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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	05/26/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00376787, IN00377163, and IN00380769. Complaint IN00376787 - Unsubstantiated due to lack of evidence. Complaint IN00377163 - Unsubstantiated. Allegation did not occur. Complaint IN00380769 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F697, and F726. Unrelated deficiency is cited. Survey dates: May 25 and 26, 2022 Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Medicare: 11 Medicaid: 94 Other: 9 Total: 114 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/1/22.	F 0000		

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

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

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			
	Based on record review and interview, the facility failed to ensure a resident who required extensive assistance with bathing, received bathing as preferred by the resident, for 1 of 3 residents reviewed for bathing. (Resident E) Finding includes: During an interview on 5/25/22 at 3:13 p.m., Resident E indicated he was to receive a shower three times a week, and had only been receiving a shower weekly and was not being assisted with bed baths instead of showers. Resident E's record was reviewed on 5/25/22 at 2:50 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and kidney disease. A Quarterly Minimum Data Set (MDS) assessment, dated 3/30/22, indicated his cognitive status was intact and required extensive assistance of one for bathing. An Annual MDS assessment, dated 1/6/22, indicated it was very important for him to choose what type of bathing he received. The Shower Schedule Binder at the Nurses' Station indicated showers were scheduled for Tuesdays and Thursdays. A shower was received on 5/21/22 in the evening and he refused his shower on 5/24/22.	F 0677	Facility requests paper compliance/desk review. F677 1-What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident E was offered a shower on 5-26-22 and declined. The shower schedule was corrected to reflect his preference of having 3 showers a week. 2-How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. A whole house audit of residents will be completed by Social Service to update preferences regarding showers by 6-18-22. Shower sheets and care plans will be updated as needed.	06/18/2022

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	The Activities of Daily Living Task form for showers in the record indicated a shower was to be given on Tuesday, Thursday, and Saturday evenings. He received a shower on 5/17/22 (Tuesday) and 5/21/22 (Saturday) and a bed bath on 5/25/22 (Wednesday). The resident was offered and had refused a shower on 5/7/22 (Saturday), 5/12/22 (Thursday), and 5/24/22 (Tuesday). Showers had not been given/offered on Tuesday 5/3/22 and 5/10/22, Thursday 5/5/22 and 5/19/22, and Saturday 5/14/22. On 5/25/22 at 3:59 p.m., the Director of Nursing indicated no other shower documentation was found that indicated he had received his showers as scheduled. He will be scheduled for a shower three times a week. This Federal tag relates to Complain IN00380769. 3.1-38(b)(2)		3-What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The DNS/Designee will educate all on ADL care including showers. CNA will be educated on where to locate the shower assignments and how to properly document showers. 4-How the corrective action will be monitored to ensure deficient practice will not recur, what quality assurance program will be put into place: The DNS/Designee will audit shower schedules 5 times a week x 4 weeks, then 3 times a week x 4 weeks then weekly x 2 months then monthly x 2 months to ensure that showers are being given as scheduled per residents' preference. Audits will occur on all shifts and units and will include weekend audits. Any negative trends will be reviewed in Monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on record review and interview, the facility failed to assess a resident for pain timely after surgery and provide pain medication upon request for 1 of 3 residents reviewed for pain. (Resident G) Finding includes: Resident G's record was reviewed on 5/25/22 at 3:53 p.m. Diagnoses included, but were not limited to, Parkinson's disease, spinal stenosis and unspecified pain. The Quarterly Minimum Data Set assessment, dated 5/12/22, indicated the resident was cognitively intact. The resident had an outpatient surgical procedure on 5/19/22 to revise a biopsy site on her neck. There was not a documented skin assessment or pain assessment completed until 5/24/22. A Nurse Progress Note, dated 5/22/22, indicated the resident was complaining of pain to the	F 0697	Facility requests paper compliance/ desk review. F697 1-What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident G was assessed for pain upon return from her surgery. A pain assessment was completed on 5-26-22. Resident G has had no further complaints of pain since 5-22-22. Interview was completed with resident to verify what over-the-counter pain medication she can tolerate. Resident stated that she can't tolerate anything, she does not have any pain and she does not want any prn pain medication.	06/18/2022

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	surgical site on her neck and requested something for pain. She was offered Tylenol, but the resident indicated she was allergic to Tylenol. The Nurse Practicioner was contacted and an order for Oxycodone (an opiod pain medication), 2.5 milligrams (mgs), every six hours as needed, was received. There was no documentation prior to survey exit indicating any non-pharmacological pain interventions had been attempted. A Physician's Order, dated 3/10/22, indicated to give Tylenol 500 mg (milliigrams) every six hours as needed for pain. The May 2022 Medication Administration Record did not indicate any Oxycodone or Tylenol had been administered. A Pain Care Plan, dated 8/31/20, indicated the resident needed monitoring and pain management related to generalized pain. Interventions included to administer pain medications as ordered, dim lighting/ quiet environment, rest and repositioning. The current Pain Management policy was received from the Nurse Consultant on 5/26/22 at 12:00 p.m. The policy indicated, "...b. Evaluate the resident for pain upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs...." and, "...c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care..." Interview with the resident 5/26/22 at 9:15 a.m., indicated after surgery she needed pain medication and didn't get anything because there was not an order for anything. Interview with the Corporate Nurse, on 5/25/22 at		2-How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. An audit of all residents was completed prior to 6-18-22 to ensure that they are receiving prn pain medication per MD order when they are requesting it, pain care plans are in place as appropriate, prescriptions for pain medications are received in a timely manner, pain is assessed to ensure pain is being managed effectively. 3-What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The DNS/designee educated all licensed nursing staff on the “Pain Management” policy, by 6-18-22. p paraid="918280373" paraeid="{43ccdead-b281-4895-9d22-fdcc4afe79c7}{5}" >4-How the corrective action will be monitored	

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	3:15 p.m., indicated the Oxycodone did not arrive until the following day, 5/23/22. They were not aware the resident had a Tylenol allergy. She also indicated there had been a skin and pain assessment when the resident returned from outpatient surgery on 5/19/22 and the resident had been provided an ice pack for pain on 5/22/22, but these had not been documented at the time. The Federal tag relates to Complaint IN00380769. 3.1-37(a)		to ensure deficient practice will not recur, what quality assurance program will be put into place: The DNS/unit managers/designee will audit 5 randomly selected residents with pain/prn pain medications to ensure that pain medications are being administered per MD orders when requested by resident, prescriptions for pain medications are received in a timely manner and that pain is being managed effectively 5x week x 4 weeks, then 3x/week x 4 weeks then weekly x 2 months then monthly x 2 months. Audits will occur on all shifts and units and will include weekend audits. Any negative trends will be reviewed in Monthly QAPI program. . Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services			

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	The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			
	Based on observation, record review, and interview, the facility failed to ensure a CNA had yearly and updated education for infection control, related to transmission based/droplet isolation procedures, for 1 of 6 employees reviewed for annual education. (CNA 1) Finding includes:	F 0726	p paraid="1994902705" paraeid="{05e5bab8-dbdd-44dd-91f2-df9789e6e162}{170}" >Facility requests paper compliance/desk review. F	06/18/2022

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	On 5/25/22 at 9:20 a.m., CNA 1 was observed on the C-Unit, with an isolation gown, gloves, and a surgical mask on. She then entered Resident P's room and was within six feet of the resident, talking with her, then picked up soiled linen, walked to the doorway and placed the soiled linen in the barrel located at the doorway of the room in the hallway. She then removed the gloves and placed in the trash barrel, touched the isolation gown mid-body and pulled the gown off with bare hands, then rolled it into a ball and placed it in the trash barrel. She then entered the resident's bathroom and washed her hands. CNA 1 was interviewed after the hand hygiene and indicated she was informed she did not need an N95 mask or eye protection. A sign on the Resident P's door indicated she was in transmission based/droplet isolation (yellow status). The sign indicated an N95 or KN95 mask and eye protection were to be worn upon entering the room. On 5/25/22 at 9:27 a.m., CNA 1 then entered Resident Q's room after donning an isolation gown and gloves. The surgical mask remained on. She indicated she was bathing the resident. A sign on the entry door indicated the room was a yellow status. An N95 mask and eye protection had not been worn by CNA 1. On 5/26/22 at 1:49 p.m., infection control education was reviewed. CNA 1's last documented infection control education for donning & doffing personal protective equipment and transmission based precautions was on 12/21/20. The Corporate RN indicated another		726 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: CNA 1 was immediately educated on proper use of PPE in the yellow zone , including proper use of N-95 mask, gloves and proper donning and doffing of PPE including gowns. Residents are being covid tested per guidelines 2 times a week, during the outbreak. 2- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents be affected. The residents that CNA 1 cared for were identified. Residents are being monitored for any s/s of Covid 19 at least daily. Covid testing continues 2 times a week. No residents in CNA 1 care were affected by the deficient practice. 3- What measures will be put	

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	education on infection control had been completed on 2/20/21. There was no further education documented. This Federal tag relates to Complaint IN00380769.		into place and what systemic changes will to ensure that the deficient practice does not recur: The corporate Infection Preventionist/DNS/designee educated all staff related to the facility policies and procedures and CDC guidelines for PPE use related to Transmission Based Precautions, PPE Donning and Doffing, the need to maintain face covering over mouth and nose, as well as the appropriate covering to be : ensuring the appropriate PPE is readily available for use as needed for Transmission Based Precautions and the procedure to follow when PPE is not available. All education was complete prior to 6-18-22. The DNS/designee will monitor education to ensure that staff are educated on infection control/TBP/proper mask placement, and proper donning and doffing of PPE at least every 12 months. 4-How will the corrective action be monitored to ensure the deficient practice will not recur:	

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			The RDCO/IP/DNS/Designee will audit 5 random staff members to include all units and shifts, daily or more often as necessary for 6 weeks and until compliance is maintained, then 3 times per week x 2 months, then weekly x 2 months to ensure appropriate PPE is in place based on TBP and transmission rate, PPE is donned/doffed appropriately, masks are . The RDCO/IP/DNS/Designee will perform daily visual rounds throughout the facility to include all units and shifts including weekends, to ensure staff are practicing appropriate Infection control practices and compliance is maintained for 6 weeks and until compliance is maintained, then 3 times per week x 2 moths, the weekly x 2 months. Audits will occur on all shifts and units and will include weekend audits. Any negative trends will be reviewed in Monthly QAPI program. The DNS/Designee will monitor Infection control in servicing logs weekly x 6 weeks and until compliance is maintained, then bi-monthly x 6 weeks then monthly x 6 weeks to ensure that staff have received infection control education at least every 12 months, more often if needed. Any concerns will be monitored	

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			through the QAPI process for a minimum of six months and until 95% compliance is achieved	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or			

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	infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			

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	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to staff not wearing the required PPE (personal protective equipment), not removing the PPE correctly, and not wearing the PPE correctly for 3 staff members observed for infection control on 2 of 3 Units (CNA 1, CNA 2, and LPN 3) and PPE not available in a timely manner for the transmission/droplet isolation rooms on 1 of 3 Units (B-Wing). This had the potential to affect 31 residents who were cared for by CNA 1, CNA 2, and LPN 3. Findings include: 1. On 5/25/22 at 9:20 a.m., CNA 1 was observed on the C-Unit, with an isolation gown, gloves, and a surgical mask on. She then entered Resident P's room and was within six feet of the resident, talking with her, then picked up soiled linen, walked to the doorway and placed the soiled linen in the barrel located at the doorway of the room in the hallway. She then removed the gloves and placed in the trash barrel, touched the isolation gown mid-body and pulled the gown off with bare hands, then rolled it into a ball and placed it in the trash barrel. She then entered the resident's bathroom and washed her hands. CNA 1 was interviewed after the hand hygiene and indicated she was informed she did not need an N95 mask or eye protection. A sign on Resident P's door indicated she was in transmission based/droplet isolation (yellow status). The sign indicated an N95 or KN95 mask and eye protection were to be worn upon entering	F 0880	p paraid="1994902705" paraeid="{acad4ae1-4ece-44d9-a9b6-95a56fafd4e9}{170}" >Facility request paper compliance/ Desk Review F880 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: · Resident P, Q and R were assessed, and no adverse effects were noted related to the deficient practice. CNA1, CNA2, and LPN3, were educated immediately on how and when to don and doff PPE including but not limited to mask, gloves, gown and eye protection and a return demonstration was completed for CNA1, CNA2, and LPN3 prior to 6-18-22. CNA1, CNA2, And LPN3 were immediately educated on the need to maintain face covering over mouth and nose as well as the appropriate covering to be . 2- How other residents having the potential to be affected by the same deficient practice will be	06/18/2022

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BRICKYARD HEALTHCARE – PORTAGE CARE CENTER	3175 LANCER ST PORTAGE, IN 46368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the room. On 5/25/22 at 9:27 a.m., CNA 1 then entered Resident Q's room after donning an isolation gown and gloves. The surgical mask remained on. She indicated she was bathing the resident. A sign on the entry door indicated the room was a yellow status. An N95 mask and eye protection had not been worn by CNA 1. The Director of Nursing (DON) indicated on 5/26/22 at 2:49 p.m., CNA 1 had been assigned to 13 residents. 2. During an observation of the B-Unit on 5/26/22 at 9:16 a.m., resident rooms 101-113 doors were marked with yellow status signs. The signs indicated an N95 or KN95 mask, isolation gown, gloves, and eye protection were to be worn. There were no PPE carts or equipment available on the hallway. LPN 3 was completing a medication pass and was observed going in and out of the rooms with an N95 mask and face shield on. No isolation gown was worn. During an interview at the time of the observation, LPN 1 indicated the facility had just placed the residents on the hallway in a yellow status. There had been no PPE placed on the hallway yet. She had informed management PPE was needed. 3. During an observation on 5/26/22 at 9:56 a.m., CNA 2 was in Resident R's room providing care. CNA 2 was wearing a face shield and an N95 mask, which was placed under the nose. The straps to the N95 were observed on the lower part of the CNA's head and on the neck and not placed to secure the mask over the nose. Gloves were worn. An isolation gown had not been worn.		identified and what corrective action will be taken. All residents be affected. All residents are being monitored at least daily for signs and symptoms of Covid- no residents were noted to have been affected by the deficient practice. 3- What measures will be put into place and what systemic changes will to ensure that the deficient practice does not recur: The corporate Infection Preventionist/DNS/designee educated all staff related to the facility policies and procedures and CDC guidelines for PPE use related to Transmission Based Precautions, PPE Donning and Doffing, the need to maintain face covering over mouth and nose, as well as the appropriate covering to be : ensuring the appropriate PPE is readily available for use as needed for Transmission Based Precautions and the procedure to follow when PPE is not available. All education was complete prior to 6-18-22 4-How will the corrective action be monitored to ensure the deficient practice will not recur: The RDCO/IP/DNS/Designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	During an interview at the time of the observation, CNA 2 indicated another CNA had been in the room and they had used the mechanical lift for the transfer of the resident to the chair. She indicated the N95 mask had just fallen down and then replaced the mask over her nose. CNA 2 then continued with care and then began to take care of the linens on the bed, the N95 mask had again fallen under her nose. There were no attempts to place the N95 back over the nose. The Director of Nursing (DON) indicated on 5/26/22 at 2:49 p.m., CNA 2 had been assigned to 14 residents. The facility Daily Census form, dated 5/24/22, indicated there were 18 residents who resided in rooms 101-113 on the B-Unit. A facility policy, titled, "Personal Protective Equipment", dated 7/2019, and received as current from the Corporate Nurse Consultant, indicated the Central Supply Clerk was responsible for maintaining adequate PPE supplies and stocking in appropriate facility locations to ensure access to staff who need them. The Personal Protective Equipment policy, received from the Corporate Nurse Consultant as current and dated 7/2019, indicated the front and sleeves of the isolation gown was considered contaminated. The gown was to be removed to prevent contamination by pulling down in a peeling motion so that the gown turns inside out, holding gown away from the body, and rolling the gown into a bundle. 3.1-18(b)		audit 5 random staff members to include all units and shifts, daily or more often as necessary for 6 weeks and until compliance is maintained, then 3 times per week x 2 months, then weekly x 2 months to ensure appropriate PPE is in place based on TBP and transmission rate, PPE is donned/doffed appropriately, masks are . The RDCO/IP/DNS/Designee will perform daily visual rounds throughout the facility to include all units and shifts including weekends, to ensure staff are practicing appropriate Infection control practices and compliance is maintained for 6 weeks and until compliance is maintained, then 3 times per week x 2 moths, the weekly x 2 months. Audits will occur on all shifts and units and will include weekend audits. Any negative trends will be reviewed in Monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved	