PRINTED: 05/06/2025

	T OF HEALTH AND HU R MEDICARE & MEDIC					B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/04/2025	
	PROVIDER OR SUPPLIE	R E - LAPORTE CARE CENTER	1700 I	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350		
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIATI DEFICIENCY)	E	(X5) COMPLETION DATE
Bldg. 00	Licensure Survey. Investigation of Co Complaint IN0045 related to the allege	155062	F 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreem by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correct is prepared and/or executed so because it is required by the provisions of federal and state law.  The facility requests paper compliance for the following citations.	nent ne t	
F 0550 SS=D Bldg. 00	accordance with 41 Quality review con 483.10(a)(1)(2)(b Resident Rights/B Based on observati interview, the facil	reflect State Findings cited in 0 IAC 16.2-3.1. npleted on 4/9/25.	F 0550	="" p=""> br="">		05/05/2025
	1	nsistently offering pleasure		1. Corrective actions taken for		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

food for 1 of 1 resident reviewed for dignity.

TITLE (X6) DATE

those residents found to have

Paula Getautas RN, DNS 04/30/2025

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155062	B. W	ING		04/04/	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1700   8	STREET		
BRICKY	ARD HEALTHCARE	- LAPORTE CARE CENTER		LA POF	RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
	(Resident 17)				been affected by the deficient	t	
					practice:		
	Finding includes:				Resident 17 preferences		
					reviewed, and care plan upda		
	-	bservation on 3/31/25 at 11:21			reflect preferences for getting		
		vas observed in bed wearing a			dressed. Diet order clarified		
		hat time, an enteral tube			pleasure feedings for all mea		
	-	g into the peg tube (a tube			2. How the facility identified o		
		o the stomach for nutrition).			residents having the potential		
		nmate was seated in a chair in			be affected by the same defic		
		t 11:25 a.m., the roommate			practice and the corrective ac	tions	
		meal and proceeded to eat in			taken:		
	the room. Resident 17 did not receive a tray and				The facility determined that a		
	was not offered any	thing to eat.			residents with preferences or	1	
					dressing and residents with		
		p.m., the resident was observed			pleasure feedings have the		
	_	a hospital gown. During an			potential to be affected by this	S	
		ne, the resident indicated she			deficient practice.		
		thing to eat for lunch, and			The Social Services Director		
		ould bring a pudding for me to			(SSD) and the Activity Director	or	
	eat."				conducted interviews of all		
					residents and/or responsible		
	_	ervations on 4/1/25 at 8:58			parties in the facility to determ		
		2:30 p.m., the resident was			their dressing preferences. A		
	observed in bed we	aring a hospital gown.			plan was initiated for any resi		
	Dymin or many days at 1	omistions on 4/2/25 -+ 10:20			with specific dressing prefere		
		ervations on 4/2/25 at 10:20			and nursing staff were educa	ıea	
		, the resident was observed in			on these preferences.	41.7	
		ital gown. During lunch, the			No other residents are current	uy	
		e received her tray in the room,			receiving pleasure feedings.		
		17 was not offered anything to			3. Measures put into place/		
		ne resident remained dressed in			System changes: All staff we		
		At 5:14 p.m., the resident's			re-educated on dignity utilizin	-	
		her dinner tray and again tasked if she wanted anything			Resident Rights policy The D	CVI	
	to eat or served a di				or designee.	•	
	io eat of served a di	mmer day.			The Department Managers of designees will complete roun		
	The record for Dog	dent 17 was reviewed on 4/2/25			times per week to ensure	นอ ป	
		esident was admitted to the			I	ecina	
		l. Diagnoses included, but were			residents' preferences for dre	_	
	1 TACHILLY OH 1 177.377.4	r. iziaznoses included. Dul Wele			r are respecied and care bland		•

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Event ID:

K0U011 Facility ID: 000023 If continuation sheet Page 2 of 48

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/04/2025	
	PROVIDER OR SUPPLIER	- LAPORTE CARE CENTER	1700 I	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	not limited to, strok paralysis on one sid (difficulty swallowi heart failure, peg tu cardiac pacemaker.  The Significant Cha assessment, dated 1 was not cognitively making and was def and personal hygier.  There was no care preferred to wear a A Physician's Order enteral feed of Jevit centimeters (cc) per.  There was no order.  During an interview 1 indicated they wo foods only if she red.  During an interview Dietary Food Mana normally send the resee if the resident reand then they would.	e, hemiplegia (weakness or e of the body), dysphagia ng), chronic kidney disease, be, high blood pressure, and a lange Minimum Data Set (MDS) /22/25, indicated the resident intact for daily decision bendent on staff for dressing ne.  Solan that indicated the resident hospital gown during the day.  To dated 3/5/25, indicated y 1.2 Cal at 55 cubic hour for 24 hours.  Indicating nothing by mouth.  To on 3/31/25 at 12:07 p.m. CNA uld serve the resident pleasure quested something.  To on 4/3/25 at 10:49 a.m., the ger indicated they do not esident any food, they wait to equested a pudding or yogurt	IAU	Any deficiencies identified will corrected immediately with re-education provided as need The Director of Nursing Servit (DNS) or designee will observe residents with pleasure feeding ensure they are being offered meals 5 times weekly for 1 mouthen 3 times weekly for 1 mouthen 1 time weekly for 4 monthen 1 time weekly for 5 monthen 1 time weekly for 1 monthen 1 ti	ded. ces ve all ng to l onth, nth, ths. nd will is. I be ded. s will ces or will PI ns or ieved ults or ain
	was no care plan ind to be dressed in a ho During an interview	foods at every meal and there dicating the resident preferred ospital gown.  on 4/3/25 at 2:00 p.m., CNA 1 always dressed the resident in			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		A. BU	X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLE B. WING 04/04/2  STREET ADDRESS, CITY, STATE, ZIP COD			ETED	
	PROVIDER OR SUPPLIER  ARD HEALTHCARE	E - LAPORTE CARE CENTER		1700 I S	STREET RTE, IN 46350		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
3.1-3(t)  F 0554 SS=E Bldg. 00  Based on observation, record review, and interview, the facility failed to ensure a resident was assessed to self-administer medications and had physician's orders to self-administer for 4 of the self-administer for 4 of the self-administer for 5 of the self-administer for 5 of the self-administer for 5 of the self-administer for 6 of the self-administer for		nin Meds-Clinically Approp on, record review, and ty failed to ensure a resident -administer medications and	F 0:	TAG	1.Corrective actions taken for those residents found to have been affected by the deficient practice:		05/05/2025
	residents reviewed in medication. (Residents include:  1. On 4/1/25 at 9:44 bag of Mucinex through plastic bin on Residents in medication.)	for self-administration of ents 44, 52, 20 and 8)  4 a.m., 1:09 p.m. and 3:50 p.m., a pat lozenges was observed in a lent 44's overbed table.			Mucinex lozenges were remove from Resident 44's overbed to Thera tears were removed from Resident 52's overbed table. The Albuterol was removed from Resident 20's room. Orders for Fluticasone and Ipratropium-Albuterol Solution were obtained for Resident 20 self-administration of medications.	ble. m om r	
	On 4/2/25 at 1:50 p.m., the bag of throat lozenges remained on the resident's overbed table.  The record for Resident 44 was reviewed on 4/3/25 at 2:05 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and chronic respiratory failure.  The 3/12/25 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was				assessment was completed for Resident 20 and orders were obtained for Resident 20 to self-administer and may keep at bedside Bio freeze Ipratropium-Albuterol Solution, and Fluticasone. A care plan for self-administration of medications was initiated.		
	indicated the resider nebulizer treatment prepared by the lice "Medications may be self-administer as lo				A self-administration of medical assessment was completed for Resident 8 and orders were obtained for Resident 8 to self-administer and may keep bedside Astepro and Mometas Furoate. A care plan for self-administration of medication was initiated.	at sone ons	
	lozenges.				2. How the facility identified ot	her	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155062	B. W	ING		04/04/	2025
				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		
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					residents having the potential		
		istration of medication			be affected by the same defici		
assessment was dated 2/9/24.				practice and the corrective ac	tions		
					taken:		
	_	v on 4/3/25 at 2:00 p.m., the			The facility determined that all		
	_	g indicated the resident was no			residents have the potential to		
		elf-administering her			affected by the deficient practi		
		e cough drops were removed			The Director of Nursing (DNS		
	from the resident's i	room.			conducted a facility wide audit		
					all other residents in the facilit	-	
					ensure no other medications v	vere	
	2. On 4/1/25 at 1:05 p.m., 2:12 p.m. and 3:50 p.m.,				at bedside. All medications		
	Resident 52 was observed in her room sleeping. A				located at bedside identified d	•	
		rs was observed on the			the audit were either removed		
	resident's overbed to	able.			orders to keep at bedside and		
					may self-administer were obta	ined	
		dent 52 was reviewed on 4/1/25			after self-administration of		
		oses included, but were not			medication assessment		
	1	gnitive disorder with behavior			completed. All medications ke	-	
	disturbance and cer	ebral aneurysm.			at bedside have current orders	s.	
					3. Measures put into place/		
		mum Data Set (MDS)			System changes:		
		2/28/25, indicated the resident			Nursing staff to be re-educate	-	
		paired for daily decision			the Director of Nursing or desi	-	
	making.				regarding the policy and proce	edure	
	m				for keeping medications at	_	
		vsician's Order Summary (POS),			bedside, self-administration of		
		nt was to receive Refresh Plus			medications and current order	s for	
		on, instill 2 drops in both eyes			medications at bedside.		
	one time a day for o	chronic dry eyes.			The DNS or designee to com	plete	
		10 1 1 1			random rounds focusing on	.	
		cian's order to self-administer			medications at bedside to incl	ude	
	the eye drops.				current order, orders for	.	
	TE1 10				medication at bedside and ord	iers	
		dministration of medication			for self-administration of		
	assessment availabl	ie for review.			medications. These rounds wi		
	<u> </u>	4/2/25 + 11 45 - 1			completed for 5 residents 5 tir	nes	
	_	v on 4/3/25 at 11:45 a.m., the			per week for 1 month, then 3		
	1	g indicated the resident did not			residents weekly for 1 month,		
l	I have an order to sel	f-administer the eve drops and	1		1 resident weekly for 4 months	۹ ا	

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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 B. WING 04/04/2025 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE they should not have been in the resident's room. The rounds will be random and will 3. During a random observation on 3/31/25 at include all 3 shifts and all units. 10:36 a.m., a nebulizer machine, a bottle of Any deficiencies identified will be Biofreeze (a topical pain medication), and a bottle corrected immediately with of Fluticasone (an allergy nasal spray) were re-education provided as needed. observed in Resident 20's room. At that time, the 4. How the corrective actions will resident indicated the staff let him do nebulizer be monitored: treatments on his own and there was a bag in his The DNS will provide the results of closet with the medication for the nebulizer that he these reviews and audits to the got from his own pharmacy. QAPI committee monthly x 6 months or until 100% compliance During an observation on 4/1/25 at 9:20 a.m., the is achieved x 3 consecutive Biofreeze, Albuterol, and Fluticasone remained in months. Results of the audits will the resident's room. The resident indicated he be adapted or adjusted as needed used them when he felt like he needed them. to maintain compliance. 5) Date of compliance: 5/5/2025 The resident's record was reviewed on 4/1/25 at 3:30 p.m. Diagnoses included but were not limited to, amputation of the left leg, COPD (chronic obstructive pulmonary disease), and acute respiratory failure with hypoxia (low oxygen levels). The 2/5/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily incision making, required partial assistance with ADLs (activities of daily living) and was independent with transfers. A Physician's Order, dated 10/6/24, indicated Albuterol Inhaled Solution three times a day. A Physician's Order, dated 12/22/24, indicated Biofreeze Gel to the left hip topically every 3 hours as needed for hip pain. There were no orders for self-administration of Albuterol and Biofreeze or to keep the medications at the bedside. There was no order for Fluticasone. The most recent Self-Administration of Medication Assessment was dated 4/23/24. There

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155062		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/04/2025	
	PROVIDER OR SUPPLIER	E - LAPORTE CARE CENTER	1700 I	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	of administering to				
	Director of Nursing self-administration performed quarterly medication was to l kept at the bedside, medication order.	y on 4/3/25 at 11:37 a.m., the gindicated medication assessments should be y and as needed. If a pe self-administered and/or it should be written in the She indicated she was not medications in the resident's pok into it.			
	10:49 a.m., a bottle spray) and Mometa	of Astepro (an allergy nasal sone Furoate (a topical ved on Resident 8's bedside			
	medications remain	ion on 4/1/25 at 2:33 p.m., both and on the bedside table. At ent indicated he used both of en he needed them.			
	3:35 p.m. Diagnos	rd was reviewed on 4/1/25 at es included but were not limited renal dialysis, COPD, diabetes			
	indicated the reside	terly MDS assessment int was cognitively intact for ing, and required substantial Ls and transfers.			
		lf-Administration of ment in the record was dated			
	During an interview	v on 4/3/25 at 11:37 a.m., the			

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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 00 COMPLETED 155062 B. WING 04/04/2025 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 DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Director of Nursing indicated medication self-administration assessments should be performed quarterly and as needed. She indicated it was something they were working on correcting. A policy titled, "Resident Self-Administration of Medication", received as current from the Director of Nursing on 4/4/25 at 8:30 a.m. indicated, " ... A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely ... Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team...". 3.1-11 F 0585 483.10(j)(1)-(4) SS=D Grievances Bldg. 00 Based on record review and interview, the facility F 0585 1. What corrective action will be 05/05/2025 failed to file a grievance form, thoroughly accomplished for those residents investigate, and resolve grievances related to a found to have been affected by the resident representative's complaints for 1 of 1 deficient practice. resident reviewed for grievances. (Resident B) Resident #B no longer resides at Finding includes: the facility. The closed record for Resident B was reviewed on 2. How other residents having the 4/3/25 at 10:43 a.m. Diagnoses included but were potential to be affected by the not limited to, diabetes, sacral (tailbone area) same deficient practice will be pressure ulcer, cancer of the large intestine, and identified and what corrective dementia. action(s) will be taken. The 1/29/25 Quarterly Minimum Data Set (MDS) All residents could be affected by assessment indicated the resident was cognitively the alleged deficient practice.

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living) and transfers.

intact for daily decision making, and required

maximum assistance with ADLs (activities of daily

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Last 30 days of progress notes

reviewed to identify any grievance

related documentation to ensure

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/04/2025	
	ROVIDER OR SUPPLIER	E - LAPORTE CARE CENTER	1700	r ADDRESS, CITY, STATE, ZIP COD I STREET DRTE, IN 46350	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  DESCRIPTION OF THE OR MATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	
TAG	A Social Services New Directory, nursing, and Administrator, the reconcerns about the multiple accusation documentation of the investigation or resonot initiated.  A Social Services New resident's representabug was found on the wound clinic, and the skin. The nurse and and his room, and for the note from the vesting finding a bug or bit. Note did not indicate complaint. A grieven During an interview indicated no grievant regarding the representable wanted everythe wanted ev	Note, dated 3/6/25, indicated the ative made accusations that a the resident when he was at the that he had bite marks on his diaide assessed the resident found no bugs or bite marks. Wound clinic did not indicate the arcs of the ance form was not initiated.  You on 4/3/25 at 3:15 p.m., the SSD makes had been filled out sentative's concerns because the notes. The SSD indicated the notes are gularly and the notes. The SSD indicated the notes are gularly and the notes. The SSD indicated the notes are gularly and the notes of the designated grievance for each of the staff member receiving the red the nature and specifics of the designated grievance form cial will take steps to resolve the record information about the eactions, on the grievance	TAG	grievance process initiated ar followed.  3. What measures will be put place and what systemic char will be made to ensure that the deficient practice does not reconstruct the department of the deficient practice does not reconstruct the department of the deficient practice does not reconstruct the deficient practice does not reconstruct the deficient practice will not recurred to ensure the deficient practice will not recur	into nges e cur.  to the res.  5.  ed to ee ays,  to onths s) will
	form The Grievance Official, or designee, will				İ

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155062	B. Wl	NG		04/04/	/2025
	ROVIDER OR SUPPLIER	E - LAPORTE CARE CENTER		1700 I S	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		propriately apprised of			The results of these audits will		
	progress towards re	solution of the grievances"			brought to QAPI meeting mon	thly	
	ment to at a fine	1 DI00455006			for 6 months or until 100%.		
	This citation relates	to complaint IN00455286.			Results of the audits will be		
	2.1.7(a)(2)				adapted or adjusted as neede	d to	
	3.1-7(a)(2)				maintain compliance.		
					5. What date the systemic		
					changes for each deficiency w	/ill	
					be completed.		
					May 5, 2025		
					="" p="">		
					="" p="">		
F 0677	483.24(a)(2)						
SS=D	ADL Care Provided for Dependent Residents						
Bldg. 00		2 12 12 14 2 14 2 14 2 14 2 14 2 14 2 1					
	Based on observation	on, record review, and	F 06	577	1. What corrective actions will	be	05/05/2025
	interview, the facili	ty failed to ensure activities of			accomplished for those reside	nts	
		were completed for dependent			found to have been affected by	y the	
		shaving and washing hair for			deficient practice:		
		ewed for ADLs. (Residents 17,					
	37, and 63)				Facial hair for Resident 17 wa		
	Findings include:				removed and care plan update		
	Findings include:				her preference to wear a gowr while in bed. Resident 37 was		
	1 During random o	bservations on 3/31/25 at 11:21			shaven and facial and chin ha		
	-	Resident 17 was observed in			were removed. Resident 63 w		
	-	ital gown. At that time, she			shaven and facial and chin ha		
		ount of facial hair on her chin.			were removed as well as rece		
					a shampoo and haircut.	3	
	During random obs	ervations on 4/1/25 at 8:58					
	a.m., 1:10 p.m. and	2:30 p.m., the resident was			2. How other residents having	the	
		aring a hospital gown and had			potential to be affected by the		
	a moderate amount	of facial hair on her chin.			same deficient practice will be		
					identified and what corrective		
	During random obse	ervations on 4/2/25 at 10:20			actions will be taken:		

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155062	B. W	ING		04/04/	2025
NAME OF E	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
					STREET		
BRICKY	ARD HEALTHCARE	E - LAPORTE CARE CENTER		LA POF	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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		30 p.m. and 5:14 p.m., the					
	resident was observed in bed wearing a hospital				All other residents were obser	ved	
	gown and had a moderate amount of facial hair on				and anyone with moderate		
	her chin.				amounts of facial/chin hair or h	nair	
					that needed shampooed was		
		dent 17 was reviewed on 4/2/25			provided care. All other reside		
		esident was admitted to the			who prefer to wear gowns revi		
	-	Diagnoses included, but were			to ensure care plans in place f	or	
		e, hemiplegia, dysphagia			this preference.		
	` •	ing), chronic kidney disease,					
		be, high blood pressure, and a			3. What measures will be put i		
	cardiac pacemaker.				place and what systemic chan	-	
	TTI 0' 'C' 401	M' ' D ( G (MDG)			will be made to ensure that the		
	-	ange Minimum Data Set (MDS)			deficient practice does not rec	ur:	
	· ·	/22/25, indicated the resident intact for daily decision			Niverina staff in completed on		
		pendent on staff for dressing	Nursing staff in-serviced on Activities of Daily Living Policy and				
	and personal hygier	·			Promoting/Maintaining Reside		
	and personal hygier	ic.			Self Determination Policy.	TIL	
	A Care Plan, dated	11/25/24, indicated the resident			Con Betermination Folloy.		
		re performance deficit related			DNS/designee to observe		
	to a stroke. The res	ident required assistance of			residents to ensure they are		
	one person with per	sonal hygiene.			groomed and free of excessive	Э	
	•				facial/chin hair and that their h		
	The CNA task secti	on indicated the resident			has been washed and that the	·y	
	received a shower of	on Tuesday and Fridays. There			are dressed unless it is their		
	was no documentat	ion the resident had been			preference to be in a gown. Th	ne	
	assisted with the rea	moval of the facial hair on her			audits to be random and to inc	lude	
	chin.				5 residents weekly x 30 days,		
					then 3 residents weekly x 30 c	lays	
	-	on 4/3/25 at 11:00 a.m., the			than 1 resident weekly x 4		
	_	indicated the resident should			months.		
	be shaved as needed	d.					
					4. How the corrective actions	will	
					be monitored: The DNS will		
	-	observation on 3/31/25 at			provide the results of these		
		ent 37 was observed sitting up			reviews and audits to the QAF	-	
		that time, he had a large			committee monthly x 6 months		
		ir observed on his face and			until 100% compliance is achie		
	chin.				x 3 consecutive months. Resu	lts	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155062	ì í	UILDING	nstruction 00	(X3) DATE ( COMPL 04/04/	ETED
	PROVIDER OR SUPPLIER	E - LAPORTE CARE CENTER		1700 I S	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
	a.m., 1:14 p.m., and	ervations on 4/1/25 at 9:00 12:30 p.m., the resident remained t of facial hair on his face and			of the audits will be adapted o adjusted as needed to maintal compliance.		
	chin.				5. Date of compliance:		
	The record for Resident 37 was reviewed on 4/1/25 at 2:50 p.m. Diagnoses included, but were not limited to, Parkinson's disease, Alzheimer's				5/5/2025		
	disease, high blood	pressure, delusions, ession, and acute kidney			="" p="">		
	assessment indicate	ly Minimum Data Set (MDS) d the resident was not alert as dependent on staff for					
	resident had an AD related to Parkinson	d on 12/9/23, indicated the L self-care performance deficit its and Alzheimer's disease. ed assistance of one person one.					
	completed showers	on indicated the resident had on 3/6, 3/10, 3/17, and 3/20/25, no documentation the l.					
	Director of Nursing be shaved as needed	on 4/3/25 at 11:00 a.m., the indicated the resident should d. She has contacted hospice one during his bath days.					
	a.m., 2:20 p.m., and 1:10 p.m., and 2:32 a.m., 11:30 a.m., an	bservation on 3/31/25 at 11:25 13:15 p.m., on 4/1/25 at 8:59 a.m., p.m., and on 4/2/25 at 10:20 d 5:20 p.m., Resident 63 was ge amount of facial hair on his					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155062	B. W	ING		04/04/	2025
NAME OF T	DROLUDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	3			STREET		
BRICKY	ARD HEALTHCARE	- LAPORTE CARE CENTER		LA POF	RTE, IN 46350		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION  The resident's hair was also		TAG	DE IOLEKO I		DATE
		ed and knotted on the back of					
	his head.	ed and knowed on the back of					
	On 4/3/25 at 9:30 a.	.m., QMA 1 and the Wound					
	Nurse were observe	ed in the room and were shown					
	the resident's hair ar	nd that he was unshaven.					
	During an interview	on 4/3/25 at 9:50 a.m., QMA 1					
	~	ce CNA came at least two					
	_	he the resident. She indicated					
	he was in need of a shave.  During an interview on 4/3/25 at 9:55 a.m., the						
		ated the resident's hair was					
	matted and his scalp						
		dent 63 was reviewed on 4/2/25					
		esident was admitted to the					
	1	. Diagnoses included, but were					
		e respiratory failure, anxiety, arthritis, and heart failure.					
	neart disease, osteo	artificis, and heart famure.					
	The 12/24/24 Signit	ficant Change Minimum Data					
		ent indicated the resident was					
	1	tood and was severely					
		on making. The resident was					
	dependent on staff f	for personal hygiene.					
	A Care Plan, revise	d on 3/4/25, indicated the					
		L self-care performance deficit					
		balance and limited mobility.					
	The resident require	ed assistance of one staff with					
	personal hygiene.						
	The CNA task secti	on indicated the resident					
		or bed bath on Wednesdays					
		omplete bed bath was last					
	given on 3/29/25.	-					

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05/06/2025 PRINTED: 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 00 COMPLETED 155062 B. WING 04/04/2025 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 DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE There was no documentation the resident was shaved or had his hair washed. During an interview on 4/3/25 at 11:09 a.m., the Director of Nursing indicated the resident should have been shaved and had his hair washed as needed. 3.1-38(a)(3)(B) 3.1-38(a)(3)(D) F 0684 483.25 SS=D Quality of Care Bldg. 00 Based on observation, record review, and F 0684 1. What corrective action will be 05/05/2025 interview, the facility failed to ensure a resident accomplished for those residents with signs and symptoms of constipation was found to have been affected by the treated for 1 of 1 resident reviewed for deficient practice: constipation, and areas of discoloration, and edema were assessed and monitored for 1 of 2 Resident 63's current bowel record residents reviewed for skin conditions reviewed to ensure resident has non-pressure related and for 1 of 1 resident had a bowel movement in past 72 reviewed for edema. (Residents 63, 57, and 122) hours. No issue identified. Findings include: Skin assessment completed on Resident 57 on 4/3/25 with 1. The record for Resident 63 was reviewed on abrasion identified. No treatment 4/2/25 at 11:45 a.m. The resident was admitted to required but area continues to be the facility on 11/22/24. Diagnoses included, but monitored for healing. were not limited to, acute respiratory failure, anxiety, heart disease, osteoarthritis, and heart Resident 122 no longer resides at facility. failure. The 12/24/24 Significant Change Minimum Data 2. How other residents have the Set (MDS) assessment indicated the resident was potential to be affected by the never/rarely understood and was severely same deficient practice will be impaired for decision making. The resident was identified and what corrective dependent on staff for ADL care and was always actions will be taken: incontinent of bowel.

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Clinical Alert Listing Report for no

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		155062	B. W	ING		04/04/2025	
NAME OF F	PROVIDER OR SUPPLIER	}	_		ADDRESS, CITY, STATE, ZIP COD		
					STREET		
BRICKY	ARD HEALTHCARE	E - LAPORTE CARE CENTER		LA POF	RTE, IN 46350		
(X4) ID	SUMMARY	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)	re COM	PLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		Г	ATE
		d on 1/19/25, indicated the for constipation related to			bowel documentation x past 3 days reviewed to identify any	othor	
		The approaches were to			resident. No other resident wa		
	-	el protocol for bowel			identified.	°	
	_	cord bowel movements each			1.00.1		
	day.				Skin sweep completed to iden	tify	
					any other skin issues not bein	-	
	A Physician's Order, dated 12/18/24, indicated				monitored. MD/family notified		
	Bisacodyl Rectal Suppository, insert 1				monitoring orders put in place	for	
		every 24 hours as needed for			any identified areas.		
	constipation.				All other wasidants with adams		
	A Physician's Order, dated 12/20/24, indicated				All other residents with edema reviewed to ensure monitoring		
	hospice care.				orders in place for nurse to as		
	nospice care.				edema daily.	3033	
	A Physician's Order	r, dated 1/31/25, Morphine					
	-	e) Solution 20 milligrams (mg)			3. What measures will be put	nto	
	give 0.25 milliliter	(ml) by mouth every 1 hour as		place and what systemic changes			
	needed (prn) for par	in.			will be made to ensure that the	•	
					deficient practice does not rec	ur:	
	-	r, dated 2/3/25 indicated					
		Concentrate) Solution 20 mg			Licensed nursing staff in-servi		
	_	(ml) by mouth every six hours			on reviewing the clinical dashl		
	for pain.				for clinical alerts to identify any resident who has not had a	'	
	A Physician's Order	r, dated 3/14/25, indicated			documented BM in the last 3 d	lavs	
	-	iquid 50 mg, give 10 ml by			and following up to ensure res	•	
		ay for constipation.			has a prn medication to addre		
		•			this or MD has been notified .		
	The resident had no	bowel movement on the					
		/25-1/5/25, 2/16/25-2/21/25,			Licensed nursing staff in-servi		
	3/3/25-3/8/25, and 3	3/22/25-3/25/25.			on Skin Assessment Policy ar	d	
					on ensuring any skin issues		
		ministration Record (MAR) for			identified are being monitored		
		5 indicated the prn suppository			resolved. CNAs in-serviced or		
	constipation.	as being administered for			Skin Audits by Nursing Assista Policy which includes reporting		
	consupation.				any skin condition that is found		
	During an interview	v on 4/3/25 at 3:00 p.m., the			during care/showers.	1	
		indicated they had no policy					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL		
		155062	B. W	ING	_	04/04/	2025	
		1	-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	t.			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	TE	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	the resident had no bowel			Licensed nursing staff educate	ed		
		ee days, they would give the as			on the need to monitor and	_		
		ations and if there were no as			document on any resident with	1		
	needed medications, the nurses should be calling the doctor. 2. During a random observation on				edema.			
					DNS/designee to review the			
	3/31/25 at 11:10 a.m., bruising was observed to Resident 57's shins and right knee.				clinical alerts during start up to	,		
	resident 3 / 5 sillis	and right knee.			ensure any resident who trigge			
	During subsequent observations on 4/1/25 at 1:33 p.m. and 4/2/25 at 10:05 a.m., the bruising remained present to the resident's shins and right knee.				for no BM x 3 days has been	Ci <del>C</del> u		
					addressed. These audits to be	ا د		
					completed 5 times weekly x 30			
	present to the resident's sinns and right knee.				days then 3 times weekly x 30			
	Resident 57's record was reviewed on 4/2/25 at				days then weekly x 4 months.			
	11:33 a.m. Diagnoses included, but were not							
	limited to, hypertensive heart disease with heart				DNS/designee to complete ski	in		
	failure and diabetes				assessments to ensure that a			
					identified skin issues are being	•		
	The 1/27/25 Quarte	rly Minimum Data Set (MDS)			assessed and are documented	_		
	assessment indicate	d the resident was cognitively			the resident's record. These a	udits		
	intact for daily deci	sion making, required			to be conducted 5 residents			
	substantial assistance	ce with ADLs, and			weekly x 30 days, then 3			
	partial/moderate ass	sistance with transfers.			residents weekly x 30 days, th	en		
					1 resident weekly x 4 months.			
		12/14/24, indicated the resident						
		nt therapy (blood thinners).			DNS/designee to review new			
	Interventions include	•			orders and progress notes du	_		
	documenting bruisi	ng.			start up to identify any residen			
					with edema to ensure monitor	-		
	-	r, dated 1/28/25, indicated to			orders in place. These audits			
	_	nd symptoms of bleeding			completed 5 times weekly x 30			
		ls, blood in urine, and bruising			days, then 3 times weekly x 30			
	every shift.				days, then weekly x 4 months.			
	The record lacked d	locumentation of assessments			/p>			
		ised shins and right knee.			5. Date of Compliance:			
	or the resident's blu	noca omino ana right kilee.			05/05/2025			
	During an interview on 4/3/25 at 11:36 a.m., the							
	-	indicated bruises should be						
	_	nented in the resident's record.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 04/04/2025			LETED		
	PROVIDER OR SUPPLIER			1700   5	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тЕ	(X5) COMPLETION
TAG	During an interview DON indicated the of the time, bruised thinners.	a LSC IDENTIFYING INFORMATION on 4/3/25 on 3:05 p.m., the resident was up and about all easily and was on blood		TAG	DEFICIENCE		DATE
	a.m., Resident 122's swollen. The ring of into his finger. At t his hands were swo	observation on 4/1/25 at 9:02 s hands were observed to be on his left hand was digging that time, the resident indicated llen, but he did not know why.					
	-	ion on 4/02/25 at 9:33 a.m., the in bed. The swelling to his hanged.					
	9:00 a.m. Diagnose	d was reviewed on 4/2/25 at es included, but were not limited bleed, heart disease, and ase.					
	indicated the reside daily decision maki physical assist with living) and transfer- edema (1 out of 4 o	I Nurse Admission Assessment nt was cognitively intact for ng, required one person ADLs (activities of daily s, and had new,1+ pitting n a scale of severity of swelling when pressed with a finger) to s.					
	· ·	ed 3/9/25, indicated the (swelling) to both arms/hands.					
	The record lacked a resident's edema.	ny other assessments of the					
	The care plan lacke monitoring or treatr	d interventions related to ment of the edema.					
	During an interview	y on 4/3/25 at 9:38 a.m. RN 2					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		X2) MULTIPLE CONSTRUCTION       X3) DATE S         A. BUILDING       00       COMPLI         B. WING       04/04/.			ETED		
		155002	D. W			04/04/	2025
	ROVIDER OR SUPPLIER	- LAPORTE CARE CENTER		1700   3	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350		
(X4) ID	SUMMARY S	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 APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		t notice the resident's hecked his vital signs.					
	Director of Nursing assessed and docum sure why the residen	on 4/03/25 at 3:06 p.m., the indicated edema should be sented regularly. She was not not had edema and would ask or to see the resident.					
	3.1-37						
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care						1
	interview, the facilit toenails were cut, kee was provided for 1 care. (Resident 63)  Finding includes:  During random obsea.m. and 4/1/25 at 8	on, record review, and ty failed to ensure a resident's ept trimmed and podiatry care of 1 resident reviewed for foot ervations on 3/31/25 at 11:25 :59 a.m., Resident 63 was a chair. On 4/2/25 at 10:20 a.m.,	F 00	587	Corrective actions taken for those residents found to have been affected by the deficient practice:  Resident 63's feet were assesby hospice nurse and podiatry services were ordered.	sed	05/05/2025
	11:30 a.m., and 5:20 observed reclined in the resident was obs	D p.m., the resident was a a Broda chair. At those times, served with very long toenails. m., QMA 1 and the Wound			2. How the facility identified oth residents having the potential to be affected by the same deficient practice and the corrective act taken:	to ent	
	both shown the resid	-			The facility determined that all residents have the potential to	be	
	-	on 4/3/25 at 9:55 a.m., the			affected by the deficient practic		
		ated the resident received			The Director of Nursing (DNS)		
	-	y would have to let hospice eeded to be trimmed.			the Nursing Manager conducte	ed a	
	The record for Resid	dent 63 was reviewed on 4/2/25 esident was admitted to the			facility wide audit of all other residents in the facility to ensu all foot care needs were met w no other deficiencies identified	/ith	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/04/2025	
	ROVIDER OR SUPPLIER	- LAPORTE CARE CENTER	1700 I	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION . Diagnoses included, but were	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	not limited to, acute heart disease, osteod The 12/24/24 Signit	e respiratory failure, anxiety, arthritis, and heart failure.		Measures put into place/     System changes:	
	never/rarely understimpaired for decision	ent, indicated the resident was tood and was severely on making. The resident was For personal hygiene.		Nursing staff to be re-educate the Director of Nursing or des regarding the policy and proceed for providing foot care.	ignee
	Social Service Dire	s by the podiatrist.  y on 4/3/25 at 11:08 a.m., the ctor indicated on 2/10/25 diatry services were not		The DNS or designee to comprandom observations focusing foot care.	•
	During an interview Director of Nursing and hospice nurse w	sident, therefore he had not ince admission.  y on 4/3/25 at 11:09 a.m., the indicated the hospice CNA were in the facility at least he week and provided his		These observations will be completed for 5 residents wee for 1 month, then 3 residents weekly for 1 month, then 1 resident monthly for 4 months Any deficiencies identified will corrected immediately with	· .
		s should have been observed.		re-education provided as need  4. How the corrective actions	
				be monitored:  The DNS will provide the result hese reviews and audits to the QAPI committee monthly x 6 months or until 100% compliatis achieved x 3 consecutive months. Results of the audits be adapted or adjusted as new to maintain compliance.	ults of ne nce will
				5. Date of compliance.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/04/2025	
	PROVIDER OR SUPPLIER	- LAPORTE CARE CENTER	1700 I	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0688 SS=D Bldg. 00	REGULATORY OR LSC IDENTIFYING INFORMATION  483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility		F 0688	5/5/2025 ="" p="">  1. Corrective actions taken for those residents found to have been affected by the deficient practice:  Orders were obtained for opticuse of the right shoulder arm for Resident 50.  2. How the facility identified of residents having the potential	onal tray
	elevated on a small tray observed on the The record for Residu/1/125 at 2:10 p.m. not limited to, Alzhside hemiplegia (we of the body), vascul blood pressure, and The 2/10/25 Annual assessment indicate cognitively intact for had a limited range side for the upper example. A Care Plan, dated had an ADL self-car to a stroke and hemifor the resident to us to support the right.	hair. At that time, her right arm was a a small bed pillow. There was no arm red on the wheelchair.  for Resident 50 was reviewed on 2:10 p.m. Diagnoses included, but were to, Alzheimer's disease, stroke, right legia (weakness or paralysis of one side r), vascular dementia, anxiety, high sure, and osteoarthritis.  5 Annual Minimum Data Set (MDS) indicated the resident was not rintact for daily decision making and ed range of motion impairment to one		be affected by the same defic practice and the corrective actaken:  The facility determined that all residents with limited range of motion and orders for assistive devices for positioning have the potential to be affected by the deficient practice. The Director Nursing (DNS) and the Nursing Manager conducted an audit of other residents in the facility will limited range of motion and or for assistive devices for position to ensure that all other resident with limited range of motion and orders for assistive devices for positioning had appropriate devices in place. No other deficiencies were identified.	tions  I tell tell tell tell tell tell tell t

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/04/2025	
	ROVIDER OR SUPPLIER	- LAPORTE CARE CENTER	1700 I :	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR support.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  3. Measures put into place/	(X5) COMPLETION DATE
	resident was to use support the right up wheelchair for joint support. every shift.	r, dated 3/29/24, indicated the a right shoulder arm tray to per extremity while upright in protection and proximal and 3/2025 Medication		System changes:  Nursing staff to be educated by the Director of Nursing or desiregarding the policy and procedulated to the use of assistive devices.	ignee
	Administration Rec shoulder tray was si wheelchair every da	ords (MAR) indicated the right gned out as being on the		The DNS or designee to composervations focusing residen with limited range of motion at orders for assistive devices.	ts
	During an interview indicated the tray w dresser and night state her wheelchair wheelchair wheelchair's daugh removed sometimes.  During an interview Director of Nursing	on 4/3/25 at 3:00 p.m., the indicated the tray was to be		These observations will be completed for 5 residents wee for 1 month, then 3 residents weekly for 1 month, then 1 resident monthly for 4 months Any deficiencies identified will corrected immediately with re-education provided as need	be
	on the resident's wh 3.1-42(a)(2)	ecicnair.		4. How the corrective actions be monitored:  The DNS will provide the resulthese reviews and audits to the QAPI committee monthly x 6 months or until 100% compliatis achieved x 3 consecutive months. Results of the audits be adapted or adjusted as new to maintain compliance.  5. Date of compliance:	Its of e nce will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  04/04/2025	
		100002	B. W.			04/04	12020
	PROVIDER OR SUPPLIER ARD HEALTHCARE	E - LAPORTE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 1700 I STREET LA PORTE, 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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
					5/5/2025 ="" p="">		
F 0689	483.25(d)(1)(2)						
SS=D	Free of Accident						
Bldg. 00	Hazards/Supervis						
		on, record review, and	F 00	589	Corrective actions taken for		05/05/2025
	interview, the facility failed to ensure residents				those residents found to have		
	_	ls had preventions in place to			been affected by the deficient		
	prevent more falls/injuries related to a floor mat beside the bed and keeping the bed in the lowest				practice:		
	position for 2 of 3 residents reviewed for falls. (Residents 37 and 63)				Resident 37's bed was placed	ın	
	(Residents 37 and 63)				the lowest position.		
	Findings include:				Resident 63's floor mat was		
	rindings include.				placed next to the bed when h	10	
	1 During random o	bservations on 4/1/25 at 9:00			was in bed.	.0	
	_	and on 4/2/25 at 3:00 p.m.,			was in bed.		
	_	served in bed. At those times,			2. How the facility identified ot	her	
		as not in the lowest position.			residents having the potential		
		1			be affected by the same defici		
	The record for Resi	dent 37 was reviewed on 4/1/25			practice and the corrective act		
	at 2:50 p.m. Diagno	ses included, but were not			taken:		
		n's disease, Alzheimer's					
	disease, high blood	pressure, delusions,			The facility determined that all		
	osteoarthritis, depre	ssion, and acute kidney			residents with fall intervention	s of	
	failure.				bed in lowest position while in	bed	
					and fall mat at bedside when i	n	
		y Minimum Data Set (MDS)			bed have the potential to be		
		d the resident was not alert			affected by the deficient practi	ce.	
		as dependent on staff transfers					
	<u> </u>	he resident had no falls since					
	the last assessment.						
	A CL DI	1 0/20/24 : 1: . 1:1			The Director of Nursing (DNS)		
		d on 9/20/24, indicated the			the Nursing Manager conduct		
		for falls. The approaches were			an audit of all other residents		
	to keep the bed in the lowest position.				the facility with fall intervention		
	A Nurses' Note dat	ed 12/28/24 at 9:28 p.m.,			bed in lowest position while in and fall mat at bedside when i		
		nt was found on the floor on			bed to ensure that intervention		
i e		OII WIN 11001 OII			. Sou to orioure trial litter veriller		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  04/04/2025	
	PROVIDER OR SUPPLIER	- LAPORTE CARE CENTER	1700 I	SADDRESS, CITY, STATE, ZIP COD STREET DRTE, IN 46350	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		o the bed.  o on 4/3/25 at 3:00 p.m., the indicated the bed should be in		were in place. No other deficiencies were identified.	
	the lowest position.			Measures put into place/     System shanges:	
	_	bservations on 3/21/25 at 2:20		System changes:	
		Resident 63 was observed in loor mat on the floor next to		Nursing staff to be educated by the Director of Nursing or desiregarding the policy and procedure to incidents and	ignee
	The record for Resident 63 was reviewed on 4/2/25 at 11:45 a.m. The resident was admitted to the facility on 11/22/24. Diagnoses included, but were not limited to, acute respiratory failure, anxiety, heart disease, osteoarthritis, and heart failure.			accidents.	
				The DNS or designee to composervations focusing residen with fall interventions of bed in	its n
	Set (MDS) assessm	ficant Change Minimum Data ent, indicated the resident was tood and was severely		lowest position while in bed ar fall mat at bedside when in be  These observations will be	
	impaired for decision dependent on staff	on making. The resident was for bed mobility and transfers.  Ty of falls since the last		completed for 5 residents weef for 1 month, then 3 residents	ekly
	assessment.			weekly for 1 month, then 1 resident monthly for 4 months Any deficiencies identified will	
	was at risk for falls.	11/25/24, indicated the resident The approaches were to place the bed at all times while the bed.		corrected immediately with re-education provided as need	ded.
		d the resident was found on bed on 11/22/24 and 11/25/24.		4. How the corrective actions be monitored:	will
	place a floor mat at the resident was in	·		The DNS will provide the result these reviews and audits to the QAPI committee monthly x 6 months or until 100% compliants are things and a compliants.	e
	_	on 4/3/25 at 11:00 a.m., the indicated the mat should have		is achieved x 3 consecutive months. Results of the audits	will

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CORRECTION	IDENTIFICATION NUMBER	Δ RII	II DINC	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		
		A. BUILDING 00 COMPLI				
	155062	B. WI	NG		04/04/	2025
OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1700   STREET LA PORTE, IN 46350				
SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
seen on the floor ne: 3.1-45(a)(2)	xt to the bed.			be adapted or adjusted as nee to maintain compliance.		
				5. Date of compliance:		
				5/5/2025 ="" p="">		
83.25(g)(1)-(3) Nutrition/Hydration	Status Maintenance					'
nterview, the facility consumption logs with a history of we eviewed for nutrition. Findings include:  1. On 3/31/25 at 11: seated in her room in was served noodles, cup. The resident in o eat.  2. On 4/2/25 at 11:38 a grilled cheese and so eating any of her me was observed drinking. The record for Residut 1:12 p.m. Diagnostimited to, mild cognothrive, and dysphatissessment, dated 1/2 p.m. Chaussessment, dated 1/2 p.m. Cha	y failed to ensure food vere completed for residents ight loss for 3 of 4 residents on. (Residents 14, 39, and 52)  254 a.m., Resident 14 was in her wheelchair. The resident meatballs, peas, and a fruit idicated she wanted nothing  2.m., the resident was served oup for lunch. She was not real. At 11:55 a.m., the resident ing her milk but not eating any  3.m. the resident was reviewed on 4/1/25 ses included, but were not intive impairment, adult failure reagia (difficulty swallowing).  3.m. the resident was reviewed on 4/1/25 ses included, but were not intive impairment, adult failure reagia (difficulty swallowing).  3.m. the resident	F 06	592	have been affected by the defi practice:  ="" p="">Residents 14 and 39" nutritional status were reviewed the dietician with recommendations initiated for resident 14.  ="" p="">Resident 52 expired of 4/5/2025.  ="" p="">The facility was unable to correct the omitted meal consumption documentation.  ="" p="">  ="" p="">2. How the facility identified other residents having the potential to be affected by same deficient practice and the corrective actions taken:  ="" p="">  ="" p="">The facility determined that all residents with a history weight loss have the potential be affected by deficient practice.	cient s d by on le g the e	05/05/2025
E Silver	SUMMARY S (EACH DEFICIENCE REGULATORY OR een on the floor ne 1-45(a)(2)  33.25(g)(1)-(3) utrition/Hydration assed on observation assed on observation terview, the facility onsumption logs we with a history of we eviewed for nutrition as served noodles, and the record in the resident in the eat.  11.25 at 11:38 a cilled cheese and so the record for Resident as observed drinking and of her me as observed drinking the record for Resident as observed drinking the record for Resident as observed drinking the Significant Challes assessment, dated 1/4 and moderate cognition	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  een on the floor next to the bed.  1-45(a)(2)  33.25(g)(1)-(3) utrition/Hydration Status Maintenance ased on observation, record review, and terview, the facility failed to ensure food onsumption logs were completed for residents ith a history of weight loss for 3 of 4 residents wiewed for nutrition. (Residents 14, 39, and 52) indings include:  On 3/31/25 at 11:54 a.m., Resident 14 was eated in her room in her wheelchair. The resident as served noodles, meatballs, peas, and a fruit up. The resident indicated she wanted nothing to eat.  In 4/2/25 at 11:38 a.m., the resident was served filled cheese and soup for lunch. She was not ting any of her meal. At 11:55 a.m., the resident as observed drinking her milk but not eating any	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Been on the floor next to the bed.  1-45(a)(2)  33.25(g)(1)-(3)  utrition/Hydration Status Maintenance  ased on observation, record review, and terview, the facility failed to ensure food bonsumption logs were completed for residents wiewed for nutrition. (Residents 14, 39, and 52)  indings include:  On 3/31/25 at 11:54 a.m., Resident 14 was tated in her room in her wheelchair. The resident as served noodles, meatballs, peas, and a fruit ap. The resident indicated she wanted nothing teat.  n 4/2/25 at 11:38 a.m., the resident was served filled cheese and soup for lunch. She was not titing any of her meal. At 11:55 a.m., the resident as observed drinking her milk but not eating any bod.  the record for Resident 14 was reviewed on 4/1/25 1:12 p.m. Diagnoses included, but were not mitted to, mild cognitive impairment, adult failure thrive, and dysphagia (difficulty swallowing).  the Significant Change Minimum Data Set (MDS) sessment, dated 1/13/25, indicated the resident and moderate cognitive impairment. The resident	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  23.25(g)(1)-(3) utrition/Hydration Status Maintenance assed on observation, record review, and terview, the facility failed to ensure food mosumption logs were completed for residents ith a history of weight loss for 3 of 4 residents viewed for nutrition. (Residents 14, 39, and 52) indings include:  On 3/31/25 at 11:54 a.m., Resident 14 was eated in her room in her wheelchair. The resident as served noodles, meatballs, peas, and a fruit up. The resident indicated she wanted nothing reat.  14/2/25 at 11:38 a.m., the resident was served filled cheese and soup for lunch. She was not ting any of her meal. At 11:55 a.m., the resident as observed drinking her milk but not eating any odd.  15/12 p.m. Diagnoses included, but were not mited to, mild cognitive impairment, adult failure othrive, and dysphagia (difficulty swallowing).  17/10/18/18/18/18/18/18/18/18/18/18/18/18/18/	SUMMARY STATEMENT OF DEFICIENCIE  SUMMARY STATEMENT OF DEFICIENCIE  GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  THE PREFIX  THE PREFIX  THE ACHORMETORY CORRECTION SIMULD AND CACHERY CORDINATION  THE ACHORMETORY OR LSC IDENTIFYING INFORMATION  THE PREFIX  THE ACHORMETORY OR LACHERY OR THE ACHORMETORY OR INFORMATION  THE PREFIX  THE ACHORMETORY OR LACHERY  THE ACHORMETORY OR LACHERY  THE	TO HEALTHCARE - LAPORTE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION ten on the floor next to the bed.  1-45(a)(2)  BEGULATORY OR LSC IDENTIFYING INFORMATION ten on the floor next to the bed.  1-45(a)(2)  BEGULATORY OR LSC IDENTIFYING INFORMATION ten on the floor next to the bed.  1-45(a)(2)  BEGULATORY OR LSC IDENTIFYING INFORMATION the facility failed to ensure food onsumption logs were completed for residents with a history of weight loss for 3 of 4 residents viewed for nutrition. (Residents 14, 39, and 52) indings include:  as aded in her room in her wheelchair. The resident as served noodles, meathalls, peas, and a fruit p. The resident indicated she wanted nothing tent.  at 4/2/5 at 11:38 a.m., the resident was served illed cheese and soup for lunch. She was not thing any of her meal. At 11:55 a.m., the resident as observed drinking her milk but not cating any tod.  be record for Resident 14 was reviewed on 4/1/25 1:12 p.m. Diagnoses included, but were not mitted to, mild cognitive impairment, adult failure otherwise, and dysphagia (difficulty swallowing).  be Significant Change Minimum Data Set (MDS) is sessment, dated 1/13/25, indicated the resident id moderate cognitive impairment.

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155062	B. W	ING		04/04/2	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			STREET		
BRICKYA	ARD HEALTHCARE	- LAPORTE CARE CENTER			RTE, IN 46350		
(X4) ID	SUMMARY	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
	assessment reference	ee period.			Excellence (DCE) conducted a		
		0.00.00			audit of all other residents with	I	
	· ·	9/30/24 and reviewed on			history of weight loss in the fac	,	
	· ·	he resident had a nutritional			in the last 30 days to ensure the	nat	
	problem or potential nutritional problem related to				food consumption was	.	
	hemiplegia and hemiparesis (muscle weakness and/or paralysis), chronic obstructive pulmonary				documented appropriately. Al	'	
					residents identified during the		
	disease (COPD), anxiety disorder, hypertension,				audit were reviewed by the		
	-	e disorder, and adult failure to			dietician with no		
	_	s for the resident to maintain			recommendations.		
	adequate nutritional	i status.			="" p="">3. Measures put into		
	A Physician's Order, dated 3/6/25, indicated the resident received a regular diet.				place/ System changes: ="" p="">		
					- p- /		
	resident received a	regular diet.			="" p="">Nursing staff educate	, <sub>4</sub>	
	A Physician's Order	r, dated 3/11/25, indicated the			by the Director of Nursing or	Α	
	-	ceiving an enteral feeding (a			designee regarding the policy	and	
		g nutrition directly into the	procedure related to				
		t through a tube) of Jevity 1.2,			documentation of food		
	-	polus five times a day.			consumption.		
	,	j			="" p="">The DNS or designed	e to	
	The resident had su	stained a 27% weight loss in			complete audits of resident with		
	the past six months.				history of weight loss to ensure		
	-				food consumption has been		
	The March 2025 Fo	ood Consumption Log indicated			documented appropriately.		
	there was no intake	documented for all three meals			="" p="">These audits will be		
	on 3/4/25. No break	kfast was documented on			completed for 5 residents wee	kly	
	3/25/25 and no dinr	ner was documented on			for 1 month, then 3 residents		
	3/10/25, 3/20/25, ar	nd 3/26/25.			weekly for 1 month, then 1		
					resident monthly for 4 months.	.	
	-	on 4/4/25 at 8:45 a.m., the			The audits will randomly include	de	
		indicated the resident's food			all three meals. Any deficienci	es	
	-	d have been documented for			identified will be corrected		
	each meal.				immediately with re-education		
					provided as needed and regist		
					dietician evaluation as needed		
	2. On 4/2/25 at 11:55 a.m., Resident 39 was				="" p="">4. How the corrective	•	
		m eating lunch. He was served			actions will be monitored:		
	soup and a grilled c	heese sandwich.			="" p="">		

K0U011

i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		155062	B. W	TNG		04/04/	2025
NAME OF P	PROVIDER OR SUPPLIER	}	_		ADDRESS, CITY, STATE, ZIP COD		
					STREET		
BRICKY	ARD HEALTHCARE	E - LAPORTE CARE CENTER		LA POF	RTE, IN 46350		
(X4) ID	SUMMARY	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
		dent 39 was reviewed on 4/2/25			="" p="">The DNS will provide		
		oses included, but were not			results of these reviews and a		
	limited to, stroke, congestive heart failure, and dependence on renal dialysis.				to the QAPI committee monthl	ух	
					6 months or until 100%		
	The Quarterly Mini	mum Data Sat (MDS)			compliance is achieved x 3 consecutive months. Results of	√ <b>f</b>	
	The Quarterly Minimum Data Set (MDS) assessment, dated 3/4/25, indicated the resident				the audits will be adapted or	וכ	
		paired for daily decision making			adjusted as needed to maintai	n	
		up or clean up assistance with			compliance.	**	
	_	issues were identified during			="" p="">		
	the assessment refe				P		
					="" p="">5. Date of compliance	e:	
	A Care Plan, dated	10/18/24 and reviewed on			="" p="">		
	2/14/25, indicated the resident had a nutritional						
	problem or potentia	l nutritional problem related to			="" p="">5/5/2025		
	being on a therapeu	tic diet due to end stage renal					
	disease (ESRD) wit	th hemodialysis. The resident					
	-	s that were restricted on his					
		t may fluctuate due to dialysis;					
	meal intakes vary; p						
	-	g difficulty due to dysphagia					
		ing). The goal was for the					
		adequate nutritional status as					
		aining weight with no					
		changes, no signs and					
		strition, and meeting estimated					
	nutrition needs.						
	The resident was he	ospitalized 3/13/25-3/16/25 and					
	had a 12% weight le	-					
	A Physician's Order	r, dated 3/18/25, indicated the					
		eive a regular diet with no salt					
	packet; no bananas,	dried fruit, potatoes,					
	_	es. Limit to four ounces of milk					
	daily and double pr	otein at meals.					
	TI M 10005	10 2 1 1 2 2					
		ood Consumption Log indicated					
		r intake was not documented					
	on 3/4/25, 3/20/25,	ana 3/2//23.					l

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 04/04/2025	
	PROVIDER OR SUPPLIER	- LAPORTE CARE CENTER	1700   3	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Director of Nursing	on 4/4/25 at 8:45 a.m., the indicated the resident's food have been documented.				
	Resident 52 was ob	:52 a.m. and 12:03 p.m., served in her room in bed ent's lunch tray was covered table.				
	the main dining roo cheese, soup, and je was encouraged to she would like some	p.m., the resident was seated in m. She was served grilled allo for lunch. The resident eat by staff and was asked if ething else. The resident want anything else and she reoffee.				
	at 3:22 p.m. Diagno limited to, neurocog	dent 52 was reviewed on 4/1/25 oses included, but were not gnitive disorder with behavior -calorie malnutrition, and y swallowing).				
	assessment, dated 2 was cognitively imp and she required set	mum Data Set (MDS) /28/25, indicated the resident paired for daily decision making tup or clean up assistance ight issues were noted during rence period.				
	1/19/25, indicated the problem or potential being at nutritional (LBW), a body mass meal intake varied, would drink coffee;	10/18/24 and reviewed on he resident had a nutritional l nutritional problem related to risk related to low body weight s index (BMI) less than 19; would decline breakfast but history of receiving a d diet due to Barrett's				

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155062		(X2) MULTIPLE O A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2025				
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	anemia, LBW; weight gain include depression, need for supplement Interventions include monitor intake and a The April 2025 Phy indicated the resident diet, mechanical soft nectar thick liquids, weighed weekly and stimulant.  The March 2025 For there was no intake dinner on 3/4/25. The for dinner on 3/7/25 During an interview Director of Nursing	gia; abnormal labs due to ght may fluctuate due to edema, in was desired; diagnoses protein calorie malnutrition; ts to meet estimated needs. led, but were not limited to, record every meal.  Sician's Order Summary (POS) int was to receive a regular fa/easy to chew texture and. The resident was also to be di was receiving an appetite  and Consumption Log indicated documented for lunch and here was no intake documented for 3/10/25, and 3/21/25.  From 4/4/25 at 8:45 a.m., the indicated the resident's food dibe monitored for each meal.					
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mg	mt/Restore Eating Skills					
g. 99	interview, the facilithe bed was elevated resident's enteral feed peg tube (a tube instead for nutrition) for 1 of feeding. (Resident 1) Finding includes:	on, record review, and ty failed to ensure the head of d to at least 45 degrees while a eding was infusing into the erted directly into the stomach of 1 resident reviewed for tube (7)	F 0693	="" p="">1. Corrective actions taken for those residents foun have been affected by the def practice: ="" p=""> ="" p="">The head of the bed resident 17 was immediately elevated to 45 degrees. ="" p="">	icient		

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

Event ID:

K0U011

Facility ID: 000023

If continuation sheet Page 28 of 48

PRINTED: 05/06/2025

	I OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/04/2025	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD STREET		
BRICKY	ARD HEALTHCARE	- LAPORTE CARE CENTER			RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
IAG	p.m., Resident 17 w flat in bed. The head elevated to at least 4	vas observed lying completely d of the bed was flat and not 45 degrees. At that time, the eral tube feeding infusing at 55		mo	="" p="">RN 1, RN 2, and CN, were educated to policy and procedure related to Care and Treatment of Feeding Tubes. ="" p="">		DATE
	CNA 2 and RN 1 w	ere immediately notified and the resident in bed.			="" p="">2. How the facility identified other residents having the potential to be affected by	U	
	both indicated the recontrol and would l	v at that time, CNA 2 and RN 2 esident played with the remote ower the head of the bed all RN 1 indicated she had			same deficient practice and the corrective actions taken: ="" p="">		
	head of the bed was	edication at 4:10 p.m., and the elevated at that time.			="" p="">The facility determine that all residents feeding tubes have the potential to be affect	S	
	at 10:45 a.m. The refacility on 11/23/24	dent 17 was reviewed on 4/2/25 esident was admitted to the . Diagnoses included, but were			by deficient practice. ="" p="">		
	not limited to, stroke, hemiplegia, dysphagia (difficulty swallowing), chronic kidney disease, heart failure, peg tube, high blood pressure, and a cardiac pacemaker.  The Significant Change Minimum Data Set (MDS) assessment, dated 1/22/25, indicated the resident was not cognitively intact for daily decision making, had no oral problems and had a feeding				="" p=""> The Director of Nurs (DNS) conducted observations all other residents with feeding tubes to ensure proper position during feeding and medication	s of J ning	
					administration. No other deficiencies were identified. ="" p="">		
	nutrition.	she received 51% or more of			="" p=""> 3. Measures put into place/ System changes: ="" p="">		
	A Care Plan, dated 11/24/24, indicated the resident required a tube feeding related to dysphagia. The approaches were to ensure the head of the bed was at least 45 degrees.				="" p="">Nursing staff educate by the Director of Nursing or designee regarding the policy	and	

A Physician's Orders, dated 3/5/25, indicated

per hour times 24 hours a day.

Enteral Feed every shift of Jevity 1.2 Cal at 55 cc

="" p="">

Treatment of Feeding Tubes.

="" p="">The DNS or designee to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/04/2025	
	PROVIDER OR SUPPLIER	- LAPORTE CARE CENTER	1700 I	SADDRESS, CITY, STATE, ZIP COD STREET PRTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	During an interview Director of Nursing resident's bed was to degrees. She was aw happened on 4/2/25 The current 2024 "C Tubes" policy provi 8:30 a.m., indicated direct staff regardin	on 4/3/25 at 11:00 a.m., the indicated the head of the be elevated to at least 45 ware of the incident that		complete observations of resi with feeding tubes to ensure appropriate positioning of residents during feedings and medication administration. ="" p="">  ="" p="">These audits will be completed 5 times weekly for month, then 3 times weekly for month, then 1 time monthly for months. The observations will randomly include all three shi Any deficiencies identified wil corrected immediately with re-education provided as nee and registered dietician evalu as needed. ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  The DNS will provide results of these reviews and a to the QAPI committee month 6 months or until 100% compliance is achieved x 3 consecutive months. Results the audits will be adapted or adjusted as needed to mainta compliance. ="" p="">   dents  1 or 1 or 4 Ifts. I be ded ation  re ethe audits ly x  of in	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR  A. BUILDING 00 COMPLETE  B. WING 04/04/202			LETED		
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - LAPORTE CARE CENTER			1700 I :	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation interview, the facility document a resident their care plan for 1 management. (Resident 20 minutes)  During an observation Resident 20 minutes and daily rating 5-8 out facility was doing for Tylenol and he did in the resident's record 3:30 p.m. Diagnoso to, amputation of the obstructive pulmonarespiratory failure valuevels).  The 2/5/25 Quarterlassessment indicate intact for daily incise.	on, record review, and ty failed to assess and t's pain in accordance with of 1 resident reviewed for pain dent 20)  on on 3/31/25 at 10:36 a.m., in pain when moving in bed. pain in his shoulder and hip of 10. He indicated all the or his pain was giving him not know why.  d was reviewed on 4/1/25 at es included but were not limited the left leg, COPD (chronic ary disease), and acute with hypoxia (low oxygen  y Minimum Data Set (MDS) d the resident was cognitively tion making, required partial Ls (activities of daily living)	F 00		="" p="">  ="" p="">1. Corrective actions taken for those residents foun have been affected by the def practice: ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  ="" p="">  The facility determine that all residents have the potential to be affected by deficient practice. ="" p="">  ="" p="">  ="" p="">  The facility determine that all residents have the potential to be affected by deficient practice. ="" p="">  ="" p="">  The Director of Nurs (DNS) conducted interviews a observation of all other reside the facility to determine preser of pain. Any resident that	d to icient ing the ie ed	05/05/2025
	Biofreeze External medication) to the l needed for hip pain.	c, dated 12/22/24, indicated Gel 4 % (a topical pain eft hip every 3 hours as			expressed or exhibited signs/symptoms of pain were assessed by an MD or NP to determine appropriate pain management program. ="" p="">		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155062		A. BUI	A. BUILDING <u>00</u>			COMPLETED	
		B. WIN	2025				
			<del>'</del>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			STREET		
BRICKY	ARD HEAI THCAR	E - LAPORTE CARE CENTER			RTE, IN 46350		
	1				,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	Coral Tablet Extended Release			="" p="">3. Measures put into		
	•	every 8 hours for osteoarthritis			place/ System changes:	**	
	of the left hip.				="" p="">Licensed nursing sta	Ħ	
	A C DI	1 12/12/24 : 1: . 1.1			educated by the Director of		
		ed on 12/13/24, indicated the			Nursing or designee regarding	the the	
		for pain related to generalized			Pain Management Policy.		
	_	ventions included monitoring			="" p="">Pain Assessment		
		characteristics: quality,			Monitoring was added for all		
	l ·	onset, duration, aggravating			residents.	- 4-	
	factors, and relieving	ig factors.			="" p="">The DNS or designed	e to	
	The record locked	documentation of regular pain			complete audits of pain assessments to ensure reside	nto	
	assessments.	documentation of regular pain			with signs/symptoms of pain h		
	assessments.				adequate pain management	lave	
	During an interview	v on 4/3/25 at 11:37 a.m., the			program in place.		
	_	g indicated pain should be			program in place.   ="" p="">		
	_	nented for a resident taking			- ρ- /		
		having pain. The EMR			="" p="">These audits will be		
	_	record) program got rid of the			completed for 5 residents 5 tir	nee	
	1	rm they had been using, and			weekly for 1 month, then 3	1103	
	_	figure out something else.			residents 3 times weekly for 1		
		inguite our communing elect			month, then 1 resident weekly	for	
	A policy titled, "Pa	in Management", received as			4 months. Any resident identif		
		t 1:20 p.m. from the DON			with signs/symptoms of pain w		
		der to help a resident attain or			be evaluated by NP or MD to		
		ghest practicable level of			determine an appropriate pain	1	
		d psychosocial well-being and			management program.		
		ge pain, the facility will: a.			="" p="">		
		e resident is experiencing pain			· .		
	_	stances when the pain can be			="" p=""> 4. How the corrective	е	
	1	age or prevent pain, consistent			actions will be monitored:		
	with the comprehen	nsive assessment and plan of			="" p="">		
	care".						
					="" p="">The DNS will provide	the	
	3.1-37(a)				results of these reviews and a	udits	
					to the QAPI committee month	ly x	
					6 months or until 100%		
					compliance is achieved x 3		
					consecutive months. Results of	of	
					the audits will be adapted or		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062  NAME OF PROVIDER OR SUPPLIER		IDENTIFICATION NUMBER 155062	A. BU	A. BUILDING 00  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD 1700   STREET		(X3) DATE SURVEY COMPLETED 04/04/2025	
BRICKYA	ARD HEALTHCARE	- LAPORTE CARE CENTER		LA POI	RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	(X5) COMPLETION DATE
					adjusted as needed to maintal compliance. ="" p=""> ="" p="">5. Date of compliance ="" p=""> ="" p=""> ="" p="">		
F 0698 SS=D Bldg. 00	483.25(l) Dialysis  Based on record review and interview, the facility failed to ensure a dialysis access site was assessed and monitored as ordered for 1 of 1 resident reviewed for dialysis. (Resident 39)  Finding includes:  The record for Resident 39 was reviewed on 4/2/25 at 9:57 a.m. Diagnoses included, but were not limited to, stroke, congestive heart failure, and dependence on renal dialysis.  The Quarterly Minimum Data Set (MDS) assessment, dated 3/4/25, indicated the resident was moderately impaired for daily decision making and he was receiving dialysis.  A Care Plan, dated 12/12/24 and reviewed on 2/14/25, indicated the resident had an alteration in kidney function evidenced by hemodialysis for end stage renal disease (ESRD). Interventions		F 06	598	="" p="">  1. Corrective actions taken for those residents found to have been affected by the deficient practice:  Resident 39's dialysis access site was assessed with no negative findings.  The facility was unable to correct the omitted AV fistula documentation.  2. How the facility identified other residents having the potential to be affected by the same deficient practice and the corrective actions		05/05/2025
	symptoms of infects swelling, warmth or	ort as needed (PRN) signs and ion to access site: redness, or drainage.			The facility determined that all residents who receive dialysis have the potential to be affect by deficient practice.		

STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER		ILDING	00	COMPLETED	
155062		B. WI	NG		04/04/	2025	
	PROVIDER OR SUPPLIER	E - LAPORTE CARE CENTER		1700 I S	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350		
(X4) ID	SUMMARY	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
	_	2025 Physician's Order					
	• • •	dicated the resident's					
		fistula (a dialysis access site) remity was to be assessed for			The Director of Nursing (DNS)		
		audible continuous bruit and			The Director of Nursing (DNS) conducted an audit of all other		
	palpable thrill every				residents receiving dialysis to		
	purpusie unini every	, smit.			ensure dialysis access sites w	ere	
	The January 2025 T	reatment Administration			assessed as ordered. Any oth		
	Record (TAR) indic				residents identified with		
	documentation the	AV fistula was assessed for			deficiencies in dialysis access		
	the evening shift on	1/13/25, 1/17/25, and 1/22/25.			assessments had a dialysis		
		nentation for the night shift on			access assessment completed	d.	
	1/17/25.						
	documentation the day shift on 2/2/2/1/25 and 2/7/25.	TAR indicated there was no AV fistula was assessed for 8/25 and the evening shift on AR indicated there was no			Measures put into place/     System changes:  Licensed nursing staff educate by the Director of Nursing or	ed	
	documentation the	AV fistula was assessed for			designee regarding the policy	and	
	the day shift on 3/2	7/25, the evening shift on			procedure related to		
	3/31/25, and the nig	ght shift on 3/23/25.			Hemodialysis.		
	Director of Nursing should have been much the current facility provided by the Dir 9:45 a.m. The policensure the dialysis a shunt or graft) was dialysis treatments:	y on 4/4/25 at 8:45 a.m., the indicated the resident's fistula conitored every shift.  "Hemodialysis" policy was sector of Nursing on 4/4/25 at by indicated the nurse would access site (for example AV checked before and after and every shift for patency by ruit and palpating for a thrill.			The DNS or designee to compaudits of dialysis access sites ensure the completion of the assessments.  These audits will be completed 2 residents 5 times weekly for month, then 2 residents 3 times weekly for 1 month, then 1 resident weekly for 4 months. observations will randomly incall three shifts. Any deficiencie identified will be corrected immediately with re-education.	d for 1 es The lude	
					provided as needed		

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER 155062				l	04/04/2025	
STREET ADDRESS, CITY, STATE, ZIP COD			0 1/0 1/					
NAME OF P	ROVIDER OR SUPPLIER				STREET			
BRICKY	ARD HEALTHCARE	- LAPORTE CARE CENTER			RTE, IN 46350			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	'	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is F Drugs Based on record rev failed to ensure med excessive duration a 1 resident reviewed residents reviewed f (Residents 44 and 6  Findings include:  1. The record for R 4/3/25 at 2:05 p.m. not limited to, ESBI beta-lactamase), net urinary tract infection  The Significant Cha assessment, dated 3 was cognitively inta	Free from Unnecessary riew and interview, the facility dications were not used for an and an excessive dose for 1 of for antibiotics and 1 of 5 for unnecessary medications.  3) esident 44 was reviewed on Diagnoses included, but were L (extended-spectrum progenic bladder, sepsis, and	F 07	57	4. How the corrective actions to be monitored:  The DNS will provide the result these reviews and audits to the QAPI committee monthly x 6 months or until 100% compliant is achieved x 3 consecutive months. Results of the audits to be adapted or adjusted as need to maintain compliance.  5. Date of compliance:  5/5/2025  =""" p=""">1. Corrective actions taken for those residents found have been affected by the definition practice:  =""" p=""">The Macrobid for Resident 44 was discontinued  =""" p=""">An order to administer Morphine and Lorazepam simultaneously was obtained if the hospice physician.  =""" p=""">2. How the facility identified other residents having the potential to be affected by same deficient practice and the corrective actions taken:  =""" p=""">The facility determine that all residents receiving long term antibiotics, Morphine, and Lorazepam have the potential	Its of e nce will eded	05/05/2025	

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

Event ID:

K0U011

Facility ID: 000023

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
155062		B. WING 04/04/2025			2025		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			STREET		
BRICKY	ARD HEALTHCARE	- LAPORTE CARE CENTER			RTE, IN 46350		
	Г				· I		OV.5
(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 DEFICIENCY)	TE	COMPLETION
TAG		a antibiotic during the last 7	+	TAG			DATE
	days.	a and blotte during the last /			be affected by deficient praction  ="" p="">The Director of Nursi		
	uays.				(DNS) with the facility Nurse	ng	
	Δ Care Plan dated	10/17/24 and reviewed on			Practitioner conducted an aud	it of	
		he resident was on antibiotic			all other residents receiving lo		
		history of frequent UTI's.			term antibiotics, Morphine, and	-	
	incrup, related to a	moory or nequent of 116.			Lorazepam to ensure the	<b>-</b>	
	A Physician's Order	r, dated 10/15/24 and listed as			antibiotics remained appropria	ite	
		2025 Physician's Order			and the timing of the Morphine		
	_	dicated the resident was to			Lorazepam remained appropri		
		an antibiotic) 100 milligrams			Any other residents identified		
	,	ression of ESBL UTI.			deficiencies appropriateness of		
					long-term antibiotics or timing		
	A Physician's Order	r, dated 11/21/24, indicated the			Morphine and Lorazepam wer		
		ench/10 cc (cubic centimeter)			corrected immediately.		
	Foley catheter. The	e catheter was discontinued on			="" p="">3. Measures put into		
	12/27/24.		place/ System changes:				
					="" p="">Licensed nursing sta	ff	
	A Physician's Order	r, dated 12/11/24, indicated the			educated by the Director of		
	resident was to rece	eive Zyvox (an antibiotic) 600			Nursing or designee regarding	the	
	mg twice a day for	10 days for a UTI.			policy related to Unnecessary		
					Drugs with emphasis on long	term	
		r, dated 12/12/24, indicated the			antibiotics, Morphine and		
		eive Meropenem (an antibiotic)			Lorazepam timing.		
	1 -	ly three times a day for 10 days			="" p="">The DNS or designed	e to	
	for a UTI.				complete audits of residents		
		110/06/04 + 10 10			receiving long term antibiotics		
		ed 12/26/24 at 12:40 p.m.,			Morphine and Lorazepam The	ese	
		nt returned from the hospital			audits will be completed for 5		
		She was diagnosed with an		residents 5 times weekly for 1			
	acute 011 and to co	ontinue the Macrobid.			month, then 3 residents 3 time	es	
	A Physician's Order	r, dated 12/31/24, indicated the			weekly for 1 month, then 1	Λον	
		r, dated 12/31/24, indicated the cive Levaquin (an antibiotic)			resident weekly for 4 months.  deficiencies identified will be	Ally	
		daily for 10 days for a UTI.			corrected immediately with		
	250 mg, two tablets	daily 101 10 days 101 a U 11.			re-education provided as need	had	
	A Physician's Order	r, dated 1/24/25, indicated the			="" p="">4. How the corrective		
		eive Imipenem-Cilastatin (an			actions will be monitored:	,	
		intravenously every 8 hours for			="" p="">The DNS will provide	the	
	10 days for a UTI.	initial should be compared to			results of these reviews and a		
1	1				i		ı

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

Event ID:

K0U011

Facility ID: 000023

If continuation sheet Page 36 of 48

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLETED		
		155062	B. W	ING		04/04/2025		
		1	<u> </u>	CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	R						
BBICK∨/	ARD HEALTHOADS	E - LAPORTE CARE CENTER	1700 I STREET LA PORTE, IN 46350					
DIVICITY	TILD HEALTHOAKE	- LAI ONTE CANE CENTER		LAFOR				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					to the QAPI committee month	ly x		
	1	r, dated 3/6/25, indicated the			6 months or until 100%			
		eive Meropenem (an antibiotic)			compliance is achieved x 3			
		ly every 12 hours for a UTI for			consecutive months. Results	of		
	5 days.				the audits will be adapted or			
					adjusted as needed to maintai	in		
		ued to receive the oral			compliance.			
	Macrobid while rec	ceiving the other antibiotics.			="" p="">			
	Daning a ' ( '	4/4/25 -4 9.45						
	_	y on 4/4/25 at 8:45 a.m., the g indicated the resident had			="" p="">5. Date of compliance ="" p="">	e:		
		rounds of IV antibiotics on top			=··· p=···>			
		c. She indicated the antibiotic			_!!!\			
		ffective any more and the			="" p="">5/5/2025 ="" p="">			
		eceiving hospice services. She			- p- /			
		d reach out to hospice and see			="" p=""> .			
		the Macrobid. 2. On 4/3/25 at			- μ- /.			
		the Waeroold. 2. On 4/3/23 at 63 was observed sitting in a						
		ir. At that time, the Wound						
		change the resident's						
		f his feet. QMA 1 entered the						
	_	ered the resident Morphine						
	Sulfate via a syring	-						
		,						
	During an interview	v at that time, QMA 1 indicated						
	_	able to determine his level of						
	pain using a numbe	er scale.						
	The record for Resi	ident 63 was reviewed on 4/2/25						
	at 11:45 a.m. The re	esident was admitted to the						
	facility on 11/22/24	4. Diagnoses included, but were						
		e respiratory failure, anxiety,						
	heart disease, osteo	arthritis, and heart failure.	1					
		ficant Change Minimum Data						
		nent indicated the resident was						
		stood and was severely						
		on making. The resident was						
		for bed mobility and transfers.						
	The resident had tw	vo unhealed Stage 2 pressure						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155062		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       04/04/2025			
	PROVIDER OR SUPPLIER	- LAPORTE CARE CENTER	1700   3	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	ulcers that were pre	sent on admission, received nti-anxiety and opioid			
	A Physician's Order hospice care.	c, dated 12/20/24, indicated			
		e, dated 1/25/25, indicated ive one tablet at bed time at 8:00			
	Lorazepam (an anti-	r, dated 1/27/25, indicated -anxiety medication) 0.5 mg, n every two hours as needed			
	Sulfate (Concentrat	c, dated 1/31/25, Morphine e) Solution 20 milligrams (mg) (ml) by mouth every one hour as			
	Morphine Sulfate (6 give 0.25 milliliter)	c, dated 2/3/25 indicated Concentrate) Solution 20 mg (ml) by mouth every six hours n., 6:00 a.m., 12:00 p.m., and 6:00			
		r, dated 2/27/25, indicated ive 1 mg by mouth one time a gitation at 8:00 a.m.			
	(MAR) indicated th Morphine Sulfate w simultaneously or v following dates and 1/8/25 at 7:15 a.m. Morphine 1/9/25 at 2:25 a.m	ery close together on the			
	1/9/25 at 2:25 a.m Morphine	tor Lorazepam and 2:26 a.m. for			

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	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 SURVEY COMPLETED 04/04/2025	
	PROVIDER OR SUPPLIEI ARD HEALTHCARE	R E - LAPORTE CARE CENTER	1700 I	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
	1/15/25 12:30 a.m.	for both Lorazepam and				
	Morphine					
	1/16/25 3:52 a.m.,	9:50 p.m., and 11:52 p.m. for				
	Lorazepam and 3:5	3 a.m., 9:50 p.m., and 11:52 p.m.				
	for Morphine					
	_	for Lorazepam and 11:25 p.m. for				
	Morphine					
		for Lorazepam and 10:54 a.m. for				
	Morphine					
	•	for both Lorazepam and				
	Morphine	or both Lorazepam and				
	Morphine	or both Lorazepain and				
	1/21/25 5:04 p.m. for both Lorazepam and					
	Morphine					
	•	and 9:50 p.m. for both Lorazepam				
	and Morphine	and you plant for come Bornes pain				
	The 2/2025 MAR i	ndicated the Lorazepam and				
	Morphine Sulfate v					
	•	very close together on the				
	following dates and					
	_	for Lorazepam and 9:01 p.m., for				
	Morphine					
	_	for both Lorazepam and				
	Morphine	S. I				
	-	For Lorazepam and 3:47 p.m. for				
	Morphine					
	The 3/2025 MAR i	ndicated the Lorazepam and				
	Morphine Sulfate v	-				
	_	very close together on the				
	following dates and	times:				
	3/3/25 3:48 p.m. fo	r Lorazepam and 3:47 p.m., for				
	Morphine					
		r Lorazepam and 4:38 p.m., for				
	Morphine					
	_	r Lorazepam and 3:28 p.m., for				
	Morphine					
	3/7/25 3:40 p.m. fo	r Lorazepam and 3:41 p.m., for				

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STATEMENT 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	ETED
		155062	B. W	ING		04/04/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	R			STREET		
BRICKY	ARD HEALTHCARE	E - LAPORTE CARE CENTER			RTE, IN 46350		
	WE THE TENTO THE	- LATORILE OF THE CENTER		12777 017	(TE, IIV 40000		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	Morphine	1.4.1					
		r both Lorazepam and Morphine					
	_	r both Lorazepam and Morphine for Lorazepam and 9:14 p.m., for					
	Morphine	or Lorazepain and 9:14 p.m., for					
	_	or both Lorazepam and					
	Morphine	or both Lorazepani and					
	*	or both Lorazepam and					
	Morphine	or both Lorazepain and					
	•	or both Lorazepam and					
	Morphine	or cour zeraz-pani and					
	•	or both Lorazepam and					
	Morphine	•					
	3/25/25 2:12 p.m. a	and 4:30 p.m. for Lorazepam and					
	2:13 p.m. and 4:30	p.m. for Morphine					
	3/30/25 1:26 p.m. f	or both Lorazepam and					
	Morphine						
	-	or both Lorazepam and					
	Morphine						
	D	4/2/25 + 0.50 ONA 1					
	_	v on 4/3/25 at 9:50 a.m., QMA 1					
		g on the resident's verbal and like how he was moaning, or					
		egs, was how they scored his					
	*	vas a chart in the computer, and					
		rvations, they checked the					
	one he was exhibiti	· •					
	one he was exmon						
	During an interview	v on 4/3/25 at 11:00 a.m., the					
	_	g (DON) indicated she had just					
	_	ice on Monday 3/31/25 to see					
	if they would provi	de a Fentanyl patch for the					
		using the prn Morphine.					
	_	v on 4/3/25 at 3:00 p.m., the					
		sing staff had a nonverbal pain					
		p on the MAR when they					
		The Morphine and Lorazepam					
		en given together and Hospice					
	was currently in the	e facility and was making					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155062	B. Wl	ING	04/04/2025		/2025
	PROVIDER OR SUPPLIER	E - LAPORTE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 1700   STREET LA PORTE, 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 OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	adjustments to the r	resident's pain medication.					
F 0761 SS=D Bldg. 00	3.1-48(a)(2) 3.1-48(a)(3) 483.45(g)(h)(1)(2) Label/Store Drugs						
3	Based on observation	on, record review, and	F 07	761	="" p="">1. Corrective actions		05/05/2025
		ty failed to ensure medications			taken for those residents foun		0070072020
	were stored correct	ly for 1 of 7 residents observed			have been affected by the def	icient	
	during medication a	administration and 1 of 4			practice:		
		for self-administration of			="" p="">LPN 1 was educated	on	
	medications. (Resid	dents 23 and 20)			medication storage policy. ="" p="">The Albuterol was		
	Findings include:				removed from Resident 20's re Orders for Fluticasone were	oom.	
	1. On 4/2/25 at 4:3	2 p.m., LPN 1 was observed			obtained for Resident 20. A		
		ons for Resident 23. When the			self-administration of medicati	on	
		sident's room, a medication cup			assessment was completed for		
	containing two pills	s was left on top of the			Resident 20 and orders were		
		well as a Tamsulosin (a			obtained for Resident 20 to		
	medication used to	relax the muscles of the			self-administer Fluticasone an	ıd	
	bladder and prostate	e) tablet which was in it's			may keep at bedside. A care բ	olan	
	original package.				for self-administration of medications was initiated.		
	Upon entering the r	oom, the LPN closed the door			="" p="">2. How the facility		
		cart was out of her view.			identified other residents having	na	
					the potential to be affected by		
	During an interview	on 4/3/25 at 2:00 p.m., the			same deficient practice and th		
		indicated the pills should not			corrective actions taken:		
	have been left on to	p of the medication cart.			="" p="">The facility determine	∍d	
					that all residents have the		
	The current facility	"Medication Storage" policy			potential to be affected by the		
	was provided by the	e Director of Nursing on 4/4/25			deficient practice. The Directo	r of	
	at				Nursing (DNS) conducted a fa	cility	
	9:45 a.m. The police	cy indicated all drugs and			wide audit of all other resident		
	biologicals would b				the facility to ensure no other		
	compartments (i.e.,	medication carts, cabinets,			medications were at bedside.	All	
	drawers, refrigerato	rs, and medication rooms)			medications located at hedsid	e	

05/06/2025 PRINTED: 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 00 COMPLETED 155062 B. WING 04/04/2025 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 under proper temperature controls. 2. During a identified during the audit were random observation on 3/31/25 at 10:36 a.m., a either removed or orders to keep nebulizer machine was observed in Resident 20's at bedside and may room. At that time, the resident indicated there self-administer were obtained after was a bag in his closet with the medication for the self-administration of medication nebulizer that he got from his own pharmacy and assessment completed. that the facility let him use it sometimes. The ="" p=""> 3. Measures put into paper bag contained 5 boxes of Albuterol (inhaled place/ System changes: Nursing medication for breathing given via nebulizer) and staff to be educated by the one box of Fluticasone (an allergy nasal spray). Director of Nursing or designee The resident indicated he used them when he felt regarding the policy and procedure like he needed them. for medication storage and resident self-administration of The resident's record was reviewed on 4/1/25 at medications. 3:30 p.m. Diagnoses included but were not limited ="" p="">The DNS or designee to to, amputation of the left leg, COPD (chronic complete random rounds focusing obstructive pulmonary disease), and acute on medications on top of respiratory failure with hypoxia (low oxygen medication carts. levels). ="" p="">These rounds will be completed 5 times per week for 1 The 2/5/25 Quarterly Minimum Data Set (MDS) month, then 3 times weekly for 1 assessment indicated the resident was cognitively month, then weekly for 4 months. intact for daily incision making, required partial The rounds will be random and will assistance with ADLs (activities of daily living) include all 3 shifts and all units. and was independent with transfers. Any deficiencies identified will be corrected immediately with A Physician's Order, dated 10/6/24, indicated re-education provided as needed Albuterol Inhaled Solution three times a day. ="" p="">The DNS or designee to There were no orders to use the resident's own complete random rounds focusing medications or to keep the medications at the on medications at bedside to bedside. There were no orders for Fluticasone. include appropriate storage of medications at bedside, orders for During an interview on 4/3/25 at 11:37 a.m., the medication at bedside and orders Director of Nursing indicated if a medication was for self-administration of to be kept at bedside, it should be written in the medications. These rounds will be medication order and if a resident brought in their completed for 5 residents 5 times own medication, it needed to be evaluated by the per week for 1 month, then 3 facility. She was not aware of the bag of residents weekly for 1 month, then medication in the resident's closet, but she would 1 resident weekly for 4 months. look into it. Any deficiencies identified will be

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION (X3) DATE SU						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155062		BUILDING 00 WING		COMPLETED 04/04/2025	
		100002	B. 11	_		04/04/	2020
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD STREET		
BRICKYA	ARD HEALTHCARE	- LAPORTE CARE CENTER	_		RTE, IN 46350		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
F 0812	A policy titled, "Red Medication", receiv of Nursing on 4/4/2 Bedside medication when it does not pro- residents The foll bedside storage to of storage prevents acc The medications pro- bedside storage are	sident Self-Administration of ed as current from the Director 5 at 8:30 a.m. indicated, " storage is permitted only esent a risk to confused lowing conditions are met for occur: a. The manner of cess by other residents b. ovided to the resident for kept in the containers ovider pharmacy".		TAG	corrected immediately with re-education provided as needer p="" p="">4. How the corrective actions will be monitored: ="" p="">The DNS will provide results of these reviews and a to the QAPI committee monthles of months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintait compliance. ="" p=""> 5) Date of compliance 5/5/2025 ="" p=""> = "" p="">	the udits y x of	DATE
SS=F Bldg. 00	Food Procurement, Store Based on observation failed to serve food related to dirty food dirty PVC pipes und kitchen observed. (The strength of the served)  During the brief Kitt Dietary Food Mana, following was observed a. There was a large spillage on top of an fryer. The side of the was also dirty with steamer was observed.	tchen Sanitation Tour with the ger on 3/31/25 at 9:38 a.m., the	F 0	812	1. What corrective action(s) will accomplished for those reside found to have been affected by deficient practice?  The grease and spillage on the and side of the deep fryer were immediately cleaned. The side the stove next to the deep fryer was immediately cleaned and grease removed. The side of the steamer was immediately cleaned up, a under the dust under the steam was cleaned/removed. No illeffects were noted due to the alleged deficient practice.	nts y the e top e e of er he	05/05/2025

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

PRINTED: 05/06/2025 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. Bl B. W	UILDING	00	COMPLETED 04/04/2025	
		155062	B. W			04/04/	2020
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
BRICKYA	ARD HEALTHCARE	E - LAPORTE CARE CENTER	1700 I STREET LA PORTE, IN 46350				
(X4) ID		STATEMENT OF DEFICIENCIE	T	ID	,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	steamer.						
	b. The oven hood vents were dirty and greasy.				The oven hood vents were cleaned.		
	c. The white PVC p	ipes under the dish machine			The white PVC pipe under the	dish	
	were very dirty witl	n a large accumulation of dried			machine and floor were cleaned		
		loor under the dish machine			immediately. The wall under t	he	
	was dirty with adhe	red dirt against the wall.			dish machine was cleaned.		
	d. There were two r	usted ceiling vents in the dish			Ceiling vents were cleaned an	d	
	room.	C			repaired to be rust free.		
	During an interview	on 4/3/25 at 10:45 a.m., the			2. How will you identify other		
	_	ger indicated all of the above			residents having the potential	to	
	was in need of clear	ning.			be affected by the same defici		
	2.1.21(1)(2)				practice and what corrective a	ction	
	3.1-21(i)(3)				will be taken?		
					All current residents have the		
					potential to be affected by this		
					alleged deficient practice.		
					3. What measures will be put i	into	
					place or what systemic change	es	
					will you make to ensure that the		
					deficient practice does not rec	ur?	
					All dietary staff were educated	I	
					regarding kitchen sanitation.		
					The dietary manager/designee	e will	
					audit the cleaning schedule fo		
					ovens, steamer, deep fryer an		
					oven hoods 2 times each wee months, then weekly x 4 mont		
					to ensure kitchen sanitation is		
					maintained is being performed		
					policy. Audits will include all	•	
					dietary shifts and weekends.		
			1				

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

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155062	(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION  G  00	(X3) DATE SURVEY COMPLETED 04/04/2025
	PROVIDER OR SUPPLIER	- LAPORTE CARE CENTER	170	EET ADDRESS, CITY, STATE, ZIP COD 10 I STREET PORTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP	BE COMPLETION
				4. How will the corrective ac be monitored to ensure the deficient practice will not re- i.e., what quality assurance program will be put into place  The Dietary manager/desig	cur,
				present the summaries of the audits to the Quality Assuration committee monthly for six months. Thereafter, if determine by the Quality Assurance committee that further monitis needed, audits will continuous.	ne ince mined itoring
				Date of Compliance: 05/05/	2025
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4) Infection Prevention			="" p="">	
Diag. 00	interview, the facili control practices we related to not donni equipment (PPE) fo precautions (EBP) a equipment during w	on, record review, and ty failed to ensure infection ere in place and implemented ing personal protective in residents in enhanced barrier and not cleaning multi-use round care for 1 of 1 resident and for 1 of 1 resident with a sidents 17 and 63)	F 0880	="" p="">1. Corrective actio taken for those residents for have been affected by the correctice: ="" p="">CNA 2, RN1, and hospice CNA's were educated policy and procedure for En Based Precautions. ="" p="">The wound nurse we educated on the policy and procedure for Cleaning and procedure for Cleaning and procedure for Cleaning and procedure for Cleaning and	und to deficient  ted on hanced was

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	00	COMPLETED	
		155062	B. W	ING		04/04/2025	
		<u>l</u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			STREET		
BDICKA	VDU NEVI THUVDI	E - LAPORTE CARE CENTER			RTE, IN 46350		
BRICKTA	ARD HEALTHCAR	E - LAPORTE CARE CENTER		LA POR	(TE, IN 40330		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Disinfection of Resident Care		
	During a random	n observation on 4/2/25 at 5:14			Equipment.		
	p.m., Resident 17 v	was observed lying completely			="" p="">2. How the facility		
	flat in bed. The hea	nd of the bed was flat and not			identified other residents havi	ng	
	elevated to at least	45 degrees. At that time, the			the potential to be affected by	the	
	resident had an ent	eral tube feeding infusing at 55			same deficient practice and th	ne	
	cubic centimeters (	cc) per hour.			corrective actions taken:		
					="" p="">The facility determine	ed	
		vere immediately notified and			that all residents who require		
	^	the resident in bed. CNA 2			Enhanced Based Precautions	and	
		ned clean gloves to both			all residents who require the u	ıse	
	•	ed to reposition the resident in			of scissors for wound care ha	ve	
	bed. The RN turned	d the tube feeding off and lifted			the potential to be affected by	the	
	up the resident's go	own and disconnected the			deficient practice.		
		the resident requested for the			="" p="">The Director of Nursi	ing	
		he room. At 5:19 p.m., the door			(DNS) and the Wound/IP nurs	se	
	_	aff came out of the room.			conducted facility wide		
	Observation inside	the room at that time, indicated			observations of all other resid	ents	
		disposable isolation gowns in			in the facility who require		
	any of the trash car	ns in the room.			Enhanced Based Precautions	to	
					ensure appropriate precautior	าร	
		a.m., the resident was observed			were being utilized. Any		
		e, there were two hospice CNAs			deficiencies observed were		
		de of the bed giving the			corrected immediately with		
	_	e bed bath. Both CNAs were			education as needed. The wo		
		ooth hands, however, neither			nurse conducted observations		
	one of them wore a	n isolation gown.			all residents requiring the use	of	
					scissors for wound care to en	sure	
		ident 17 was reviewed on 4/2/25			the appropriate cleaning of		
		resident was admitted to the			equipment. No additional resid	dents	
		4. Diagnoses included, but were			were identified.		1
		ke, hemiplegia, dysphagia			="" p="">3. Measures put into		
	` •	ring), chronic kidney disease,			place/ System changes:		
		abe, high blood pressure, and a			Nursing staff and hospice		1
	cardiac pacemaker.	•			providers educated by the Dir		1
					of Nursing or designee regard	•	
	_	ange Minimum Data Set (MDS)			the policy and procedure relat		
	· ·	1/22/25, indicated the resident			Enhanced Barrier Precautions	3.	1
		y intact for daily decision					
	making, had no ora	al problems and had a feeding					1

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. WI	NG		04/04/2025
NAME OF 1	PROVIDER OR SUPPLIER	· ?		STREET A	ADDRESS, CITY, STATE, ZIP COD	-
					STREET	
BRICKY	ARD HEALTHCARE	E - LAPORTE CARE CENTER		LA POF	RTE, IN 46350	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, i	ICY MUST BE PRECEDED BY FULL	EDED BY FULL PREFIX CF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	nutrition.	she received 51% or more of			Nursing staff responsible for wound care were educated to	
	nutrition.				policy and procedure related to	
	A Physician's Orde	r, on the 4/2025 Physician			cleaning and disinfection of	
	1	dicated the resident was in			resident care equipment.	
	Enhanced Barrier P					
	_	v on 4/4/25 at 11:00 a.m., the			The DNS or designee to comp	
		Clinical Education was made			random observations focusing	
		ot donning gowns when			residents that require enhance	ed
		he resident and had no			based precautions to ensure	
	additional informat	ion to provide.			appropriate precautions are	
	The current 2025 "	Enhanced Barrier Precautions"			maintained.	
		the DON on 4/3/25 at 3:00 p.m.,			These observations will be	
		for EBP will be obtained for			completed for 5 residents wee	•klv
		ing tubesPersonal Protective			for 1 month, then 3 residents	,,,,,
		and gloves) for enhanced			weekly for 1 month, then 1	
		was necessary when			resident monthly for 4 months	
		ntact care activities such as			The rounds will be random an	d will
		hanging briefs and device care			include all 3 shifts and all unit	S.
	with feeding tubes.				Any deficiencies identified will	be
					corrected immediately with	
	2 Dunin 1	tugatus aut alianmenti			re-education provided as need	ded.
	_	treatment observation on the Wound Nurse was				
		scissors to remove a white			The DNS or designee to comp	olete
		ze) bandage to the left foot.			observations focusing on resid	
		was completed, she used the			that require the use of scissor	
		t the new bandage. She did			wound care to ensure appropri	<b> </b>
		rs after removing the dirty			cleansing and disinfection of	
		nd Nurse then performed the			scissors.	
		ht foot. Using the same dirty				
		old white kerlix bandage off			These observations will be	
		reatment was completed, she			completed 5 times weekly for	
	1	scissors to cut the new			month, then 3 times weekly for	
	bandage to the foot	•			month, then 1 time weekly for	4
	<u></u>	and and the second			months. Any deficiencies	
		v at that time, the Wound			identified will be corrected	
	I Nurse was aware sh	ne did not clean her scissors in	1		I immediately with re-education	l

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	A. BUILDING <u>00</u>			COMPLETED	
		155062	B. WING			04/04/	2025	
	PROVIDER OR SUPPLIEF	R - LAPORTE CARE CENTER	1	1700 I S	ADDRESS, CITY, STATE, ZIP COD STREET RTE, IN 46350			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	between dirty and c pressure areas.	lean bandages and between			provided as needed.			
	at 11:45 a.m. The refacility on 11/22/24	dent 63 was reviewed on 4/2/25 esident was admitted to the b. Diagnoses included, but were be respiratory failure, anxiety,			4. How the corrective actions to be monitored:			
	heart disease, osteo	arthritis, and heart failure.			The DNS will provide the resul these reviews and audits to the QAPI committee monthly x 6	е		
		ficant Change Minimum Data tent indicated the resident was			months or until 100% compliar is achieved x 3 consecutive	nce		
	I	tood and was severely			months. Results of the audits			
		on making. The resident had 2 pressure ulcers that were			be adapted or adjusted as nee to maintain compliance.	eded		
		dated 2/21/25 and 3/19/25,			5. Date of compliance:			
	indicated to cleanse wound cleanser, pa	the right and left heels with t dry, apply silver alginate and red gauze. Wrap with rolled			5/5/2025			
	_	y on 4/4/25 at 9:30 a.m., the gindicated the scissors should after each use.						
	Resident Care Equi Senior Director of O	Cleaning and Disinfection of pment" policy, provided by the Clinical Education, indicated se equipment shall be cleaned or each use.						
	3.1-18(b)							

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