 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, | | | |

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| | the residents' goals and preferences, and 483.65 of this subpart.<br>Based on observation, interview, and record review, the facility failed to ensure residents received necessary respiratory care and services in accordance with professional standards of practice for 2 of 2 residents reviewed for respiratory care. Physician oxygenation orders were not followed and humidification bottles were not changed when empty. (Resident 63, Resident 49)<br><br>Findings include:<br><br>1. During an observation on 9/26/22 at 10:13 A.M., Resident 63 was observed resting in bed with oxygen on via nasal cannula at 3 L (liters).<br><br>During an observation on 9/27/22 at 8:57 A.M., Resident 63 was observed sitting in a wheelchair with oxygen on via nasal cannula at 3 L.<br><br>During an observation on 9/28/22 at 8:59 A.M., Resident 63 was observed resting in bed with oxygen on via nasal cannula at 3 L.<br><br>On 9/27/22 at 8:26 A.M., Resident 63's clinical record was reviewed. The diagnoses included, but were not limited to, asthma and chronic obstructive pulmonary disease (COPD).<br><br>The current orders included, but were not limited to, oxygen at 2 L via nasal cannula continuously every day and night shift for COPD, dated 9/14/22.<br><br>A current care plan for oxygen therapy, dated 9/8/22, included, but was not limited to the following intervention, administer oxygen as needed per physician order. | F 0695 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Oxygen flow rate was adjusted as ordered and new humidification bottles were added to oxygen concentrators with current date for Residents #49 and #63, Resident #49's oxygen filter was cleaned.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what correct action will be taken. The facility recognizes that all residents have the potential to be affected by this deficient practice. Residents receiving oxygen per order were checked to ensure proper flow rate, and all humidification bottles present and not empty, with current date marked. Oxygen filters were checked and cleaned to ensure there was no lint present.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Respiratory/oxygen education will be provided for nursing staff. Audits will be conducted to ensure flow rates are correct with clean filters, and humidification bottles are present and are not empty. | 10/28/2022 |

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| | During an interview on 9/28/22 at 9:11 A.M., Qualified Medical Assistant (QMA) 3 indicated Resident 63 should be on 2 L of oxygen. At that time, QMA 3 indicated Resident 63 would not touch the oxygen concentrator to increase the flow. 2. On 9/26/22 at 9:56 A.M., Resident 49 was observed wearing oxygen per nasal cannula at 3.5 L. The filter of the oxygen machine was observed to have a thin layer of lint on the outside. The humidifier bottle was dated 9/16/22 and was out of water.<br><br>On 9/27/22 at 11:28 A.M., Resident 49 was observed wearing oxygen per nasal cannula at 3.5 L. The humidifier bottle was dated 9/16/22 and was out of water.<br><br>On 9/28/22 at 8:28 A.M., Resident 49 was observed wearing oxygen per nasal cannula at 3.5 L. The humidifier bottle was dated 9/16/22 and was out of water.<br><br>On 9/26/22 at 2:00 P.M., Resident 49's clinical record was reviewed. The diagnoses included, but were not limited to, COPD, acute respiratory failure with hypoxia, and shortness of breath.<br><br>The most recent quarterly MDS (Minimum Data Set) assessment dated 9/1/22 indicated a moderate cognitive impairment. The MDS indicated Resident 49 required extensive assist of two staff for bed mobility, transfer, and toileting, and received oxygen therapy while a resident.<br><br>A current potential for respiratory distress care plan, dated 1/16/12, included but were not limited to the following interventions, oxygen as ordered per nasal cannula at 2 liters to prevent hypoxia related to COPD, revised 12/11/18. | | Audits will be conducted 5x per week for one month, 4x per week for one month, 3x per week for one month, 2x per week for one month and 1x per week for two months.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed. | |

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| | The current physician orders included, but were not limited to:<br>O2 (oxygen) at 2LPM (liters per minute) via nasal cannula, dated 6/8/22.<br>Change prefilled water bottles, oxygen tubing on oxygen concentrator and humidification weekly and as needed, dated 4/8/21.<br><br>During an interview on 9/28/22 at:10:20 A.M., LPN 4 and CNA 3 indicated Resident 48 did not adjust the level of her oxygen machine.<br><br>On 9/28/22 at 10:50 A.M., a current Oxygen Administration policy, dated 2022, was provided and indicated "...Oxygen is administered under orders of a physician...Staff shall...Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Change humidifier bottle when empty, every 72 hours..."<br><br>3.1-47(a)(6) | | | |
| F 0804 SS=E Bldg. 00 | 483.60(d)(1)(2)<br>Nutritive Value/Appear, Palatable/Prefer Temp<br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>Based on observation, interview, and record review, the facility failed to provide appetizing and palatable meals for 1 of 1 lunch trays sampled on 1 of 2 units. Food was served cold and bland. (Unit | F 0804 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Dietary Services | 10/28/2022 |

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| | 4, Resident 22, Resident 54, Resident 57, Resident 52, Resident 43)<br><br>Findings include:<br><br>1. During an interview on 9/25/22 at 11:35 A.M., Resident 22 indicated the food was usually served cold and had no taste.<br><br>2. During an interview on 9/26/22 at 8:43 A.M., Resident 54 indicated the food could be better.<br><br>3. During an interview on 9/26/22 at 9:46 A.M., Resident 57 indicated the food was "nasty" and that food was cold.<br><br>4. During an interview on 9/26/22 at 9:50 A.M., Resident 52 indicated the food does not have a good taste.<br><br>5. During an interview on 9/26/22 at 8:49 A.M., Resident 43 indicated the food was served cold and was bland.<br><br>During record review on 9/27/22 at 11:00 A.M., Resident Council meeting minutes were review from March, 2022 through September 2022. The following concerns were documented:<br>March 2022 - "Food is cold... Meat is hard/dry"<br>April 2022 - "Coffee coming out cold"<br>May 2022 - "Want the food to be prepared better"<br>June 2022 - "Still having issues with food being cold"<br>July 2022 - "Still having all the same food issues... Meals coming up cold (only thing not cold is the drinks)"<br><br>During an observation on 9/28/22 at 12:00 P.M., the Unit 4 meal trays were being distributed to resident rooms from a meal cart. The individual | | Manager will meet with Resident #22, #54, #57 , #52 and #43 to discuss food concerns and ensure food comes up at proper temperature and seasoning to resolve bland taste.<br><br>How will other residents having the potential to be affected by this deficient practice be identified.<br>The facility recognizes that all residents have the potential to be affected by this deficient practice.<br>Dietary Manager will interview other residents regarding taste of food and temperature of food when served to ensure they are receiving food at proper temperatures and taste.<br>How<br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>Dietary staff will be educated on proper temperature during food service and food palpability.<br>Audits will be conducted 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month and 1s weekly for one month to ensure food is at proper temperature and food is palpable.<br><br>How will the corrective action be monitored to ensue the deficient practice does not recur., i.e. what quality assurance program will be put into place. Audits will be | |

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| | meals were covered with an insulated dome without the use of a base. At 12:05 P.M., a hall tray was sampled. The following temperatures were obtained and tasted/consistency was noted:<br>Chicken - 85 degrees Fahrenheit<br>Mashed Potatoes - 120 degrees Fahrenheit. Taste was bland.<br>Vegetable Medley - 105 degrees Fahrenheit. Taste was bland.<br><br>During an interview on 9/28/22 at 12:24 P.M., the Registered Dietician (RD) indicated they are aware there have been issues with the food, and that they were unaware as to why the kitchen was not using the plate dome cover bases. The RD indicated the kitchen had trouble finding the correct size dishes for the covers.<br><br>On 9/28/22 at 1:55 P.M., the Facility Administrator supplied a facility policy titled, Record of Food Temperatures, dated 2017. The policy included, "Hot foods will be held at 135 degrees Fahrenheit or greater."<br><br>3.1-21(a)(2) | | reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed. | |
| F 0812 SS=E Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent | | | |

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| | facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, interview, and record review, the facility failed to ensure food was stored and handled in a sanitary manner during 2 of 2 kitchen observations. Food was stored unlabeled and uncovered, air vents had built up dust, ice was built up towards the back of the walk-in freezer, and the drywall ceiling above the oven was crumbling.<br><br>Findings includes:<br><br>During a kitchen observation on 9/25/22 at 9:04 A.M., 6 air vents above the dishwasher and 2 three-compartment sinks had build up, dark colored, dust. One of the vents was loose hanging from the duct. The drywall ceiling above the oven was cracked and missing a basketball sized piece of drywall. White debris was observed under the oven and stove. Two bags of food in the walk in freezer were unlabeled and undated. The walk-in freezer had built up ice towards the back of the freezer that had accumulated on top of 2 boxes of ice cream cups.<br><br>During a kitchen observation on 9/28/22 at 10:10 A.M., 6 air vents above the dishwasher and 2 three-compartment sinks had build up, dark colored, dust. One of the vents was loose hanging from the duct. The drywall ceiling above the oven | F 0812 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Food will be stored and handled in a sanitary manner. Food will be labeled and covered. Air vents will be free of dust, the ice build-up will be cleaned in the walk in freezer and the drywall above the oven will be repaired.<br><br>How will other residents having the potential to be affected by this deficient practice be identified. The facility recognizes that all residents at the facility have the potential to be affected by this deficient practice.<br><br>What measures or systemic changes will be made to ensure that the deficient practice does not recur. Dietary staff will be educated on proper sanitation and cleaning procedures, proper labeling and storage of food and reporting repairs required to the Maintenance Director. Audits will | 10/28/2022 |

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| | was cracked and missing a basketball sized piece of drywall. White debris was observed under the oven and stove. Two bags of food in the walk in freezer were unlabeled and undated. The walk-in freezer had built up ice toward the back of the freezer that had accumulated on top of 2 boxes of ice cream cups.<br><br>During an interview on 9/28/22 at 10:25 A.M., the Registered Dietician (RD) indicated they had told maintenance about the ice build up in the freezer, that stored food should be labeled and dated, and that they were unaware of the hole in the ceiling and the dust build up on the vents.<br><br>On 9/28/22 at 11:10 A.M., the RD supplied an undated facility policy titled, General Sanitation, and an undated policy titled, Date Marking for Food Safety. The policies included, "...as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary... food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded"<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | be conducted 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month and 1x weekly for two months.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality insurance program will be put into place. Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed. | |
| F 0880<br>SS=D<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program. | | | |

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

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| | their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place during 2 of 6 resident medication administrations and 1 of 1 residents during incontinence care. Staff handled resident medications with bare hands, staff failed to sanitize the end of an insulin pen, and staff failed to sanitize hands and change gloves between dirty to clean tasks. (Resident 13, Resident 44, Resident 63)<br><br>1. During an observation on 9/27/22 at 8:44 A.M., RN (Registered Nurse) 11 was preparing medications for Resident 13. RN 11 dropped a tablet on top of the medication cart, picked it up with their bare hand, placed it into the medication cup with Resident 13's other medications, then administered the medication to Resident 13.<br><br>During an interview on 9/28/22 at 11:05 A.M., LPN | F 0880 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents # 13, #44 and #63 were found to not be affected by this practice. Observation of medication administration for Resident #13 conducted with no finding. Observation of insulin pen administration for Resident #44 conducted with no findings. Observation of incontinence care was conducted for Resident #63 with no findings.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective | 10/28/2022 |

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| | (Licensed Practical Nurse) 4 indicated staff should not handle medications with their bare hands.<br><br>On 9/28/22 at 2:35 P.M., the Facility Administrator supplied a facility policy titled, Medication Administration, dated 2017. The policy included, "13. Remove medication from source, taking care not to touch medication with bare hand."<br><br>2. During an observation on 9/28/22 at 11:25 A.M., LPN 6 was preparing a Humalog Kwikpen insulin dose for Resident 44. LPN 6 failed to wipe the end of the insulin pen with an alcohol wipe prior to putting on the needle.<br><br>During an interview on 9/28/22 at 11:47 A.M., LPN 4 indicated insulin pens should be wiped with an alcohol wipe to sanitize the end prior to putting on the needle.<br><br>Manufacturers instructions, reviewed 9/29/22 at 10:22 A.M., from uspl.lilly.com/humalog, revised 4/2020, included, "...Step 1: Pull the Pen Cap straight off... Wipe the Rubber Seal with an alcohol swab..."3. During an observation on 9/28/22 at 10:54 A.M., CNA (Certified Nursing Assistant) 2 and CNA 7 provided incontinence care for Resident 63. CNA 2 cleaned the resident and failed to sanitize hands and change gloves before CNA 2 placed the new brief on Resident 63.<br><br>During an interview on 9/28/22 at 11:00 A.M., LPN 4 indicated handwashing and changing gloves should be completed after the resident was cleaned and before the new brief was placed on the resident.<br><br>During an interview on 9/28/22 at 1:00 P.M., the DON (Director Of Nursing) indicated it was the facility's policy for staff to change gloves between | | action will be taken. The facility recognizes that all residents have the potential to be affected by this deficient practice. Random observations of insulin pn administration will be conducted on residents receiving insulin by pen, residents requiring incontinent care and medication administration,<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. An infection control inservice will be conducted for nursing staff. Audits will be conducted to ensure proper infection control standards are met with medication pass, insulin pen administration and incontinence care. Audits will be conducted 7x per week for six weeks, 5x per week for four weeks, 3x per week for four weeks, 2x per week for four weeks and 1x per week for two weeks.<br><br>How will the corrective action be monitored to ensure the deficient practice does not recur, i.e. what quality assurance program will be put into place. Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed. | |

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| | dirty to clean tasks.<br><br>3.1-18(b)(1) | | | |
| F 0921 SS=E Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, and homelike environment for 6 of 21 rooms reviewed during the survey. Resident areas were missing baseboard trim, resident walls had holes, resident restrooms were not clean, a restroom light was not functioning, and resident's personal hygiene items were left unlabeled and uncovered in shared restrooms. (Room, 24, Room 27, Room 68, Room 61, Room 57, Room 48)<br><br>Findings include:<br><br>1. During an observation on 9/26/22 at 9:36 A.M., the restroom in Room 24 contained a lantiseptic cream container that was open without a lid on a shelf above the commode.<br><br>During an observation on 9/28/22 at 9:17 A.M., the restroom in Room 24 contained a lantiseptic cream container that was open without a lid on a shelf above the commode.<br><br>During an interview on 9/28/22 at 11:47 A.M., LPN (Licensed Practical Nurse) 4 indicated lantispetic creams should be stored with the lid on.<br><br>2. During an observation on 9/26/22 at 9:52 A.M., the restroom in Room 27 was missing the baseboard trim along a bathroom wall under a | F 0921 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The lantiseptic cream in the restroom of room #24 was closed and put away, the baseboard in the restroom of room #27 will be replaced, the light in the restroom of room 68 was replaced, the toothbrushes in the restroom of room 61 were labeled and put away, and the used washcloths sent to laundry.<br>The toothbrushes in the restroom of room #57 were labeled and put away, the wall near the restroom in Room 48 will have the baseboard replaced and the hole repaired, The resident rooms #24, 27, 68, 61, 57, and 48 were cleaned.<br><br>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. The facility recognizes that all residents have the potential to be affected by this deficient practice. Resident | 10/28/2022 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155384 | A. BUILDING 00<br>B. WING | 09/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER | 402 19TH STREET<br>TELL CITY, IN 47586 |

| (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 |
|---|---|---|---|---|
| | window.<br><br>During an observation on 9/28/22 at 9:12 A.M., the restroom in Room 27 was missing the baseboard trim along a bathroom wall under a window<br><br>3. During an observation on 9/28/22 at 9:29 A.M., the restroom light was not functioning in Room 68. At that time, the resident in Room 68 indicated they had told staff about the light not functioning the day prior.<br><br>During an interview on 9/28/22 at 11:42 A.M., Maintenance 34 indicated something was tripping the light and causing it to not work.<br><br>4. During an observation on 9/25/22 at 10:48 A.M., the restroom in Room 61, shared by 4 residents, contained multiple toothbrushes unlabeled and uncovered above the restroom sink.<br><br>During an observation on 9/28/22 at 9:38 A.M., the same restroom in Room 61 contained an unlabeled and uncovered toothbrush on the back of the sink, a pile of used washcloths on the back of the sink, and 2 unlabeled and uncovered toothbrushes on a shelf above the sink.<br><br>5. During an observation on 9/25/22 at 10:55 A.M., the restroom in Room 57, shared by 4 residents, contained unlabeled and uncovered toothbrushes.<br><br>During an observation on 9/28/22 at 9:40 A.M., the restroom in Room 57 contained 4 toothbrushes unlabeled and uncovered above the restroom sink.<br><br>6. During an observation on 9/26/22 at 11:10 A.M., | | rooms will be checked to ensure restrooms and rooms are clean, with personal items stored.<br><br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Audits will be conducted 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month and 1x weekly for two months to ensure restrooms are clean, personals are stored, baseboards are in place and functional, walls are free of holes and rooms are clean. Housekeeping staff will be educated on cleaning procedures for resident rooms and restrooms. Nursing staff will be educated on proper storage of personal items.<br><br>How will the corrective action be monitored to ensure the deficient practice does not recur., i.e. what quality assurance program will be put into place. Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed. | |

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| | the wall near the restroom in Room 48 was missing the baseboard trim and had small hole at the bottom of the wall.<br><br>During an observation on 9/28/22 at 10:45 P.M., the wall near the restroom in Room 48 was missing the baseboard trim and had small hole at the bottom of the wall.<br><br>During an interview on 9/28/22 at 11:42 A.M., Maintenance 34 indicated he was unaware of the missing baseboard trim and holes in the walls or resident rooms and restrooms, but would fix them.<br><br>During an interview on 9/28/22 at 10:48 A.M., Housekeeping 18 indicated they sweep, wipe surfaces, pick up trash, and mop each resident room daily.<br><br>On 9/28/22 at 1:55 P.M., the Facility Administrator supplied a facility policy, titled Resident Environmental Quality, dated 2022. The policy included, "It is the policy of this facility to bed designed, constructed, equipped, and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public."<br><br>3.1-19(f) | | | |