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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00435959, IN00436410, IN00438937, and IN00441573. Complaint IN00435959 - No deficiencies related to the allegations were cited. Complaint IN00436410 - No deficiencies related to the allegations were cited. Complaint IN00438937 - Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00441573 - Federal/state deficiencies related to the allegations are cited at F684. Survey dates: August 19, 20, 21, 22, and 23, 2024 Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census Bed Type: SNF/NF: 138 Total: 138 Census Payor Type: Medicare: 6 Medicaid: 101 Other: 31 Total: 138 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/28/24.	F 0000	The facility respectfully requests paper compliance/desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Latoya Haggard	Executive Director	09/11/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to ensure medical appointments were completed in a timely manner for 1 of 1 resident reviewed for a medical referral. (Resident B) Finding includes: The record for Resident B was reviewed on 8/20/24 at 3:40 p.m. Diagnoses included, but were not limited to, stroke, aphasia (a language disorder) following a stroke, hemiplegia and hemiparesis (muscle weakness and paralysis) following a stroke affecting the left non-dominant side, seizures, and altered mental status. The resident was admitted to the facility on 3/7/24. The Quarterly Minimum Data Set (MDS) assessment, dated 7/26/24, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 3/8/24, indicated an appointment with the resident's Neurologist was to be scheduled in one month. An appointment was scheduled for 4/16/24 at 9:30 a.m. Nurses' Notes, dated 4/16/24 at 10:41 a.m., indicated the resident's appointment was rescheduled for 5/8/24 at 10:45 a.m. due to transportation did not show up for the appointment. The transportation company indicated the pick up time was entered in the portal at 5:00 p.m. on 4/15/24 and that did not give them enough time to see it. Nurses' Notes, dated 5/8/24 at 11:53 a.m., indicated the resident's daughter was contacted concerning	F 0684	On 8/23/24 Resident B's appointment was confirmed for September 19, 2024. All residents have the potential to be affected. An audit was completed for all residents with a medical referral to ensure appointments were made and residents attended. The DCE (Director of Clinical Education)/designee will in-service all nursing staff on the importance of scheduling and carrying out all doctor appointments utilizing the “Provision of Physician Ordered Services” facility policy prior to the date of alleged compliance. The DNS (Director of Nursing Services)/designee will audit 5 residents' charts 5 times a week for 2 months, then 5 residents 3 times a week for 2 months, then 5 residents weekly for 2 months to ensure appointments are made and carried out as ordered. Audits will include all shifts, units and weekends. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a	09/18/2024

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the appointment with the Neurologist had been rescheduled. A transportation request was submitted. A Physician's Order, dated 5/8/24, indicated the resident was to see the Neurologist on 5/14/24 at 12:45 p.m. There was no documentation in the nursing progress notes on 5/14/24 to indicate the resident was seen by the neurologist. A Physician's Order, dated 6/7/24, indicated the resident was to see the Neurologist on 6/11/24 at 1:00 p.m. There was no documentation in the nursing progress notes on 6/11/24 to indicate the resident was seen by the neurologist. A Physician's Order, dated 8/15/24, indicated the resident was to be seen by the Neurologist on 8/19/24 at 9:30 a.m. There was no documentation in the nursing progress notes on 8/19/24 to indicate the resident was seen by the neurologist. Nurses' Notes, dated 8/20/24 at 8:49 a.m., indicated the resident's daughter was contacted to discuss the neurology appointment. An appointment was scheduled for 9/19/24. During an interview on 8/23/24 at 10:19 a.m., the C Wing Unit Manager indicated there had been issues getting the resident seen by the neurologist. For his first scheduled appointment, transportation did not show up. For the next appointment, his wheelchair did not fit through the door at the office, then they changed		minimum of six months and until 95% compliance is achieved. ="" p="">	

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	neurologists. Another time, he couldn't get off the transportation van, and his last appointment on 8/19/24 was supposed to be on 9/19/24. The Unit Manager indicated the resident had not been seen by a neurologist since admission. Facility Calendar Notes, provided by the C Wing Unit Manger, indicated on 4/16/24 transportation was unavailable and the appointment was rescheduled, on 5/14/24 the resident's wheelchair was not able to fit through the office doors and the resident would need to see a different neurologist, on 6/14/24 transport staff were unable to get the resident off of the van and the appointment was rescheduled, and on 8/19/24 there was an error with the appointment date. The resident's appointment was scheduled for 9/19 rather than 8/19/24. During an interview on 8/23/24 at 1:45 p.m., the Executive Director indicated alternative measures should have been attempted to get the resident seen by the neurologist. This citation relates to Complaint IN00441573. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on record review and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing related to offloading heels when in bed for 1 of 5 residents reviewed for pressure ulcers. (Resident D) Finding includes:	F 0686	The physician's order was revised and implemented for Resident D to offload heels while in bed. An audit was completed for all residents with pressure ulcers to ensure implementation of all ordered/care planned pressure ulcer interventions.	09/18/2024

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During random observations on 8/19/24 at 3:00 p.m. and 3:45 p.m., on 8/20/24 at 10:10 a.m., 3:07 p.m., and 3:55 p.m., and on 8/21/24 at 1:39 p.m. and 2:45 p.m., Resident D was observed lying in bed. At those times, the resident's heels were not offloaded while in the bed. The heels were lying directly on the mattress. On 8/22/24 at 2:55 p.m., the Wound Nurse removed the resident's sock so his pressure ulcer could be observed. The wound was located on the left heel and had black and dark maroon intact tissue to the wound bed. The surrounding skin was starting to flake off. There was no drainage noted. The record for Resident D was reviewed on 8/20/24 at 3:15 p.m. Diagnoses included, but were not limited to, urine retention, anemia, high blood pressure, obstructive uropathy (a disorder of the urinary tract that occurred due to obstructed urinary flow), anxiety, schizophrenia, mood disturbance, dementia, and depression. The 8/4/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had no pressure ulcers during the assessment reference period. A Care Plan, dated 8/12/24, indicated the resident had a pressure ulcer to the left heel. The approaches were to float the heels. A Change of Condition Note, dated 8/11/24 at 2:11 p.m., indicated the resident was noted to have a pressure related area to the right heel measuring 4 centimeters (cm) by 4 cm. The wound nurse was notified.		The DCE/designee will in-service all nursing staff on the “Pressure Ulcer Prevention and Management” facility policy prior to the date of alleged compliance. The DNS(Director of Nursing Services)/designee will aassess and monitor 5 residents with pressure ulcers for implementation of all ordered/ care-planned pressure ulcer interventions. Audits will be completed 5 times a week for 2 months, then 5 residents 3 times a week for 2 months, then 5 residents weekly for 2 months to ensure implementation of all oredered/care planned pressure ulcer interventions. Audits will include all shifts, units and weekends. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Wound Nurse Practitioner (NP) Note, dated 8/14/24 at 1:07 p.m., indicated the resident had a deep tissue injury (a form of pressure ulcer) to the left heel that measured 4 cm by 3.5 cm. The wound base had 100% of epithelial tissue (a layer of skin cells) and the wound edges were intact. The treatment recommendations were to apply skin prep to the base of the wound twice daily, leave open to air, and float the heels while in bed with the use of heel boots. Physician's Orders, dated 8/11/24, indicated to off load heels at bedtime for skin integrity. During an interview on 8/22/24 at 11:30 a.m., the Wound Nurse indicated the resident's heels should be offloaded all the time while in bed. During an interview on 8/22/24 at 2:00 p.m., the Executive Director had no additional information to provide. 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure a call light was in reach and preventative fall measures were in use for residents who were identified as a fall risk for 2 of 5 residents reviewed for falls. (Residents C and D) Findings include: 1. During a random observation on 8/20/24 at 11:40 a.m., Resident C was in her room in bed. The resident's eyes were closed and her call light was observed on the floor underneath her bed.	F 0689	Facility ensured call light was within reach for Residents C and Resident D immediately upon notification. Facility ensured that Resident D's bed was in low position and floor mat was in place while resident was in bed. CNA 1 and the ACU Unit Manager were immediately educated on the need to ensure all fall interventions are in place per MD orders. The facility has determined that all	09/18/2024

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/20/24 at 3:05 p.m., the resident remained in her bed and was watching television. The call light remained on the floor underneath the bed. At 3:12 p.m., a CNA entered the resident's room. The CNA exited the room after providing care. At 3:25 p.m., the resident was observed in bed and the call light was in reach. The record for Resident C was reviewed on 8/21/24 at 3:32 p.m. Diagnoses included, but were not limited to, repeated falls, anxiety, and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 5/17/24, indicated the resident was cognitively intact. The resident required substantial to maximum assistance with bed mobility and transfers. The resident had not had any falls since the prior assessment. A Care Plan, dated 1/3/23 and reviewed on 6/18/24, indicated the resident was at risk for falls related to a history of falls and weakness. Interventions included, but were not limited to, keep call light or personal items available and in easy reach. The Fall Risk Assessment, dated 8/13/24, indicated the resident was a fall risk. During an interview on 8/23/24 at 2:54 p.m., the Executive Director indicated the resident's call light should have been in reach. 2. During random observations on 8/19/24 at 3:00 p.m. and 3:45 p.m., and on 8/20/24 at 10:10 a.m., 3:07 p.m., and 3:55 p.m., Resident D was observed lying in bed. At those times, the resident's bed was in a high position and there was no floor mat on the ground.		residents have the potential to be affected. An audit was conducted, and no other residents were identified as being affected. The DCE/designee will in-service all nursing staff on the “Accidents and Supervision” facility policy prior to the date of alleged compliance. The (DNS)/designee, will complete 5 random residents that are identified as residents with high risk for falls/accident to ensure appropriate interventions are implemented. Audits will be completed 5 times a week for 2 months, then 3 times a week for 2 months, then weekly for 2 months. Audits will include all shifts and units and weekends. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record for Resident D was reviewed on 8/20/24 at 3:15 p.m. Diagnoses included, but were not limited to, urine retention, anemia, high blood pressure, obstructive uropathy (a disorder of the urinary tract that occurred due to obstructed urinary flow), anxiety, schizophrenia, mood disturbance, dementia, and depression. The 8/4/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had no falls since the last assessment and had a urinary catheter. A Care Plan, initiated on 7/25/24, indicated the resident was at risk for falls related to confusion and poor safety awareness. The approaches were to have a mat beside the bed and keep the bed in a low position. Physician's Orders, dated 11/26/24, indicated a floor mat every shift for fall prevention. The Treatment Administration Record for the month of 8/2024, indicated the floor mat was signed out as being down and in place for the day shift on 8/19-8/20/24. During an interview on 8/22/24 at 9:55 a.m., CNA 1 indicated she was aware the resident was to have a floor mat beside the bed, and it was in the closet. During an interview on 8/22/24 at 10:05 a.m., the ACU Unit Manager indicated she was aware the resident needed a floor mat beside the bed and it was kept in the closet because his roommate was ambulatory and they did not want him to trip over it.			

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 8/22/24 at 2:00 p.m., the Executive Director indicated she had no additional information to provide. The current 2023 "Accidents and Supervision" policy, provided by the Executive Director on 8/22/24 at 11:42 a.m., indicated "Implementation of Interventions-using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: e. Ensuring that the interventions are put into action. Monitoring and Modifications - Monitoring is the process of evaluation the effectiveness of care plan interventions. - Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: Ensuring that interventions are implemented correctly and consistently" This citation relates to Complaint IN00438937. 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure Foley catheter bags and tubing were kept off of the floor for 1 of 1 resident reviewed for catheters. (Resident D) Finding includes: During random observations on 8/19/24 at 9:56 a.m. and 11:40 a.m., Resident D was observed sitting in a high back wheelchair. The bottom of the catheter bag was observed on the floor under the wheelchair.	F 0690	On 8/22/24 resident D's catheter was corrected and placed below the level of their bladder while up in chair and placed in a basin when in bed d/t resident bed lowered to the floor. CNA 1 and the ACU Unit Manager were immediately educated on the need to ensure catheter drainage bags and tubing do not touch the floor and that the catheter drainage bag is kept below the level of the bladder.	09/18/2024

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During a random observation on 8/21/24 at 1:39 p.m., the resident was observed in bed. The bed was very low to the ground and the catheter bag and tubing was observed laying on the floor mat. On 8/22/24 at 10:00 a.m., the resident was observed sitting in the high back wheelchair. At that time, the catheter bag was hanging right below the arm rest of the wheelchair and not below his waist. The record for Resident D was reviewed on 8/20/24 at 3:15 p.m. Diagnoses included, but were not limited to, urine retention, anemia, high blood pressure, obstructive uropathy (a disorder of the urinary tract that occurred due to obstructed urinary flow), anxiety, schizophrenia, mood disturbance, dementia, and depression. The 8/4/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making. The resident had a urinary catheter. A Care Plan, revised on 7/19/24, indicated the resident had a history of chronic/recurring urinary tract infections. The approaches were to keep the drainage bag of the catheter below the level of the bladder at all times and off the floor. A Care Plan, revised on 7/19/24, indicated the resident had an indwelling catheter related to urine retention and obstructive uropathy. The approaches were to keep the drainage bag of the catheter below the level of the bladder at all times and off the floor. A Physician's Order, dated 5/26/24, indicated Foley catheter, size 14 French and 10 cubic		All residents with a catheter have the potential to be affected. An audit was completed, and no other residents were identified as being affected. The Director of Clinical Education/designee will in-service all clinical staff regarding the "Catheter Care" faciilty policy prior to the date of alleged compliance. The DNS/designee will audit 5 random residents with catheters to ensure that catheter drainage bags are hanging below the level of the bladder and catheter drainage bags and tubing are not touching the floor. Audits will be completed 5 times a week for 2 months, then 5 residents 3 times a week for 2 months, then 5 residents weekly for 2 months. Audits will include all shifts, units and weekends. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved. ="" p="">	

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	centimeter (cc)balloon. Physician's Orders, dated 8/6/24 and discontinued on 8/14/24, indicated Augmentin (an antibiotic medication) 500-125 milligrams (mg), give 1 tablet by mouth three times a day for ESBL (Extended-Spectrum Beta-Lactamase infection caused by bacteria that produce an enzyme that was resistant to many commonly used antibiotics) for 7 days. During an interview on 8/22/24 at 9:55 a.m., CNA 1 indicated she was aware the catheter bag and tubing were on the floor because the bed had to be in a low position. She was told by the Unit Manager to put the bag and tubing in a basin. During an interview on 8/22/24 at 10:05 a.m., the ACU Unit Manager indicated she observed the catheter bag and tubing on the floor mat and instructed the CNA to put it in a basin. The catheter bag was to be below the resident's waist. The current 2023 "Indwelling Catheter Use and Removal" policy, provided by the Executive Director on 8/22/24 at 3:00 p.m., indicated "If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care polices and procedures that include but are not limited to: ... d. Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures. Additional care practices include: e. Securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the waist ..." 3.1-41(a)(2)			

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 1 of 2 residents reviewed for respiratory care. (Resident 90) Finding includes: During random observations on 8/19/24 at 10:36 a.m. and 3:35 p.m., Resident 90 was observed wearing oxygen per nasal cannula at just under 3 liters per minute. During random observations on 8/22/24 at 9:56 a.m. and 11:12 a.m., the resident was observed wearing oxygen per nasal cannula. The oxygen flow rate was set right under 3 liters. During a random observation on 8/23/24 at 8:46 a.m., the resident was observed awake in bed. The resident was wearing oxygen per nasal cannula. The oxygen flow rate was set directly below 3 liters. The record for Resident 90 was reviewed on 8/19/24 at 10:45 a.m. Diagnoses included, but were not limited to, insomnia (difficulty sleeping), chronic obstructive pulmonary disease (COPD), and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 7/22/24, indicated the resident was cognitively intact for daily decision making and she wore oxygen. Physician's Orders, dated 4/30/24, indicated the resident was to have continuous oxygen at 2 liters per minute per nasal cannula.	F 0695	On 8/22/24 resident 90's oxygen flow rate was corrected to 2L/NC as per physician order. Assessment was completed, no concerns noted. MD was made aware. QMA 1 was immediately educated regarding the need to ensure the oxygen flow rate is set per physician's orders. The facility has determined that all residents with oxygen have the potential to be affected. An audit was conducted, and no other residents were identified as being affected. The Director of Clinical Education/designee will in service all clinical staff regarding the "Oxygen Administration" facility policy prior to the date of alleged compliance. The DNS/designee will complete audits for 5 random residents who receive oxygen to ensure their flow rate is set as ordered by the physician. Audits will be completed 5 times a week for 2 months, then 5 residents 3 times a week for 2 months, then 5 residents weekly for 2 months. Audits will include all shifts, units and weekends. Any negative trends will be	09/18/2024

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Medication Administration Record (MAR), dated August 2024, indicated the oxygen was signed out as being given at 2 liters on the following dates: 8/19/24, 8/20/24, 8/21/24 and 8/22/24. During an interview on 8/22/24 at 9:35 a.m., the Executive Director (ED) indicated the resident's oxygen should have been on at the correct flow rate. During an interview on 8/22/24 at 10:22 a.m., QMA 1 indicated the oxygen ball should be directly in the middle of the 2 liter line if the resident was on 2 liters of oxygen. She had signed off in Resident 90's MAR that the oxygen was given at 2 liters per nasal cannula on 8/22/24 for the AM shift. 3.1-47(a)(6)		reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved. ="" p="">	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to not sanitizing and disinfecting multiple resident use equipment for a random observation during medication pass. (Residents 71 and 53) Finding includes: During medication administration pass on 8/22/24 at 8:10 a.m., LPN 1 was observed checking Resident 71's blood pressure, pulse, and temperature with reusable instruments. After she had finished, she brought all of the items back to the medication cart and placed them to the side. The LPN did not sanitize the blood pressure	F 0880	Resident 71 and resident 53 were assessed and no ill effects related to the deficient practice were noted. The nurse was immediately in serviced on the infection control guidelines on sanitizing and disinfecting equipment from resident to resident. LPN 1 was immediately re-educated on the need to ensure all multi-use equipment is sanitized and disinfected between resident use. The facility determined that all residents have the potential to be affected. An audit was conducted,	09/18/2024

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	08/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	machine and cuff, thermometer, or the pulse oximetry device. LPN 1 prepared, poured, and administered the resident's medication and left the room. She moved the medication cart across the hall to Resident 53's room. At 8:27 a.m., she took the blood pressure machine, thermometer, and pulse oximetry device into his room and checked his vital signs. The items had not been sanitized after they were previously used. After checking his vital signs, she brought all of the devices to the medication cart and cleaned them with a germicide wipe. During an interview at that time, LPN 1 was aware the reusable equipment was to be cleaned and sanitized after each use. During an interview on 8/22/24 at 2:00 p.m., the Executive Director had no additional information to provide. The current 2024 "Cleaning and Disinfection of Resident-Care Equipment" policy, provided by the Executive Director on 8/22/24 at 3:00 p.m., indicated "Staff shall follow established infection control principles for cleaning and disinfecting reusable, non critical equipment. General guidelines include: ... b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. ... d. Multiple resident use equipment shall be cleaned and disinfected after each use..." 3.1-18(b)		and no other residents were identified as being affected. The DCE/designee will in-service all nursing staff on the facility policy for “Cleaning and Disinfection of Resident-Care Equipment” facility policy prior to the date of alleged compliance. Infection Preventionist/designee will audit 5 random staff members to ensure that staff are following policy and procedures for cleaning and disinfection of equipment from resident to resident. Audits will be completed 5 times a week for 2 months, then 5 staff 3 times a week for 2 months, then 5 staff weekly for 2 months. Audits will include all shifts, units and weekends. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	