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

IT OF DEFICIENCIES OF CORRECTION			JILDING	ONSTRUCTION  00	(X3) DATE COMPL <b>05/25</b> /	ETED
			1700   3	STREET		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
IN00404690, IN00404 the allegations are of Complaint IN00406 the allegations are of Complaint IN00408 related to the allegation are of Complaint IN00408 related to the allegation are of Complaint IN00408 related to the allegation and F84 Survey dates: May 2 Facility number: 00 Provider number: 1: AIM number: 10028 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 6 Medicaid: 47 Other: 12 Total: 65 These deficiencies raccordance with 410 Quality review complete.	206061 and IN00408752.  690 - No deficiencies related to ited.  6061 - No deficiencies related to ited.  6752 - Federal/State deficiencies tions are cited at F580, F600, 12.  624 and 25, 2023.  60023  65062  689400	F 00	000	is the center's credible allegat of compliance. Preparation ar execution of this plan of corre does not constitute admission agreement by the provider of truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because	ion nd/or ction or the	
Notify of Changes	(Injury/Decline/Room, etc.)					
	ROVIDER OR SUPPLIER ARD HEALTHCARE  SUMMARY S (EACH DEFICIEN REGULATORY OR  This visit was for th IN00404690, IN004  Complaint IN00406 the allegations are c  Complaint IN00408 related to the allegar F609, F610 and F84  Survey dates: May 2  Facility number: 00 Provider number: 1: AIM number: 10028  Census Bed Type: SNF/NF: 65 Total: 65  Census Payor Type: Medicare: 6 Medicaid: 47 Other: 12 Total: 65  These deficiencies r accordance with 410  Quality review com  483.10(g)(14)(i)-(in Notify of Changes	ROVIDER OR SUPPLIER  ARD HEALTHCARE - LAPORTE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  This visit was for the Investigation of Complaints IN00404690, IN00406061 and IN00408752.  Complaint IN00404690 - No deficiencies related to the allegations are cited.  Complaint IN00406061 - No deficiencies related to the allegations are cited.  Complaint IN00408752 - Federal/State deficiencies related to the allegations are cited at F580, F600, F609, F610 and F842.  Survey dates: May 24 and 25, 2023.  Facility number: 000023  Provider number: 155062  AIM number: 100289400  Census Bed Type: SNF/NF: 65 Total: 65  Census Payor Type: Medicare: 6 Medicaid: 47 Other: 12	ROVIDER OR SUPPLIER  RRD HEALTHCARE - LAPORTE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  This visit was for the Investigation of Complaints IN00404690, IN00406061 and IN00408752.  Complaint IN00404690 - No deficiencies related to the allegations are cited.  Complaint IN00408752 - Federal/State deficiencies related to the allegations are cited at F580, F600, F609, F610 and F842.  Survey dates: May 24 and 25, 2023.  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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Kelly Bradford, RN, BSN Director of Nursing Services 06/15/2023

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DLI811 Facility ID: 000023 If continuation sheet Page 1 of 18

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155062	B. Wl	ING		05/25/	2023
NAME OF B			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	C		1700   S	STREET		
BRICKYA	ARD HEALTHCARE	E - LAPORTE CARE CENTER		LA POR	RTE, IN 46350		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		mmediately inform the					
	resident; consult v						
		tify, consistent with his or					
	her authority, the resident representative(s) when there is-						
	(A) An accident involving the resident which results in injury and has the potential for						
	requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);						
	(C) A need to alte	r treatment significantly					
	(that is, a need to	discontinue an existing					
	form of treatment	due to adverse					
	-	to commence a new form					
	of treatment); or						
		ransfer or discharge the					
		facility as specified in					
	§483.15(c)(1)(ii).						
		notification under paragraph					
	1-11	ection, the facility must					
	·	tinent information specified					
	upon request to the	s available and provided					
		ie priysician. ist also promptly notify the					
	, ,	esident representative, if					
	any, when there is	-					
	(A) A change in ro						
	· ,	ecified in §483.10(e)(6); or					
		esident rights under Federal					
		gulations as specified in					
	paragraph (e)(10)						
		ust record and periodically					
		ss (mailing and email) and					
	phone number of	, -					
	representative(s).						
	§483.10(g)(15)						
	3 100.10(9)(10)						

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Event ID:

DLI811

Facility ID: 000023

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155062	B. W	ING		05/25	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			STREET		
BRICKY	ARD HEALTHCARE	- LAPORTE CARE CENTER			RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		mposite distinct part. A					
	1	mposite distinct part (as					
	defined in §483.5) must disclose in its						
	admission agreem						
	_	uding the various locations					
		composite distinct part,					
		the policies that apply to					
	room changes between its different locations under §483.15(c)(9).  Based on record review and interview, the facility						
			EO	500	Droparation and/or everyting	of	06/26/2022
		dents' family and Physicians	F 05	080	Preparation and/or execution this plan of correction does no		06/26/2023
					· ·		
	were notified following a resident to resident incident that required staff intervention for 2 of 3				constitute admission or agreed by the provider of the truth of the		
	residents reviewed for abuse. (Residents B and C)				facts alleged or conclusions se		
	residents reviewed	ioi abase. (Residents B and C)			forth in the statement of	Ci	
	Finding includes:				deficiencies. The plan of corre	ection	
	I manig morado.				is prepared and/or executed s		
	Resident B's record	was reviewed on 5/24/23 at			because it is required by the	ololy	
		t diagnosed included, but were			provisions of federal and state	law.	
		lar depression, unspecified			'		
	_	etes Mellitus. She resided in			1. Family and physician were		
	room 39-2.				notified per the Director of Nu	rsing	
					Services (DNS) on 5/26/2023.	-	
		um Data Set (MDS)			2. The Director of Nursing		
		/9/23, indicated the resident			completed a review of the med	dical	
		act and was able to transfer			records for all other residents		
	and bed mobility w	ith supervision.			a noted change requiring fami	-	
					and/or legal representative an		
		are Plan indicated the resident			physician notification over the		
		lated to bipolar disorder that			30 days to ensure appropriate		1
		by the facility. Interventions			notification occurred with no o		
		signs of depression including			deficient practices identified. 3	3.	
		e statements and repetitive			Licensed nursing staff will be		
	anxious or health re	elated complaints.			re-educated per the		
	D 11 4 C	1 5/04/00			DNS/Designee on the "Notification of the "Notificat		
		was reviewed on 5/24/23 at			of Changes" policy by date of		
		dent was admitted to the facility			compliance. All Nurses' notes		
		9-1. Diagnoses included, but			physician orders will be review		
		urinary tract infection, sepsis			daily per the DNS/designee to		1
	and psychotic disor	der with delusions.			ensure that the physician and	tne	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/25/2023 155062 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1700 I STREET BRICKYARD HEALTHCARE - LAPORTE CARE CENTER LA PORTE, IN 46350 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE family/legal guardian have been The Admission MDS assessment, dated 5/10/23. notified of any changes that indicated the resident was moderately cognitively require notification and that the impaired, and required extensive assist of one notification is documented in the staff for transfers and bed mobility. medical record. These reviews will be on-going. All identified changes General notes, dated 5/6, 5/7 and 5/8/23, indicated will also be discussed in the the resident was exhibiting behaviors of morning "Clinical Start-up" confusion, wandering, yelling out at night, 5x/week to ensure that the throwing television off dresser and scratching family/legal guardian have been notified and that the notification is documented. 4. If any deficient A confidential interview with Employee 1, on practices are identified the 5/24/23, indicated on 5/5/23 around 8:00 p.m., she Director of Clinical Education or entered the residents' room and observed designee will provide additional Resident B standing over Resident C, there was training for the identified licensed an electric cord around her neck and Resident B nurse. 5. The DNS will present the was holding the ends of the cord. The residents findings of the reviews every month were separated. Employee 1 notified the nurse on to the Quality Assessment duty, LPN 1 of what had happened. Process Improvement Committee (QAPI). The QAPI committee to Interview with LPN 1, on 5/25/23 at 9:47 a.m., review for any trends or patterns of indicated she had been notified by Employee 1 deficient practices (3 deficient and CNA 1 of what had been witnessed. She practices in 1 month will be assessed Resident C for injuries and called the considered as a trend/pattern) and Director of Nursing (DON) to report the event. make further recommendations as The LPN indicated she did not notify family necessary. members or Physicians at that time, she thought the DON was going to take care of it. Resident B was moved into a different room that night. Interview with the Social Service Director (SSD), on 5/24/23 at 3:22 p.m., indicated she had notified Resident B's family of the room change. Resident C did not get a new roommate so family had not been notified. The SSD indicated she had not been aware of the incident on 5/5/23 until 5/24/23. The residents' records lacked documentation of the event or that family or Physicians had been

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155062 B. WING 05/25/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1700 I STREET BRICKYARD HEALTHCARE - LAPORTE CARE CENTER LA PORTE. IN 46350 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE notified. This Federal tag relates to Complaint IN00408752. 3.1-5(a)(1)F 0600 483.12(a)(1) SS=D Free from Abuse and Neglect Bldg. 00 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; F 0600 p="" xml:="" paraid="628400245" 06/26/2023 Based on interview and record review, the facility paraeid="{1e1bf4c6-3ef2-4d67-be3 failed to protect a resident's (Resident C) right to e-b7bb084affb9}{186}">Preparation be free from physical abuse by another resident and/or execution of this plan of (Resident B) for 1 of 3 residents reviewed for correction does not constitute abuse. admission or agreement by the provider of the truth of the facts Finding includes: alleged or conclusions set forth in the statement of deficiencies. The A confidential interview with Employee 1 on plan of correction is prepared 5/24/23, indicated on 5/5/23 around 8:00 p.m., and/or executed solely because it Employee 1 entered the residents' room and is required by the provisions of observed Resident B standing over Resident C. federal and state law. There was an electric cord around her neck and p="" xml:="" paraid="628400245"

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Event ID:

Resident B was holding the ends of the cord. The

residents were separated. Employee 1 notified the

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Facility ID: 000023

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paraeid="{1e1bf4c6-3ef2-4d67-be3

e-b7bb084affb9}{186}">

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTIO			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLE	
		155062	B. W	ING		05/25/2	023
NAME OF I	DROVIDED OD CUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF				STREET		
BRICKY	ARD HEALTHCARE	- LAPORTE CARE CENTER		LA POF	RTE, IN 46350		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	nurse on duty, LPN	1 of what had happened.				450	
	1	A 1 5/25/22 4 11 10			p="" xml:="" paraid="6284002		
		A 1, on 5/25/23 at 11:18 a.m.,			paraeid="{1e1bf4c6-3ef2-4d6	7-be3	
		ening of 5/5/23, she had been across the hall when she			e-b7bb084affb9}{186}">		
	-	across the nan when she alling for help. On entering the			p="" xml:="" paraid="6284002	<sub>45"</sub>	
		dent B standing over Resident		paraeid="{1e1bf4c6-3ef2-4d67-be3			
	·	ad an electrical cord around			e-b7bb084affb9}{186}">	. 200	
	her neck.  Interview with LPN 1 on 5/25/23 at 9:47 a.m., indicated she had been notified by Employee 1						
					p="" xml:="" paraid="6284002	45"	
					paraeid="{1e1bf4c6-3ef2-4d6		
					e-b7bb084affb9}{186}">1. Res	sident	
	and CNA 1 of what had been witnessed. She				C no longer resides in the faci	ility.	
	assessed Resident C for injuries and called the				Resident C's physician and		
	Director of Nursing	(DON) to report the event.			husband were notified of the	event	
	Resident B was mo	ved into a different room that			that occurred on 5/5/2023. It v	vas	
	night.				determined per investigation t	hat	
					resident B was trying to assist	i l	
		Administrator on 5/24/23 at 3:25			Resident C to untangle hersel		
	•	ad been made aware of the			from the call-light cord and wa		
		e days later when a staff			not attempting to injure Reside	ent	
		d him and asked about it. He			C injuries occurred to either		
		he staff member was. He			resident in the event. Residen		
		had been involved with the			had no recollection of the eve	nt	
		dicated Resident C had been			per interviews.		
	loud and confused s	since admission.			2. All residents have the poter		
	Interview with the	DON on 5/24/22 at 2.15			to be affected. DNS complete	ua	
		OON on 5/24/23 at 3:15 p.m., N 1 notified her of the event on			review of the last 30 days of	th no	
		Resident B was very agitated			behaviors within the facility wideficient practices noted. 3. A		
		rical cord was going to end up			staff will be re-educated on the		
		te's neck. Resident B was			"Abuse, Neglect and Exploitat		
		t room. There was no			policy per the Director of Clini		
		no report made to IDOH.			Education (DCE) or designee		
	ascamentation and	no report inductio in one.			to the date of compliance. 4.	-	
	Interview with Soci	al Services on 5/24/23 at 3:22			behaviors, events, and/or cha		
	p.m., indicated when she came to work the				of condition will be reviewed b	-	
		5/8/23, she was told by the			Interdisciplinary Team in the	,	
		were concerned with Resident			clinical morning meeting 5		
	-	ing Resident B. and had			times/week to ensure that		

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155062 B. WING 05/25/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1700 I STREET BRICKYARD HEALTHCARE - LAPORTE CARE CENTER LA PORTE, IN 46350 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE moved Resident B to another room as a proactive appropriate interventions are in measure. place related to the identified behavior/events/or change of a. Resident C's record was reviewed on 5/24/23 at condition. DNS/designee will 11:24 a.m. The resident was admitted to the facility interview/assess 5 residents per on 5/4/23 into the same room as Resident B. week for 4 weeks to determine Diagnoses included, but were not limited to, whether or not an alleged violation urinary tract infection, sepsis and psychotic has occurred, then 3 residents per disorder with delusions. week for 2 months then 1 resident weekly for 3 months. The The Admission MDS assessment, dated 5/10/23. DNS/Designee will also interview 3 indicated the resident was moderately cognitively staff members per week for 8 impaired, and required extensive assist of one weeks then 1 staff member weekly staff for transfers and bed mobility. for 4 months to ensure compliance and accurate reporting of General notes, dated 5/6, 5/7 and 5/8/23, indicated behaviors/events/or changes in the resident was exhibiting behaviors of condition to ensure no alleged confusion, wandering, yelling out at night, violations have occurred. throwing television off dresser and scratching Audits/observations/interviews will staff. be conducted randomly, across all 3 shifts, and will include There was no documentation related to the weekends. Any deficient practices observed incident involving her roommate on will be addressed immediately, 5/5/23. and re-education will be completed immediately. 5. The results of b. Resident B's record was reviewed on 5/24/23 at these audits will be reviewed 10:28 a.m. Diagnoses included, but were not monthly in the Quality Assurance limited to, bipolar depression, unspecified Process Improvement (QAPI) dementia and Diabetes Mellitus. meetings for 6 months or until 100% compliance is achieved x 3 The Annual Minimum Data Set (MDS) consecutive months. The QAPI assessment, dated 4/9/23, indicated the resident committee will review for any was cognitively intact and was able to transfer trends or patterns of deficient and move in bed with supervision. practices (3 deficient practices in 1 month will be considered as a A Mental Health Care Plan indicated the resident trend/pattern) and make further had health needs related to bipolar disorder that recommendations as necessary. will adequately met by the facility. Interventions

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Event ID:

included to monitor signs of depression including verbalizing negative statements and repetitive

DLI811

Facility ID: 000023

If continuation sheet

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155062	B. W			05/25	/2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
BRICKYA	ARD HEALTHCARE	- LAPORTE CARE CENTER			STREET RTE, IN 46350		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	anxious or health re	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	anxious of health fe	rated complaints.					
	A Social Services G	General Note, dated 5/4/23,					
	indicated the resider	nt had not had any behaviors,					
	delusions or hallucinations in the look back period.  A General Note, dated 5/5/23, indicate the resident						
was being moved to a different room due to high							
	irritation/anxiety with roommate.						
		"Abuse, Neglect and					
Exploitation", indicated, ""Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with							
		arm, pain or mental anguish,					
		taff to resident abuse and					
	certain resident to re	esident altercations"					
	This Federal tag rela	ates to Complaint IN00408752.					
	3.1-27(a)(1)						
F 0609	483.12(b)(5)(i)(A)(	(B)(c)(1)(4)					
SS=D	Reporting of Alleg						
Bldg. 00	. , , .	oonse to allegations of					
		xploitation, or mistreatment,					
	the facility must:						
	§483.12(c)(1) Ens	ure that all alleged					
	violations involving	<u> </u>					
	•	treatment, including					
	injuries of unknow						
		of resident property, are					
		tely, but not later than 2 egation is made, if the					
		the allegation involve abuse					
		s bodily injury, or not later					
		e events that cause the					
	allegation do not i	nvolve abuse and do not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DLI811

Facility ID: 000023

If continuation sheet Page 8 of 18

06/23/2023 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155062 B. WING 05/25/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1700 I STREET BRICKYARD HEALTHCARE - LAPORTE CARE CENTER LA PORTE, IN 46350 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate

F 0609

corrective action must be taken. Based on record review and interview, the facility failed to ensure a resident to resident incident involving abuse was reported to the Indiana Department of Health (IDOH) as required for 2 of 3 residents reviewed for abuse. (Residents B and C)

Finding includes:

Resident B's record was reviewed on 5/24/23 at 10:28 a.m. Resident diagnosed included, but were not limited to, bipolar depression, unspecified dementia and Diabetes Mellitus. She resided in room 39-2.

The Annual Minimum Data Set (MDS) assessment, dated 4/9/23, indicated the resident was cognitively intact and was able to transfer and bed mobility with supervision.

A Mental Health Care Plan indicated the resident had health needs related to bipolar disorder that will adequately met by the facility. Interventions included to monitor signs of depression including verbalizing negative statements and repetitive

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

- 1. The 5/5/23 Event involving residents B and C was reported to the Indiana Department of Health on 5/31/2023.
- 2. All residents have the potential to be affected by the alleged deficient practice. Prior to the date of compliance, the Executive Director (ED) reviewed all abuse allegations in the past . No other residents were found to be affected by the deficient practice.

3. On 6/6/23 the Regional Director

06/26/2023

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155062	B. W	ING		05/25/	2023
		l		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIE	R			STREET		
BRICKY	ARD HEAI THCARI	E - LAPORTE CARE CENTER			RTE, IN 46350		
	Г				I	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+-	TAG		.,	DATE
	anxious or health re	elated complaints.			of Clinical Operations (RDCC	"	
	Dogidant Clamacan	d was reviewed on 5/24/23 at			re-educated the ED and the	(DNC)	
					Director of Nursing Services	(טואס)	
	11:24 a.m. The resident was admitted to the facility on 5/4/23. Diagnoses included, but were not				regarding the "Abuse/Neglect/Exploitation"		
	_	tract infection, sepsis and			policy guidelines, The Long-T	- erm	
	psychotic disorder	-			Care Abuse and Incident	CIIII	
	psycholic disorder	man actuatons.			Reporting Policy" and the		
	The Admission MI	OS assessment, dated 5/10/23,			"Allegation of Abuse or Negle	ect	
		ent was moderately cognitively			Checklist." All staff will also to		
		ired extensive assist of one			re-educated per the DNS/des		
	staff for transfers a				regarding the	95	
		,			Abuse/Neglect/Exploitation p	olicv	
	General notes, date	ed 5/6, 5/7 and 5/8/23, indicated			guidelines. Specifically, this	,	
		chibiting behaviors of			education will focus on the		
		ing, yelling out at night,			facility's responsibility to ensu	ıre	
		off dresser and scratching			alleged violations involving		
	staff.				potential abuse are immediat	ely	
					reported to the Executive Dire	-	
	A confidential inter	rview with Employee 1, on			and respective State Agency	as	
	5/24/23, indicated	on 5/5/23 around 8:00 p.m. She			indicated. This training will be	,	
	entered the residen	ts room and observed Resident			completed prior to the date of	f	
	1	esident C, there was an electric			compliance.		
		ck and Resident B was holding			4. The DNS/designee to rand	lomly	
		d. The residents were			interview 3 staff members pe	r	
		ee 1 notified the nurse on duty,			week x 8 weeks, then 1 staff		
	LPN 1 of what had	happened.			member weekly for 4 months		
					regarding signs/symptoms of		
		A 1, on 5/25/23 at 11:18 a.m.,			abuse and abuse reporting		
		rening of 5/5/23, she had been			guidelines. Any education		
	_	across the hall when she			deficiencies noted will be		
		alling for help. On entering the			corrected immediately.		
		ident B standing over Resident			DNS/designee to randomly	1	
		an electrical cord around her			interview 5 residents per wee		
	neck.				4 weeks then 3 residents per		
	Interview with I DM	N. 1. on 5/25/22 at 0:47 a			week for 2 months then 1 res		
		N 1 on 5/25/23 at 9:47 a.m.,			weekly for 3 months to deterr	riine	
		been notified by Employee 1			if a violation was reported or	ftha	
		t had been witnessed. She			suspected and to determine i	ı ine	
	assessed Resident (	C for injuries and called the	I		violation was reported to the		

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		155062	B. W			05/25/	۷۷۷۵
NAME OF P	PROVIDER OR SUPPLIER	<b>.</b>			ADDRESS, CITY, STATE, ZIP COD		
BRICKV/	ARD HEALTHCARE	E - LAPORTE CARE CENTER			STREET RTE, IN 46350		
				1	KTE, IIV <del>1</del> 0000		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		(DON) to report the event.			appropriate agencies within a		
	Resident B was mo	ved into a different room that			timely manner. Any deficiencie	es	
	night.				identified will be reported to the	е	
	Interview with the	Administrator on 5/24/23 at 3:25			Indiana Department of Health		
		ad been made aware of the			immediately. 5. The DNS will present the		
	*	e days later when a staff			findings of the reviews every r	nonth	
	member approached him and asked about it. He				to the Quality Assessment		
	did not recall who the staff member was. He indicated the DON had been involved with the incident. The incident had not been reported to				Process Improvement Commi		
					(QAPI). The QAPI committee review for any trends or patter		
	IDOH.	in had not been reported to			deficient practices (3 deficient		
					practices in 1 month will be		
		OON on 5/24/23 at 3:15 p.m.,			considered as a trend/pattern)		
		N 1 notified her of the event on			make further recommendation	s as	
		l Resident B was very agitated rical cord was going to end up			necessary.		
		te's neck. Resident B was					
		t room. There was no report					
	made to IDOH.						
	TTI . 1'	WAL - N. 1					
	Exploitation", indic	"Abuse, Neglect and ated." VII					
	*	e A. The facility will have					
		that include: 1. Reporting of all					
	-	the Administrator, state					
		ctive services and all other					
	required agencies	within specified time frames"					
	This Federal tag rel	ates to Complaint IN00408752.					
	3.1-28(c)						
F 0610	483.12(c)(2)-(4)						
SS=D	•	nt/Correct Alleged Violation					
Bldg. 00	, , ,	oonse to allegations of					
	the facility must:	oploitation, or mistreatment,					
	are radiity must.						
	§483.12(c)(2) Hav	e evidence that all alleged					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155062 B. WING 05/25/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1700 I STREET BRICKYARD HEALTHCARE - LAPORTE CARE CENTER LA PORTE, IN 46350 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility F 0610 06/26/2023 Preparation and/or execution of failed to ensure a resident to resident incident this plan of correction does not involving abuse was thoroughly investigated for constitute admission or agreement 2 of 3 residents reviewed for abuse. (Residents B by the provider of the truth of the and C) facts alleged or conclusions set forth in the statement of Finding includes: deficiencies. The plan of correction is prepared and/or executed solely Resident B's record was reviewed on 5/24/23 at because it is required by the 10:28 a.m. Resident diagnosed included, but were provisions of federal and state law. not limited to, bipolar depression, unspecified dementia and Diabetes Mellitus. 1. Resident B no longer resides in the facility. Resident C was The Annual Minimum Data Set (MDS) assessed at the time of the event assessment, dated 4/9/23, indicated the resident per the licensed nurse, and no was cognitively intact and was able to transfer psychosocial distress or adverse and move in bed with supervision. effects were noted related to the occurrence. A Mental Health Care Plan indicated the resident had health needs related to bipolar disorder that 2. All residents have the potential will adequately met by the facility. Interventions to be affected by the alleged included to monitor signs of depression including deficient practice. Prior to the date verbalizing negative statements and repetitive of compliance, the Executive anxious or health related complaints. Director (ED) reviewed all abuse allegations in the past . No other

Resident C's record was reviewed on 5/24/23 at

residents were found to be

STATEMEN	T OF DEFICIENCIES	F DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	00	COMPI	LETED	
		155062	B. W	ING		05/25	/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIE	R			STREET			
BRICKY/	ARD HEALTHCAR	E - LAPORTE CARE CENTER			RTE, IN 46350			
	WO HEVELLIOAN	L-LA ONIE OANE OLIVIEN		LATOR				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ident was admitted to the facility			affected by the deficient pract	tice.	1	
		39-1. Diagnoses included, but						
		, urinary tract infection, sepsis			3. On 6/6/23 the Regional Dir			
	and psychotic disor	rder with delusions.			of Clinical Operations (RDCC	))		
	The Admit-it - NAT	DC aggregation to date 4.5/10/22			re-educated the ED and the	(DNC)		
		OS assessment, dated 5/10/23,			Director of Nursing Services	(סמט)	1	
	indicated the resident was moderately cognitively impaired, and required extensive assist of one				regarding the			
	staff for transfers a				"Abuse/Neglect/Exploitation"	orm		
	stati for transfers a	na oca mounty.			policy guidelines, The Long-T Care Abuse and Incident	CIIII		
	General notes date	ed 5/6, 5/7 and 5/8/23, indicated			Reporting Policy" and the			
		hibiting behaviors of			"Allegation of Abuse or Negle	ct		
	confusion, wandering, yelling out at night,				Checklist." Education focused			
	throwing television off dresser and scratching				the facility's responsibility to	2 011		
	staff.	on dresser and seratening			ensure that in response to			
					allegations of abuse, that the			
	A confidential inte	rview with Employee 1, on			alleged violations are thoroug			
		on 5/5/23 around 8:00 p.m. She			investigated and reviewed to	,··· <i>y</i>		
		ts' room and observed			prevent further potential even	ıts.		
	Resident B standin	g over Resident C, there was						
		ound her neck and Resident B			4. DNS/designee to randoml	V		
	was holding the en-	ds of the cord. The residents			interview 5 residents per wee	-		
		nployee 1 notified the nurse on			4 weeks then 3 residents per			
	duty, LPN 1 of wha	at had happened. She indicated			week for 2 months then 1 res			
	she was instructed	not to document anything			weekly for 3 months to deterr	mine		
	about the incident.				if a violation was reported or			
					suspected and to determine i	f the		
		A 1 on 5/25/23 at 11:18 a.m.,			reported violation was thorou	ghly		
		ening of 5/5/23, she had been			investigated. Any deficiencies	6		
	1	across the hall when she			identified will be corrected			
		alling for help. On entering the			immediately. The ED/design			
		ident B standing over Resident			will audit all allegations of abo	use		
	· ·	an electrical cord around her			to ensure the allegations are			
	neck.				thoroughly investigated and			
					resident/staff interviews are			
		N 1 on 5/25/23 at 9:47 a.m.,			conducted per the		1	
	indicated she had been notified by Employee 1				Abuse/Neglect/Exploitation" p	-		
		t had been witnessed. She			utilizing the "Allegation of Abu			
		C for injuries, and called the			or Neglect Checklist." The Au	idits	1	
	Director of Nursing	g (DON) to report the event.			will be completed per the			

f ·		· ′	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155062	B. W	ING		05/25/	2023
	PROVIDER OR SUPPLIEF	R - LAPORTE CARE CENTER		1700   8	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	She indicated she w	vas told it was not necessary to about the incident. Resident B			ED/designee for all events/allegations of abuse ar	ud.	
		ifferent room that night.			will be reviewed per the RDCO and		
	Interview with the	Administrator, on 5/24/23 at			will be on-going.		
	-	he had been made aware of the			5. The ED will provide the results		
	incident two or three days later when a staff				of these audits to QAPI month	ly x	
		d him and asked about it. He			6 months or until 100%		
		he staff member was. He			compliance is achieved x 3 consecutive months. Results of	√f	
	indicated the DON had been involved with the incident.				the audits will be adapted or	)	
	meraent.				adjusted as needed to maintai	n	
	Interview with the l	DON on 5/24/23 at 3:15 p.m.,			compliance.		
	indicated when LPN notified her of the event on				'		
	5/5/23, she was told	d Resident B was very agitated					
	and afraid the electr	rical cord was going to end up					
		te's neck. Resident B was					
		t room. There was no					
	documented investi	gation of the event.					
		"Abuse, Neglect and					
	_	eated, "V. Investigations of glect and Exploitation A. An					
		ation is warranted when					
		neglect or exploitation or					
	_	glect or exploitation occur6.					
		nd thorough documentation of					
	the investigation						
	This Federal tag rel	ates to Complaint IN00408752.					
	3.1-28(d)						
F 0842	483.20(f)(5), 483.	70(i)(1)-(5)					
SS=D		s - Identifiable Information					
Bldg. 00		ident-identifiable information.					
-	•	ot release information that					
	is resident-identifi						
		y release information that is					
	, ,	le to an agent only in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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Facility ID: 000023

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06/23/2023 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155062 B. WING 05/25/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1700 I STREET BRICKYARD HEALTHCARE - LAPORTE CARE CENTER LA PORTE, IN 46350 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records. regardless of the form or storage method of the records, except when release is-(i) To the individual, or their resident representative where permitted by applicable law: (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of

abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155062	l í	ILDING	ONSTRUCTION  00	(X3) DATE COMPI 05/25/	LETED
	PROVIDER OR SUPPLIER	E - LAPORTE CARE CENTER		1700   8	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	§483.70(i)(4) Med retained for- (i) The period of ti (ii) Five years from when there is no in (iii) For a minor, 3 reaches legal age §483.70(i)(5) The contain- (i) Sufficient information (i) Sufficient information (ii) A record of the (iii) The comprehe services provided (iv) The results of screening and results of scre	ical records must be  me required by State law; or in the date of discharge requirement in State law; or years after a resident under State law.  medical record must mation to identify the resident's assessments; ensive plan of care and inany preadmission ident review evaluations and inducted by the State; urse's, and other licensed	F 08		p="" paraid="327240368" paraeid="{e1c27b52-157a-4f0-d-1314583ef8b8} {149}">Preparation and/or execution of this plan of correct does not constitute admission agreement by the provider of t truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becaus is required by the provisions or federal and state law. p="" paraid="327240368" paraeid="{e1c27b52-157a-4f0-d-1314583ef8b8}{149}">	ction or he se it f	06/26/2023

PRINTED: 06/23/2023

	T OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED 1B NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155062	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE COMP	SURVEY LETED 5/2023
NAME OF	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD STREET		
BRICKY	ARD HEALTHCARE	- LAPORTE CARE CENTER		RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	Interview with CNA indicated on the ever assisting a resident heard Resident C caroom, she saw Resi C, Resident C had a neck.  Cross reference F60  Resident B's record 10:28 a.m. Resident not limited to, bipoid dementia and Diabor room 39-2.  There was no docur observed by staff or Resident C's record 11:24 a.m. The resion 5/4/23. Diagnoso limited to, urinary the psychotic disorder with the series of the During a phone into 9:47 a.m., she indicated to the Director of Nother was no need to the reway needs to the reway no need to the reway needs	A 1 on 5/25/23 at 11:18 a.m., ening of 5/5/23, she had been across the hall when she alling for help. On entering the dent B standing over Resident an electrical cord around her 00 & F610.  was reviewed on 5/24/23 at t diagnosed included, but were lar depression, unspecified etes Mellitus. She resided in mentation of the the incident in 5/5/23.  was reviewed on 5/24/23 at dent was admitted to the facility es included, but were not ract infection, sepsis and with delusions.		p="" paraid="327240368" paraeid="{e1c27b52-157a-4 d-1314583ef8b8}{149}">1. A entry note was added to the medical record for resident I C to document the event the occurred on 5/5/2023. p="" paraid="327240368" paraeid="{e1c27b52-157a-4 d-1314583ef8b8}{149}">2. All other residents had the potential to be affected by the deficient practice. 3. License nursing staff to be re-educated the Director of Nursing Serve (DNS)/designee on the "Documentation in Medical Records" policy prior to date compliance. 4. All behavior events, and/or changes of condition will be reviewed by Interdisciplinary Team in the clinical morning meeting 5 til week to ensure that an appropriate representation of the actual behavior, event, and/or changes of condition is documented in the medical record. The DNS/Designee will interview 3 random staff members 2 the week for 4 weeks and then 3 random staff members 2 the week for 4 weeks and then 3 random staff members a week for 4 weeks and then 3 random to ensure compliance accurate reporting and	A late B and at B and	
		ndicated they did not		documentation of behaviors		

document anything.

This Federal tag relates to Complaint IN00408752.

events, and/or changes in

will be conducted randomly,

condition. The audits/observations

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

PRINTED: 06/23/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155062	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/25/2023		
NAME OF PROVIDER OR SUPPLIER  BRICKYARD HEALTHCARE - LAPORTE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 1700   STREET LA PORTE, IN 46350				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	3.1-50(a)(1)				across all 3 shifts, and will include weekends. If any deficient practices are identified, re-education will be completed immediately. 5. The DNS will present the findings of the revievery month to the Quality Assessment Process Improvement Committee (QAFThe QAPI committee to review any trends or patterns of deficipractices (3 deficient practices 1 month will be considered as trend/pattern) and make further recommendations as necessar	diews PI). v for ient s in a		

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