STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	07/12/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 5, 6, 7, 8, 11, and 12, 2022. Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census Bed Type: SNF/NF: 118 Total: 118 Census Payor Type: Medicare: 10 Medicaid: 81 Other: 27 Total: 118 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/14/22.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 3 of 3 residents reviewed for self-administration of medication. (Residents 44, 60 and 263)	F 0554	Facility requests paper compliance/ Desk review F-554 What corrective action(s) will be accomplished for those residents	08/04/2022

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

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	Findings include: 1. During a random observation on 7/5/22 at 2:15 p.m., Resident 44 was observed in bed. At that time, he had 2 tubes of ointments on the over bed table. There was a tube of over the counter Aspercreme and a tube of Bacitracin ointment. On 7/722 at 9:45 a.m., both tubes of ointments were observed on the over bed table. The record for Resident 44 was reviewed on 7/7/22 at 9:30 a.m. The resident was admitted to the facility on 4/14/21. He was admitted to the hospital on 5/26/22 and returned back to the facility on 6/1/22. Diagnoses included, but were not limited to, quadriplegia, bacteremia, ESBL in the urine, COPD, neuromuscular dysfunction of the bladder, and major depressive disorder. The 6/8/22 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and had an indwelling catheter. There was no Care Plan for the resident to self-administer any ointments or medications. There were no Physician's Orders for the Aspercreme or the Bacitracin ointments. There was no self- administration of medication assessment noted for the resident. Interview with the B-Wing Unit Manager on 7/7/22, indicated the resident had no orders to self- administer or an assessment to self-administer his own medications. There were no orders for the Aspercreme or Bacitracin ointments. 2. During an interview with Resident 60 on 7/5/22		found to have been affected by the deficient practice? Residents 44, 60, and 263 were assessed and noted to have no injury from medications left at bedside. Residents, families, and physicians updated. A medication self-administration assessment was completed on residents 44, 60, and 263 for self-administration of medication. Orders obtained from physicians as indicated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. A house sweep of all resident's rooms was completed to identify any other medications that were at the bedside. No other medications were noted. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: The DEC educated nursing staff, Letters were mailed and residents on medication administration.	

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	at 11:16 a.m., a bottle of an over the counter medication of Pepto Bismol was observed on the resident's over bed table. The resident indicated he would take the medication when his stomach was upset. On 7/6/22 11:45 a.m., and 2:00 p.m., the bottle of Pepto Bismol remained on the resident's over bed table while he was at dialysis. On 7/7/22 at 9:45 a.m., the bottle of Pepto Bismol was observed on the resident's over bed table. The record for Resident 60 was reviewed on 7/8/22 at 1:10 p.m. Diagnoses included, but were not limited to, muscle wasting, abdominal pain, end stage renal disease, chronic kidney disease, major depressive disorder, chronic pain, urine retention, stroke, heart failure, anemia, anxiety, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/22 indicated the resident was cognitively intact. There was no Care Plan for the resident to self-administer any medications. There were no Physician's Orders for the Pepto Bismol and there was no self-administration of medication assessment noted for the resident. Interview with the B-Wing Unit manager on 7/7/22 at 10:00 a.m., indicated she was unaware the resident had a bottle of Pepto Bismol on his over bed table. Interview with the Director of Nursing on 7/8/22 at 2:00 p.m., indicated residents were not to have medications at the bedside. If they wanted to self-administer their own medications, they		Residents and families were educated that if they want a medication to inform nursing, so that we may contact physician to obtain an order. All education will be completed by 8-4-22. Any resident who wishes to self-administer will have a medication self-administration assessment completed. Staff will determine if the resident is safe to self-administer based on the results of the assessment. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Resident advocates/designee will audit residents' rooms for medications left at bedside 5 times a week x 6 months. If medication noted advocates/designee will immediately report to nurse. Audits will occur on all shifts and weekends. Any negative trends will be reviewed in Monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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	needed an assessment and a Physician's Order to do so.3. On 7/5/22 at 2:31 p.m., hydrocortisone cream 2.5%, an unlabeled bottle of antacid tablets, and a package of Benadryl capsules were noted on Resident 263's bedside table. On 7/6/22 at 1:14 p.m., hydrocortisone cream 2.5%, an unlabeled bottle of antacid tablets, and a package of Benadryl capsules were noted on the resident's bedside table. Resident 263's record was reviewed on 7/6/22 at 1:20 p.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 6/24/22, indicated the resident was cognitively intact. A Physician's Order, dated 7/5/22 at 3:00 p.m., indicated hydrocortisone cream 2.5% apply to abdomen topically every shift for rash and resident could keep at bedside. A Physician's Order, dated 7/3/22 at 12:15 p.m., indicated Benadryl allergy capsule 25 milligram (mg), 1 capsule every four hours as needed for itching. The record lacked an order for antacid tablets. The record lacked a self-administration of medications assessment. Interview with the Director of Nursing (DON) on 7/8/22 at 2:48 p.m., indicated the resident should have had a self-administration of medications assessment completed and corresponding orders placed for the resident to self-administer			

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	medications. 3.1-11(a)			
F 0623 SS=B Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently			

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	to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone			

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	number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were notified in writing related to a transfer to the hospital for 4 of 5 residents reviewed for hospitalization. (Residents 39, 163, 68, and 97) Findings include: 1. The record for Resident 39 was reviewed on 7/11/22 at 11:47 a.m. Diagnoses included, but were not limited to, cerebral palsy, low back pain, overactive bladder, and neurogenic bladder. The Quarterly Minimum Data Set (MDS)	F 0623	Facility Requests paper compliance/ desk review What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents/families of residents 39, 163, 68, and 97 were provided with the state transfer forms from recent hospitalizations.	08/04/2022

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	assessment, dated 6/20/22, indicated the resident was cognitively intact for daily decision making. Nurses' Notes, dated 4/7/22 at 8:42 a.m., indicated the resident was complaining of acute pain to the left side and groin area. The resident had a history of urinary issues. The Physician was notified and the resident was transported to the hospital. The resident was readmitted to the facility on 4/14/22. There was no documentation indicating the resident received a copy of his transfer form. Interview with the Director of Nursing on 7/11/22 at 4:10 p.m., indicated there was no documentation indicating the resident received a copy of his transfer form when he was sent to the hospital. 2. The record for Resident 163 was reviewed on 7/11/22 at 9:43 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance and disorganized schizophrenia. The Quarterly Minimum Data Set (MDS) assessment, dated 6/21/22, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. Nurses' Notes, dated 5/27/22 at 4:19 p.m., indicated the resident was walking with staff in the hallway when her legs collapsed and she fell against the wall and slid down. The CNA assisted the resident to the floor. This had occurred at 9:20 a.m., the resident was unresponsive to stimuli for 7 minutes with her eyes not focusing. The resident was transported to the hospital via 911. The resident was transferred to the inpatient		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. A house audit was completed to identify any resident who was sent to hospital in 30 days. A State transfer form was mailed to all families of those residents who were identified. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices not recur: Nursing staff by the DCE/designee, on completion of the State transfer form with all transfers/discharges. Education included sending a copy to hospital, copy to family/resident and original to be placed in resident chart. Social Services to mail copy to family. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Unit managers/designee will audit all transfer/discharges that occur 5	

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	psychiatric hospital following her hospital evaluation. She returned to the facility on 6/14/22. There was no documentation indicating the resident's Responsible Party had received written notification of the state transfer form. Interview with the Director of Nursing on 7/11/22 at 11:35 a.m., indicated the state transfer form should have been mailed to the resident's Responsible Party. 3. The record for Resident 68 was reviewed on 7/8/22 at 9:21 a.m. The resident was admitted to the hospital on 5/17/22 and returned back to the facility on 5/19/22. She had another hospital admission on 6/23/22 and was readmitted on 7/5/22. Diagnoses included, but were not limited to, low back pain, dementia with behaviors, homicidal ideations, psychotic disorder with delusions, atrial fibrillation, type 2 diabetes, osteomyelitis of the right ankle and foot, congestive heart failure, peripheral vascular disease, high blood pressure, cellulitis, chest pain, stroke, anxiety disorder, major depressive disorder, and anemia. The 5/28/22 Minimum Data Set (MDS) assessment, indicated the resident was severely impaired for decision making. The resident was depressed, had a poor appetite, and was easily annoyed. She had rejected care 1 to 3 days during the assessment period. The resident was an extensive assist with 1 person physical assist with bed mobility, dressing, personal hygiene, and toilet use. Nurses' Notes, dated 5/17/22 at 7:15 p.m., indicated the resident had been complaining of pain to the abdomen and bilateral lower extremities. The resident was crying and indicated		times a week x 2months, then 5 times every other week x 2 months then 5 times a month for the completion of 6 months. Any negative trends will be reviewed in Monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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	she needed to go to hospital because there was something wrong. The resident was sent to the Emergency Room and was admitted to the hospital. Nurses' Notes, dated 6/23/22 at 3:05 p.m., indicated the resident was being sent to the Neuro Behavioral Hospital as a direct admission. There was no documentation if the State transfer form was completed and sent to the resident's Responsible Party at the time of both discharges. Interview with the Director of Nursing on 7/11/22 at 11:45 a.m., indicated she could not find any of the State transfer forms and was unaware if the form was being sent to the resident's responsible party.4. Resident 97's record was reviewed on 7/7/22 at 3:31 p.m. Diagnoses included, but were not limited to, paraplegia, heart failure, hypertension, neurogenic bladder, arthritis, osteoporosis, anxiety, depression, and respiratory failure. The Admission Minimum Data Set (MDS) assessment, dated 6/2/22, indicated the resident was cognitively intact and required extensive assistance for most activities of daily living including bed mobility, transfer, personal hygiene, and toileting. A Progress Note, dated 7/6/22 at 8:00 p.m., indicated the resident presented with symptoms of a heavy chest, cough with yellow sputum, and difficulty taking deep breaths. A respiratory assessment was completed, with noted inspiratory wheezes and lung sounds were diminished at the bases. The physician was notified, and an order was received to send to the emergency room for evaluation.			

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	A Progress Note, dated 7/6/22 at 8:42 p.m., indicated the resident was transferred to the hospital and report was called to the hospital. The record lacked documentation of the State transfer form being sent in writing with the resident or to the resident's representative. Interview with the Director of Nursing (DON) on 7/8/22 at 2:48 p.m. indicated she could not provide any further documentation regarding the State transfer form. 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.			

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	§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on record review and interview, the facility failed to develop an initial plan of care within 48 hours of admission for 1 of 26 residents whose care plans were reviewed. (Resident 97) Finding includes: Resident 97's record was reviewed on 7/7/22 at 3:31 p.m. The resident was admitted to the facility on 5/26/22. Diagnoses included, but were not limited to, paraplegia, heart failure, hypertension, neurogenic bladder, arthritis, osteoporosis, anxiety, depression, and respiratory failure. The Admission Minimum Data Set (MDS) assessment, dated 6/2/22, indicated the resident	F 0655	Facility Requests Paper Compliance/ Desk Review F-655 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 97 baseline care plan was completed immediately.	09/04/2022

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	was cognitively intact and required extensive assistance for most activities of daily living including bed mobility, transfer, personal hygiene, and toileting. The record lacked documentation of a baseline Care Plan created within 48 hours of admission. Interview with the Director of Nursing (DON) on 7/8/22 at 2:48 p.m. indicated she could not provide any further documentation regarding the baseline care plan. 3.1-30(a)		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All new admission residents be affected. An audit of new admissions in the last 30 days was completed and no other deficiencies were found. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: Licensed nursing staff were educated by the DCE/designee on completing the base line care plan within 48 hours of admission. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Unit managers will audit all admissions to ensure that baseline care plans are completed within 48 hours. This practice will be ongoing Any negative trends will be reviewed in Monthly QAPI program.	

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	155187	A. BUILDING 00 B. WING	07/12/2022

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			Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure residents and/or their	F 0657	Facility request paper compliance/ Desk review	08/04/2022

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	Responsible Party were invited to attend and participate in care planning conferences for 7 of 7 residents reviewed for participation in care planning. (Residents 10, 39, 84, 44, 60, 90, and 16) Findings include: 1. Interview with Resident 10 on 7/8/22 at 8:28 a.m., indicated he had not participated in any care conferences and he did not remember being invited to a care conference. The record for Resident 10 was reviewed on 7/7/22 at 2:52 p.m. Diagnoses included, but were not limited to, stroke and malignant neoplasm of the head, face, and neck. The Annual Minimum Data Set (MDS) assessment, dated 6/17/22, indicated the resident was cognitively intact for daily decision making. The resident's Quarterly MDS assessments, dated 3/21/22 and 12/21/21, indicated the resident was cognitively intact. A General Note, dated 4/21/22 at 4:15 p.m., indicated the Interdisciplinary Team (IDT) met for a Care Plan meeting to review the resident's plan of care. The resident's family was sent an invitation via mail. The resident's Care Plan was reviewed and updated as needed. The same entry was completed on 1/21/22 and 9/17/21. There was no documentation indicating if the resident and/or his family attended the care conference. Interview with the Director of Nursing on 7/11/22 at 11:35 a.m., indicated the resident should have been invited to his care conference as well, not		F-657 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 84, 10, 39, 60, 90, 44, and 16 and responsible parties if applicable were invited to attend a care plan to be held in July 2022. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. Upcoming care plan dates reviewed with MDS coordinator and invitations were sent out with dates and times of scheduled care plan meetings to residents and families. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices not recur: Social Service Director, Social Service Memory Care Director educated on completing invitations to families and residents 2 weeks prior to Care plan date as able, if care plans are needed to be held sooner families will be called and residents will be invited in person. The BOM/designee will be responsible for mailing/ delivering invitations to families and residents. All participants of care plan meetings were educated to use the UDA Care plan meeting	

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	just his family. 2. Interview with Resident 39 on 7/6/22 at 10:54 a.m., indicated he was not invited to his Care Plan meetings. The record for Resident 39 was reviewed on 7/11/22 at 11:47 a.m. Diagnoses included, but were not limited to, cerebral palsy, low back pain, overactive bladder, and neurogenic bladder. The Quarterly Minimum Data Set (MDS) assessment, dated 6/20/22, indicated the resident was cognitively intact for daily decision making. A General Note, dated 3/18/22 at 5:16 p.m., indicated the Interdisciplinary Team (IDT) met for a Care Plan meeting to review the resident's plan of care. The resident's family was sent an invitation via mail. The resident's Care Plan was reviewed and updated as needed. The same entry was completed on 10/5/21. There was no documentation indicating if the resident and/or his family attended the care conference. Interview with the Director of Nursing on 7/11/22 at 3:50 p.m., indicated the resident should have been invited to his care conference. 3. Interview with Resident 84's wife on 7/5/22 at 1:52 p.m., indicated she was not invited to his care conferences. She did not recall receiving an invitation in the mail or being told in person. Resident 84's record was reviewed on 7/7/22 at 9:51 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and adult failure to thrive.		minutes tool in PCC to document. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The DON/Designee will Audit the care plan schedule two times a week x 6 months to ensure that invitations are and correct documentation is being completed. Any negative trends will be reviewed in Monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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The Quarterly Minimum Data Set (MDS) assessment, dated 6/15/22, indicated the resident had a short and long term memory problem and was severely impaired for daily decision making.

A General Note, dated 6/9/22 at 2:55 p.m., indicated the Interdisciplinary Team (IDT) met for a Care Plan meeting to review the resident's plan of care. The resident's family was sent an invitation via mail. The resident's Care Plan was reviewed and updated as needed. The same entry was completed on 1/7/22.

There was no documentation indicating if the resident's family attended the care conference.

Interview with the Director of Nursing on 7/11/22 at 11:35 a.m., indicated documentation should have been completed if the resident's wife had attended the Care Plan meeting. 4. During an interview on 7/5/22 at 2:10 p.m., Resident 44 indicated he had not been invited to attend a care planning conference.

The record for Resident 44 was reviewed on 7/7/22 at 9:30 a.m. The resident was admitted to the facility on 4/14/21. He was admitted to the hospital on 5/26/22 and returned back to the facility on 6/1/22. Diagnoses included, but were not limited to, quadriplegia, bacteremia, ESBL in the urine, COPD, neuromuscular dysfunction of the bladder, and major depressive disorder.

The 6/8/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact and had an indwelling catheter.

A Social Service Progress Note, dated 8/19/21 at 1:25 p.m., indicated "IDT (Interdisciplinary Team)

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	met for care plan meeting to review resident plan of care. Resident family sent invitation via mail. Resident currently planned long term care. Resident code status in place as Full Code. Resident care plans reviewed and updated prn [as needed]. Will follow up prn." (sic) A Social Service Progress Note, dated, 4/21/22 at 4:17 p.m., indicated "IDT met for care plan meeting to review resident plan of care. Resident family sent invitation via mail. Resident currently planned long term care. Resident code status in place as FULL CODE. Resident care plans reviewed and updated prn. Will follow up prn." (sic) A Social Service Progress Note, dated 6/2/22 at 2:27 p.m., indicated "IDT met for care plan meeting to review resident plan of care. Resident family sent invitation via mail. Resident currently planned long term care. Resident code status in place as FULL CODE. Resident care plans reviewed and updated prn. Will follow up prn." (sic) There was no documentation in the clinical record regarding the Care Plan meeting, if the resident attended, and the content that was reviewed. Interview with the Director of Nursing on 7/11/22 at 11:25 a.m., indicated there was no documentation the resident attended the Care Plan conference. 5. During an interview on 7/5/22 at 11:02 a.m., Resident 60 indicated he had not been invited or attended a care plan conference The record for Resident 60 was reviewed on 7/8/22 at 1:10 p.m. Diagnoses included, but were not			

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	limited to, muscle wasting, abdominal pain, end stage renal disease, chronic kidney disease, major depressive disorder, chronic pain, urine retention, stroke, heart failure, anemia, anxiety, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/22 indicated the resident was cognitively intact. A Social Service Progress Note, dated 10/5/21 at 11:57 a.m., indicated "IDT (Interdisciplinary Team)met for care plan meeting to review resident plan of care. Resident family sent invitation via mail. Resident currently planned long term care. Resident code status in place as FULL CODE. Resident care plans reviewed and updated prn. Will follow up prn." (sic) A Social Service Progress Note, dated 2/3/22 at 4:05 p.m., indicated "IDT met for care plan meeting to review resident plan of care. Resident family sent invitation via mail. Resident currently planned long term care. Resident code status in place as FULL CODE. Resident care plans reviewed and updated prn. Will follow up prn." (sic) There was documentation in the clinical record regarding, the Care Plan meeting, if the resident attended or was invited, and the content that was reviewed. Interview with the Director of Nursing on 7/11/22 at 11:25 a.m., indicated there was no documentation the resident attended the Care Plan conference. 6. During an interview with Resident 90 on 7/6/22 at 11:16 a.m., he indicated he had not been invited			

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	to a care conference or attended one in a long time. The record for Resident 90 was reviewed on 7/7/22 at 10:55 a.m. Diagnoses included, but were not limited to, type 2 diabetes, cellulitis of left lower limb, peripheral vascular disease, high blood pressure, end stage renal disease, congestive heart failure, angina, neuromuscular dysfunction of the bladder, urine retention, anxiety disorder, and major depressive disorder. The 5/31/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact, had an indwelling catheter and received dialysis. In the last 7 days the resident received insulin 7 times. A Social Service Progress Note, dated 12/14/21 at 4:55 p.m., indicated "IDT (Interdisciplinary Team) met for care plan meeting to review resident plan of care. Resident family sent invitation via mail. Resident currently planned long term care. Resident code status in place as DNR. Resident care plans reviewed and updated prn. Will follow up prn." (sic) A Social Service Progress Note, dated 4/14/22 a 1:11 p.m., indicated "IDT met for care plan meeting to review resident plan of care. Resident family sent invitation via mail. Resident involved with care plan and decisions regarding care plans. Resident currently planned long term care. Resident code status in place as DNR Resident care plans reviewed and updated prn. Will follow up prn." (sic) There was no documentation in the clinical record regarding the Care Plan meeting, if the resident attended, and the content that was reviewed.			

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	Interview with the Director of Nursing on 7/11/22 at 11:25 a.m., indicated there was no documentation the resident attended the Care Plan conference. Interview with the Administrator on 7/11/22 at 12:45 p.m., indicated he had spoken to the Social Service Director, who was new to Long Term Care, and informed her to document who attended the meetings and the content that was reviewed. 7. During an interview on 7/5/22 at 11:35 a.m., Resident 16 indicated she had not been invited to care conferences. Resident 16's record was reviewed on 7/7/22 at 1:09 p.m. Diagnoses included, but were not limited to, high blood pressure, depression, and non-Alzheimer's dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 6/11/22, indicated the resident was severely cognitively impaired. A Nurses' Note, dated 4/18/22 at 1:10 p.m., indicated the Interdisciplinary Team (IDT) met for a Care Plan meeting to review the resident's plan of care and the resident's family was sent an invitation via mail. A Nurses' Note, dated 6/9/22 at 3:44 p.m., indicated the IDT met for a Care Plan meeting to review the resident's plan of care and the resident's family was sent an invitation via mail. Interview with the Director of Social Services on 7/11/22 at 10:43 a.m., indicated the IDT notes should indicate if the resident and/or resident's representative declined to attend or were present at the meeting.			

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	Interview with the Director of Nursing (DON) on 7/11/22 at 11:33 a.m., indicated the Nurses' Notes were generic and did not directly address if the resident or resident representative attended the meeting. 3.1-35(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to dining and nail care for 3 of 4 residents reviewed for ADL's. (Residents 49, 98, and 103) Findings include: 1. On 7/5/22 at 11:30 a.m., Resident 49 was served her lunch. She was served a pureed diet. She did not receive a magic cup nutritional supplement nor a health shake. At 11:45 a.m., the resident had not eaten any of her food and had not been provided cueing or assistance by staff. On 7/6/22 at 11:34 a.m., the resident was again served a pureed diet for lunch. She did not receive a magic cup nutritional supplement nor a health shake. At 11:45 a.m., the resident had not eaten any or her food and had not been provided cueing or assistance by staff. The record for Resident 49 was reviewed on 7/7/22	F 0677	Facility Requests paper compliance/ Desk review F-677 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 49 and 98 were placed together at a table for meals and staff have been assigned to assist them. Resident 49 has received her supplements per order. Resident 103 received nail care immediately. How other residents having the potential to be affected by the same deficient practice will be	08/05/2022

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	at 8:47 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 5/6/22, indicated the resident was severely impaired for daily decision making. She required extensive assist for bed mobility and transfers and supervision with eating. The Care Plan, dated 5/3/22, indicated the resident had a physical functioning deficit related to impaired cognition and weakness. Interventions included, but were not limited to, provide assistance with eating as needed. Provide verbal cues and physical assistance as needed to complete the task. Interview with the Director of Nursing on 7/11/22 at 3:50 p.m., indicated the resident should have received assistance and/or cueing with her meal. 2. On 7/5/22 at 11:30 a.m., Resident 98 was served her lunch. Her meat was cut up by staff at that time. She took a few bites of her food and then proceeded to not eat any more. At 11:45 a.m., the resident had received no cueing and/or assistance from staff. On 7/6/22 at 11:30 a.m., the resident was served her lunch. She took a few bites of her food and then proceeded to not eat anymore. At 11:45 a.m., the resident had received no cueing and/or assistance from staff. The record for Resident 98 was reviewed on 7/11/22 at 8:45 a.m. Diagnoses included, but were not limited to, displaced fracture of the right femur, Alzheimer's disease, and dementia without		identified and what corrective action(s) will be taken: An audit of all residents' fingernails was completed and any needing or wanting their nails cut or cleaned were addressed at the time of the audit. An audit of residents receiving supplements at meals was completed no other deficiencies noted. An audit of residents needing assistance with eating was identified. All needing to be assisted will be assisted to dining room for meals as tolerated. If then staff will assist in rooms. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices not recur: Dietary staff were in serviced by dietary double checking tray cards for all supplements that are to be provided for meals. Nursing staff were in serviced, by the checking the tray card when the meal is delivered to ensure ordered supplements are on the tray. If the supplement is not on the tray, they are to call the kitchen to get it. Education will be completed by 7-30-22. Table arrangements have been reworked to place those who need assistance with feeding together and staff assigned to assist them. Shower sheets have been modified to include nail care	

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	behavior disturbance. The Significant Change Minimum Data Set (MDS) assessment, dated 6/2/22, indicated the resident was moderately impaired for daily decision making. She required extensive assist with bed mobility, transfers, and eating. The Care Plan, dated 6/1/22, indicated the resident had a physical functioning deficit related to cognitive impairment and recent hip fracture. Interventions included, but were not limited to, provide assistance with eating as needed. Provide verbal cues and physical assistance as needed to complete the task. Interview with the Director of Nursing on 7/12/22 at 9:35 a.m., indicated the resident should have been provided assistance or cueing with her meals. 3. During an interview on 7/6/22 at 10:35 a.m., Resident 103 indicated she had asked for her nails to be cleaned and cut for the last two weeks, but the staff had not helped her. The resident's nails were observed to be long and dirty. Resident 103's record was reviewed on 7/7/22 at 10:35 a.m. Diagnoses included, but were not limited to, high blood pressure, heart failure, anxiety, and depression. The Admission Minimum Data Set (MDS) assessment, dated 6/1/22, indicated the resident required extensive assistance with personal hygiene and bathing. Interview with the C-Wing Unit Manager on 7/7/22 at 2:54 p.m., indicated nail care was to be completed with showers or bathing, but it was not listed on the shower sheet. The C-Wing Unit Manager indicated she would be addressing the		which is to be signed out by CNA providing the shower at least 2 times weekly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Dietary manager/dietician/designee will audit 10 residents with dietary supplements 5 times a week to ensure supplements are on meal trays for 2 months, then 10 residents 5 times every other week x 2 months then 10 residents 5 times a week monthly to complete 6 months. Unit manager/designee will audit 10 residents' fingernails 5 times a week x 2 months, then 10 residents' fingernails 5 times every other week x 2 months then 10 residents' fingernails monthly to complete 6 months. Unit manager/designee will audit 5 residents who require assistance with eating 5 times a week x 2 months to ensure staff are assisting them, then 5 residents every other week x 2 months then 5 residents monthly to complete 6 months. The unit manager will update the list of residents as needed. All audits will be done on different shifts and include the	

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	resident's fingernails immediately. A Progress Note, dated 7/7/22 at 3:35 p.m., indicated the resident was provided care to fingernails. 3.1-38(a)(2)(D) 3.1-38(a)(3)(E)		weekend. Any negative trends will be reviewed in Monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure areas of bruising and cellulitis were assessed and monitored. The facility also failed to ensure side rails were padded in a timely manner and treatments were completed and signed out as ordered for 4 of 4 residents reviewed for skin conditions (non-pressure related). (Residents 112, 68, 263, and 106) Findings include: 1. On 7/5/22 at 11:04 a.m., Resident 112 was	F 0684	Facility requests paper compliance/ desk review F-684 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 112 side rails were padded on 7-7-22. Resident 112 is	08/04/2022

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

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	observed with a dressing to her right hand. She had reddish/purple bruising to her left hand and left and right forearms. There was also an area of reddish/purple discoloration to the resident's right temple area. On 7/6/22 at 10:30 a.m., the resident was observed in her wheelchair in the dining area. The discoloration to the resident's arms and temple area remained. She was wearing a short sleeve shirt at that time. On 7/7/22 at 8:33 a.m. and 10:28 a.m., the resident was observed in her room in bed. Her assist rails were not padded. At 11:28 a.m., the resident was slouched down in her wheelchair in the unit dining room. The resident's eyes were closed. She was wearing a short sleeved shirt and the areas of discoloration were visible to her arms and hands. The resident was taken back to her room at 11:30 a.m. At 11:35 a.m., the resident was sleeping in her bed. The assist side rails were now padded with black foam. The record for Resident 112 was reviewed on 7/7/22 at 10:10 a.m. Diagnoses included, but were not limited to, repeated falls, dementia without behavior disturbance, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 6/24/22, indicated the resident was moderately impaired for daily decision making. She required limited assistance with bed mobility and transfers. The resident was also identified as having skin tears and having non-surgical dressings applied. A Change of Condition Note, dated 6/26/22 at 12:46 p.m., indicated the resident was found on the floor on her right side in the "Coca Cola" room		no longer in the facility. Resident 68, and order was obtained for treatment to her bi- lower legs. Resident 263 was assessed and treatment in place per order, Resident 106 was assessed, and treatment was in place per order. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. A skin sweep of residents was completed on 7-14-22 and 7-15-22. No new skin issues were identified. All current areas have orders in place. All interventions in place. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices do not recur: Licensed nurses have been in serviced on documenting areas of discoloration immediately, as well as ensuring the intervention is put into place immediately. Licensed nurses have been in serviced on ensuring that treatment orders are in place at the time of admission and/or at the time a wound is	

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	next to her wheelchair with the back of her head touching the wall. No visible injuries were noted. A Change of Condition Note, dated 6/28/22 at 1:30 a.m., indicated the resident was heard calling out for help. She was found lying on her right side on the hallway floor outside of the dining room. The resident was complaining of right hip/thigh pain with movement. The old bruising to her bilateral arms and hands remained. The resident was sent to the emergency room for evaluation. The Weekly Skin Assessment, dated 7/4/22, indicated there was no documentation related to discoloration to the right temple area. A Change of Condition Note, dated 7/6/22 at 2:22 p.m., indicated the resident was noted to have a bruise measuring 3 centimeters (cm) x 2 cm to the right temple. The bruising was noted to be purple and yellow in color. The resident was noted to have had two recent falls. The resident also leaned to the right when in bed. Her grip rails for positioning would be padded for safety. Physician's Orders, dated 7/6/22, indicated the bruise to the resident's right temple was to be monitored every shift and her assist rails were to be padded. Interview with the Director of Nursing on 7/12/22 at 9:39 a.m., indicated an assessment of the bruising to the resident's right temple area should have been completed in a more timely manner and the assist rails should have been padded when the order was received. 2. On 7/6/22 at 11:44 a.m. Resident 68 was observed sitting in a wheelchair by her bed. There were white ace bandages noted to both lower legs. The right bandage was down around her ankle and there were open and red		noted. Licensed nurses in serviced on completion and documentation of all treatments as well as refusal of treatments. Education was given to Licensed nurses regarding residents who refuse and to make attempts every shift to assess and or dress any wounds. Education will be completed by 7-30-22 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Wound nurse/designee will audit all new admissions with wounds to ensure treatments are in place this will be an ongoing process. Unit managers/designee will audit of 5 residents with active treatments 5 times a week for 2 months then 5 residents every other week x 2 months then 5 residents monthly until the completion of 6 months to ensure treatments are completed as ordered. Audits will occur on all shifts and include the weekends. All risk management will be audited 5 times a week by IDT team in the morning meeting. IDT will ensure that documentation is completed, and interventions are in place, this will be an ongoing process. Any negative trends will be reviewed in Monthly QAPI	

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	blistered areas all over her shin. The bandage on her left leg was soiled with dried bloody drainage. On 7/7/22 at 3:45 p.m., the resident was seated in her wheelchair in her room. Both lower legs were observed with the same soiled ace bandages as the day before. The right bandage was around her ankle with the same open and red areas noted to her leg. The left leg bandage remained soiled with dried bloody drainage. On 7/8/22 at 7:45 a.m., the resident was observed in bed with her eyes closed. Both lower legs were observed out from under the sheets. The same ace bandages were in place as previously observed. Interview with the B-Wing Unit Manager on 7/12/22 at 10:00 a.m., indicated the resident had refused all of her treatments and would not allow anyone to observe her skin. The record for Resident 68 was reviewed on 7/8/22 at 9:21 a.m. The resident was admitted to the hospital on 5/17/22 and returned back to the facility on 5/19/22. She had another hospital admission on 6/23/22 and was readmitted on 7/5/22. Diagnoses included, but were not limited to, low back pain, dementia with behaviors, homicidal ideations, psychotic disorder with delusions, atrial fibrillation, type 2 diabetes, osteomyelitis of the right ankle and foot, congestive heart failure, peripheral vascular disease, high blood pressure, cellulitis, chest pain, stroke, anxiety disorder, major depressive disorder, and anemia. The 5/28/22 Minimum Data Set (MDS) assessment, indicated the resident was severely		program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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	impaired for decision making. The resident was depressed, had a poor appetite, and was easily annoyed. She had rejected care 1 to 3 days during the assessment period. The resident was an extensive assist with 1 person physical assist with bed mobility, dressing, personal hygiene, and toilet use. She had no pressure sores or other vascular ulcers. The Care Plan, dated 7/6/22, indicated the resident had an infection related to cellulitis. The nursing approaches were to administer antibiotics and treatments as ordered. Physician's Orders, dated 7/6/22, indicated Bactrim DS (an antibiotic) Tablet 800-160 milligrams (mg). Give 1 tablet by mouth every 12 hours for bacterial infection related to cellulitis. There were no treatment orders for the resident's bilateral lower leg cellulitis. Nurses' Notes, dated 7/5/22 at 2:53 p.m., indicated the writer tried to do an admission assessment and obtain vitals and the resident refused times 3. The resident was making statements that she does not live here and when she goes back home she will let them look at her. The writer then tried to redirect the resident but the resident still refused all assessments. The Physician and daughter were notified. Nurses' Notes, dated 7/6/22 at 5:45 a.m., indicated the resident had continued to refuse all care and started tearing down her curtains in her room. Her skin was warm and dry to touch, respirations were even and unlabored, with no noted anxiety. The dressings to her bilateral lower extremities remained intact and she refused for the writer to perform a skin check.			

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Nurses' Notes, dated 7/7/22 at 2:07 p.m., indicated the resident was alert with confusion and her skin was warm and dry to touch. Antibiotic therapy continued as ordered related to a bacterial infection to her legs. Treatment was refused.

Nurses' Notes, dated 7/8/22 at 4:55 a.m., indicated the resident had refused all care this shift.

Nurses' Notes, dated 7/8/22 at 5:30 p.m., indicated the writer attempted to remove the dressings from the resident's bilateral lower legs and assess the areas as well as apply new dressings. The resident told the writer no. The writer explained risks and benefits in layman's terms, for example the possibility of infection, making her sick, and/or losing a limb. The resident stated "you don't know what you were talking about" and attempted to kick the writer, stating to leave her alone.

Nurses' Notes, dated 7/9/22 at 4:40 p.m., indicated the resident was noted with green purulent drainage on both lower extremities with blisters on both lower legs. The resident would not allow the wounds to be measured. The resident was noncompliant with wound care and screamed "leave me the f### alone". The resident was encouraged several times to let staff clean the wounds and change the dressings, and the risk and benefits were explained multiple times. The residents' rights were respected. The family was at the bedside and aware of the resident refusing care. The Physician was notified and awaiting a call back.

Nurses' Notes, dated 7/10/22 at 5:28 p.m., indicated the resident had blistered areas to bilateral lower legs. A treatment was in place at this time. The doctor was updated on the status of

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	the wounds and current treatment. A new order was received for a wound culture. Nurses' Notes, dated 7/10/22 at 6:14 p.m., indicated the bilateral leg treatment was done via day shift with daughter present. Physician's Orders, dated 7/10/22 at 8:47 a.m., indicated to apply Silvadene cream to open areas on bilateral lower legs, cover with non adherent dressing, and wrap with kerlix every shift. There were no Physician's Orders for any type of treatment for the cellulitis prior to 7/10/22 after the resident had been readmitted to the facility. There was no continued documentation regarding nursing staff trying every day and shift to assess and/or treat the resident's cellulitis. The Treatment Administration Record (TAR) for the month of 7/2022 indicated an order, dated 6/6/22, to monitor skin/wounds for signs and symptoms of infection such as swelling, redness, warm, discharge, odor and to notify the physician of significant findings every shift. The assessment was signed out as being completed 7/6-7/10/22. Interview with the B-Wing Unit Manager on 7/12/22 at 10:30 a.m., indicated she had tried so many times during the day shift to assess and/or treat the resident's cellulitis. There were no treatments for the cellulitis when the resident was readmitted. Now, the current treatment must be done every shift, so if the resident refused then the next shift would try. Interview with the Director of Nursing on 7/8/22 at 1:40 p.m., indicated there were no Physician's Orders for the cellulitis, however, the resident had			

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	not allowed any nursing staff to assess her legs since she had been back. There was no treatment to assess the area every day or to even look at the resident's lower legs due to the diagnosis of bacterial infection of the lower legs. 3. Resident 263's record was reviewed on 7/6/22 at 1:20 p.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 6/24/22, indicated the resident was cognitively intact. A Care Plan, dated 6/30/22, indicated the resident had altered skin integrity related to an abscess on the right axilla. Interventions included, but were not limited to, complete treatments as ordered. Physician's Orders, dated 6/20/22, indicated to wash abscess to right axilla with soap and water and pat dry with gauze. The Treatment Administration Record (TAR) for June 2022, indicated the treatment to axilla was not signed out as completed on 6/21/22 and 6/25/22. Interview with the Director of Nursing (DON) on 7/8/22 at 2:48 p.m., indicated she could not provide any further information regarding the incomplete treatments to the right axilla. 4. Interview with Resident 106 on 7/5/22 at 3:15 p.m., indicated the resident's heel treatments were not always completed as ordered. Resident 106's record was reviewed on 7/8/22 at 10:25 a.m. Diagnoses included, but were not limited to, high blood pressure, heart failure, diabetes mellitus, anxiety disorder, depression,			

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	and cellulitis of the left lower limb. The Quarterly Minimum Data Set (MDS) assessment, dated 6/21/22, indicated the resident was cognitively intact. Physician's Orders, dated 6/14/22, indicated cleanse bilateral heels with normal saline, pat dry, apply kenalog cream, cover with polymem foam, and then wrap with kerlix every day shift every other day. The Treatment Administration Record (TAR) for June 2022, indicated the bilateral heel treatment was not signed out as completed on 6/16/22, 6/22/22 and 6/26/22. Physician's Orders, dated 6/14/22, indicated apply Eucerin cream to bilateral feet every evening shift. The Treatment Administration Record (TAR) for June 2022, indicated the application of Eucerin cream to bilateral feet was not signed out as completed on 6/17/22, 6/21/22 and 6/26/22. Interview with the Director of Nursing (DON) on 7/8/22 at 2:48 p.m., indicated she could not provide any further information regarding the treatments to the bilateral heels and feet. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with			

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	professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services related to not obtaining a treatment timely and not completing weekly skin assessments for 1 of 2 residents reviewed for pressure ulcers. (Resident 68) Finding includes: On 7/6/22 at 11:44 a.m., Resident 68 was observed sitting in a wheelchair by her bed. There were white ace bandages noted to both lower legs. The right bandage was around her ankle and there were open and red blistered areas all over her shin. The bandage on her left leg was soiled with dried bloody drainage. On 7/7/22 at 3:45 p.m., the resident was seated in her wheelchair in her room. Both lower legs were observed with the same ace bandages as the day before. The right bandage was around her ankle with the same open and red areas. The left leg bandage remained soiled with dried bloody drainage. . On 7/8/22 at 7:45 a.m., the resident was observed in bed with her eyes closed. Both lower legs were observed out from under the sheets. The same ace bandages were in place as before.	F 0686	Facility requests paper compliance/ desk review F-686 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 68 has current treatment orders for areas to bi- heels. Treatments are rendered as resident allows. Attempts are made on all shifts if she refuses. Skin assessment completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. A list of residents with wounds was identified. Those residents were audited, and all	08/04/2022

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	Interview with the B-Wing Unit Manager on 7/12/22 at 10:00 a.m., indicated the resident had refused all of her treatments and would not allow anyone to observe her skin. The record for Resident 68 was reviewed on 7/8/22 at 9:21 a.m. The resident was admitted to the hospital on 5/17/22 and returned back to the facility on 5/19/22. She had another hospital admission on 6/23/22 and was readmitted on 7/5/22. Diagnoses included, but were not limited to, low back pain, dementia with behaviors, homicidal ideations, psychotic disorder with delusions, atrial fibrillation, type 2 diabetes, osteomyelitis of the right ankle and foot, congestive heart failure, peripheral vascular disease, high blood pressure, cellulitis, chest pain, stroke, anxiety disorder, major depressive disorder, and anemia. The 5/28/22 Minimum Data Set (MDS) assessment, indicated the resident was severely impaired for decision making. The resident was depressed, had a poor appetite, and was easily annoyed. She had rejected care 1 to 3 days during the assessment period. The resident was an extensive assist with 1 person physical assist with bed mobility, dressing, personal hygiene, and toilet use. She had no pressure sores or other vascular ulcers. The Care Plan, dated 6/6/22, indicated pressure ulcer, actual, due to diabetes and peripheral vascular disease. There was a necrotic area to the left heel and a Stage 2 pressure ulcer to the right heel. The Nursing approaches were to monitor for signs and symptoms of infection such as swelling, redness, warm, and discharge, and skin check performed during bathing and treatments as		were noted to have current treatment orders in place. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: Licensed nurses were in serviced by the DCE to obtain treatment orders for residents with wounds timely. In servicing included the completion of treatments per order and documentation of completion or refusals. Education included attempting dressing changes on each shift if resident refuses. Education completed by 7-30-22 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Wound nurse/designee will audit and assess new admissions to ensure treatment orders are in place this will be an ongoing process. Wound nurse/designee will audit 5 residents with wounds 5 times a week x 2 months to ensure dressings are in place, then 5 residents every other week x 2 months, then 5 residents monthly for the duration of 6 months. Unit managers/designee will audit TAR's/skin assessments	

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	ordered. Weekly Skin Review Assessments indicated the resident refused on 4/26/22. There were no Weekly Skin Reviews for 5/2022. The next documented Weekly Skin Review Assessment was on 6/7/22, which indicated "Resident would not allow nurse to assess skin, was only able to see necrotic area to left heel. Resident would not allow this nurse to measure or treat." A Weekly Skin Review Assessment, dated 6/10/22, indicated the resident felt no pain upon palpation of bulla. No redness or irritation surrounding mass. There was no foul odor noted and the area was firm to touch. Staff will continue to monitor for change in size and color. Bulla measured 11.5 centimeters in depth and 13.9 centimeters in length and was filled with clear serous fluid. The next Weekly Skin Review was on 6/24/22 and indicated the resident remained hospitalized at this time. Nurses' Notes, dated 6/3/22 at 4:33 p.m., indicated staff attempted 3 times to assess the resident's feet for open areas with refusal. Staff will continue to encourage the resident to let a nurse assess her. Nurses' Notes, dated 6/5/22 at 2:59 p.m., indicated the resident approached the nurse while counting narcotics, stating she wanted to go to the hospital after breakfast. She was told she could not go without an order from the physician. She became very angry and left the unit. Later, she requested to go to the hospital because her feet were bleeding and had holes in them. Upon examination, the following was noted: left foot had		of 5 residents with active treatments 5 times a week for 2 months then 5 residents every other week x 2 months then 5 residents monthly until the completion of 6 months to ensure treatments and skin assessments are completed as ordered. Audits will include all shifts and weekends. Any negative trends will be reviewed in Monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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

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	a necrotic area on the heel with no bleeding, the right foot was swollen with no bleeding, but had a small dry red area. Nurses' Notes, dated 6/6/22 at 8:30 a.m., indicated the resident was propelling herself in the hallway with socks and shoes on. The writer approached the resident and asked if she could look at her feet, as the nurses were concerned she had an area to her heels. She responded "There is no reason to be looking at my feet. This one was swollen [pointed to her right foot] yesterday but it is much better and that's it." Staff explained if she had an area on her foot, the doctor would need to be notified to get a treatment. The resident again refused an assessment of her feet. The physician was notified and informed that the nurse had identified a necrotic area on her left heel and the resident's declination of an assessment. A new order was obtained and continue to attempt to assess. Nurses' Notes, dated 6/6/22 at 10:08 a.m., indicated therapy attempted to assess the resident for wound care, however, the resident refused. Nurses' Notes, dated 6/6/22 at 12:30 p.m., indicated the Director of Nursing was able to assess and measure the areas on both feet. The left heel had a dark hard necrotic area measuring 3 centimeters (cm) by 4 cm. The heel was intact with no redness noted to the wound bed. The right heel, identified as a Stage 2, had a 1 cm by 1 cm open area surrounded by hard colored peeling skin. There was a 0.5 cm by 0.5 cm scabbed area to the side of the open area. The physician was made aware and new treatments were obtained for the right heel. Physician's Orders, dated 6/6/22, indicated to			

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	cleanse the right heel with normal saline or wound cleanser and apply Hydrocolloid every 3 days. Apply skin prep to the wound on the left heel until resolved every shift and document refusals. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor and notify physician of significant findings every shift. A COMS-Skin Only Evaluation, dated 6/6/22, indicated there was a Deep Tissue Pressure Injury to the left heel that measured 3 cm by 4 cm with necrotic tissue on the heel, and a Stage 2 pressure ulcer to the right heel that measured 1 cm by 1 cm with granulation tissue noted. The heel was firm and warm to touch. There were no other COMS-Skin Only Evaluations completed after 6/6/22 for the pressure ulcers. On 6/10/22 one had been initiated but was incomplete. The resident returned from the Neuropsychiatric Hospital on 7/5/22. Nurses' Notes, dated 7/5/22 at 2:53 p.m., indicated the writer tried to do an admission assessment and obtain vitals and the resident refused times 3. The resident was making statements that she did not live here and when she goes back home she will let them look at her. The writer then tried to redirect the resident but the resident still refused all assessments. The Physician and daughter were notified. Nurses' Notes, dated 7/6/22 at 5:45 a.m., indicated the resident had continued to refuse all care and started tearing down her curtains in her room. Her skin was warm and dry to touch, respirations were even and unlabored, with no noted anxiety. The dressing to her bilateral lower extremities remained			

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	intact and she refused for the writer to perform a skin check. Nurses' Notes, dated 7/7/22 at 2:07 p.m., indicated the resident was alert with confusion and her skin warm and dry to touch. Antibiotic therapy continued as ordered related to bacterial infection to legs. Treatments were refused. Nurses' Notes, dated 7/8/22 at 4:55 a.m., indicated the resident had refused all care this shift. Nurses' Notes, dated 7/8/22 at 5:30 p.m., indicated the writer attempted to remove the dressings from the resident's bilateral lower legs and assess the areas, as well as apply new dressings. The resident told staff no. Staff explained risks and benefits in layman's terms, for example the possibility of infection, making her sick, and/or losing a limb. The resident stated, "you don't know what you were talking about" and attempted to kick the writer, stating "leave me alone." Nurses' Notes, dated 7/9/22 at 4:40 p.m., indicated the resident was noted with green purulent drainage on both lower extremities with blisters on both lower legs. The resident would not allow the wounds to be measured. The resident was noncompliant with wound care and screamed "leave me the f### alone". The resident was encouraged several times to allow staff to clean the wounds and change the dressings, and risk and benefits were explained multiple times. The residents' rights were respected. The family was at the bedside and aware of the resident refusing care. The Physician was notified and awaiting call back. Nurses' Notes, dated 7/10/22 at 5:28 p.m., indicated the resident had blistered areas to			

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	bilateral lower legs. A treatment was in place at this time. The doctor was updated on the status of the wounds and current treatment. A new order was received for a wound culture. Nurses' Notes, dated 7/10/22 at 6:14 p.m., indicated the bilateral leg treatment was done via day shift with the daughter present. Physician's Orders, dated 7/10/22 at 9:04 a.m., indicated to cleanse the right heel with normal saline, apply Calcium alginate to the wound and cover every shift for wound care, and document refusals. Cleanse the left heel with normal saline and apply Calcium alginate to the wound and cover every shift and document refusals. The 6/2022 Treatment Administration Record (TAR) indicated the right heel hydrocolloid was refused on 6/7, blank on 6/10 and 6/13, coded as a "7" on 6/19 and refused on 6/22/22. The left heel skin prep for the day shift was blank on 6/19, evening shift was blank on 6/10, 6/13, and 6/23/22, and blank on the midnight shift on 6/9, 6/13, 6/20, and 6/22/22. The 6/2022 TAR indicated to monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor notify physician of significant findings every shift assessment was blank on the day shift on 6/19, on the evening shift on 6/10, 6/13, 6/18, 6/23, and on the midnight shift on 6/9, 6/13, 6/20 and 6/22/22. Interview with the Director of Nursing on 7/8/22 at 1:40 p.m., indicated there was no other documentation regarding the pressure sores to the heels after 6/6/22. 3.1-40(a)(2)			

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure residents with suprapubic foley catheters had them	F 0690	Facility requests paper compliance/ Desk review	08/04/2022

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	changed on a monthly basis and nursing staff provided foley catheter care every shift for 2 of 2 residents reviewed for catheters. (Residents 44 and 90) Findings include: 1. During an interview on 7/5/22 at 2:11 p.m., Resident 44 indicated foley catheter care was not being done. The resident pulled down the bed sheet and lifted up his abdomen. He was observed with a suprapubic foley catheter. There was a large amount of dried blood and crusty skin around the stoma. The resident indicated it had not been cleaned or changed in "a while." During follow up interviews with the resident on 7/7/22 at 9:45 a.m. and on 7/8/22 at 7:43 a.m., he indicated no staff had cleaned the catheter. On 7/8/22 at 12:40 p.m., the B-Wing Unit Manager went into the resident's room for an assessment of the resident's stoma and suprapubic catheter. The linens were removed and the stoma was observed. There was a moderate amount of dried blood and crusty skin surrounding the stoma and catheter. The resident informed the Unit Manager no staff had cleaned it or placed a gauze sponge around it for quite some time. The record for Resident 44 was reviewed on 7/7/22 at 9:30 a.m. The resident was admitted to the facility on 4/14/21. He was admitted to the hospital on 5/26/22 and returned back to the facility on 6/1/22. Diagnoses included, but were not limited to, quadriplegia, bacteremia, ESBL in the urine, COPD, neuromuscular dysfunction of the bladder, and major depressive disorder. The 6/8/22 Quarterly Minimum Data Set (MDS)		F-690 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Catheter care orders were obtained for both resident 44 and 90. Catheter care was given. Appointments made for residents 44 and 90 to have their suprapubic catheter changed in July. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Residents who have catheters were identified, and an audit was completed with no other deficiencies noted. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: The DCE educated Licensed nurses to ensure that all new admissions/readmissions who have catheters have orders for catheter care, including catheter	

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	assessment, indicated the resident was cognitively intact and had an indwelling catheter. A Care Plan, revised on 6/10/22, indicated the resident had suprapubic catheter in place and was at risk for complications. A Care Plan, revised on 6/10/22, indicated the resident was at risk for complications related to use of suprapubic catheter. The nursing approaches were to provide catheter care per staff. An Urinalysis, collected on 5/30/22, indicated large amount of leukocytes and WBC (white blood cells, indicative of infection). The final culture results, on 6/2/22, indicated greater than 100,000 Escherichia Coli ESBL (bacterial organism) and greater than 100,000 of Providencia Stuarti (bacterial organism). Physician's Orders, dated 6/6/22, indicated contact isolation for ESBL in urine. There were no orders for suprapubic foley catheter care or orders when to change the foley catheter. Physician's Orders, dated 6/29/22, indicated Cefdinir (an antibiotic) capsule 300 milligrams (mg). Give 1 capsule by mouth two times a day for infection for 7 days. This was discontinued on 7/7/22. The 6/2022 and 7/2022 Treatment Administration Record (TAR) indicated there was no treatment ordered to do suprapubic catheter care every shift. An Urology consult, dated 5/27/22 while the		change per physician orders. Nursing education included setting up appointments for residents to get to the physician's office. Education will be completed by 7-30-22 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Unit managers/designee will audit all new admissions/readmissions with those residents who have catheters to ensure catheter care orders and change orders are in place this will be on ongoing process. Unit managers will audit 5 with catheters 5 weekly x 2 months, then 5 residents every other week, then 5 residents monthly until the completion of six months to ensure that catheter care is completed as ordered. Audits will be completed on different shifts and will include the weekends. Any negative trends will be reviewed in monthly QAPI program. Any Concerns will be monitored through QAPI process for a minimum of six months and until 95% compliance of achieved.	

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	resident was in the hospital, indicated the resident had a complicated Urinary Tract Infection (UTI) and was on broad spectrum antibiotics with urine cultures pending. The resident's suprapubic catheter was changed this admission and he would need monthly catheter changes as an outpatient. An Infectious Disease Nurse Practitioner Note, dated 6/30/22 at 10:08 a.m., indicated the resident was being seen for a follow-up of UTI/ESBL, recently completed antibiotics as documented previously. No adverse reaction such as loose stools or diarrhea due to Meropenem course of therapy were reported. The patient was currently on Cefdinir by his primary provider, no ESBL reported. The plan was to continue the Cefdinir as ordered by his prior provider and monitor for any adverse reactions to antibiotics. There was no documentation the resident had any follow up appointments to the Urologist's office after his readmission on 6/1/22. There was no documentation the resident had the suprapubic catheter changed since 5/27/22. Interview with the Director of Nursing on 7/11/22 at 10:50 a.m., indicated the resident's suprapubic catheter was changed in the hospital during the 5/27-6/1/22 stay. The catheter was to be changed monthly. There were no orders for foley catheter care to be done every shift. 2. During an interview with Resident 90 on 7/6/22 at 11:21 a.m., he indicated the nurses do not clean around his suprapubic catheter. He was supposed to get it replaced every 30 days, and he was having a hard time getting it replaced as he had told the nurses, however, no one had done anything about it. Observation of the catheter			

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and stoma site indicated the area was pink with no gauze sponge around the catheter.

The record for Resident 90 was reviewed on 7/7/22 at 10:55 a.m. Diagnoses included, but were not limited to, type 2 diabetes, cellulitis of left lower limb, peripheral vascular disease, high blood pressure, end stage renal disease, congestive heart failure, angina, neuromuscular dysfunction of the bladder, urine retention, anxiety disorder, and major depressive disorder.

The 5/31/22 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact, had an indwelling catheter and received dialysis.

A Care Plan, updated 6/2/22, indicated an alteration in elimination and had a suprapubic catheter for a diagnosis of neuromuscular dysfunction of his bladder and end-stage renal disease. The nursing approaches were to provide treatment to the catheter site as per order.

Physician's Orders, dated 6/23/21 and discontinued on 3/3/22, indicated to provide suprapubic catheter care with soap and water every shift and as needed, monitor for signs and symptoms of infection, odor, and color. Staff may irrigate with normal saline every shift and as needed for patency and occlusion.

There were no Physician's Orders to monitor or assess the suprapubic catheter site every shift or orders to provide foley cath care every shift at the time of readmission from the hospital on 3/7/22.

The Treatment Administration Record (TAR) for 3/2022 from 3/7 to 3/31/22, 4/2022, 5/2022, 6/2022 and 7/1-7/7/22 indicated suprapubic cath care was

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	not completed. The suprapubic catheter was changed in the hospital during the admission in 3/2022. The resident had missed an urologist appointment on 3/11/22 and it was rescheduled for 4/22/22. Nurses' Notes, dated 4/22/22 at 12:30 p.m., indicated the resident left for an appointment. Interview with the Director of Nursing on 7/12/22 at 10:00 a.m., indicated the resident had another appointment with the urologist on 5/27/22 and that was missed as well. There were no other appointments made for the resident to have his suprapubic catheter changed. An appointment was now made for 7/21/22 to have his catheter changed. During the call, the physician's office indicated the catheter was to be changed monthly. There was no documentation of any suprapubic catheter care after readmission on 3/7/22. 3.1-41(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident			

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	preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure supplements were provided as ordered for 1 of 4 residents reviewed for nutrition. (Resident 49) Finding includes: On 7/5/22 at 11:30 a.m., Resident 49 was served her lunch. She was served a pureed diet. She did not receive a magic cup nutritional supplement nor a health shake. On 7/6/22 at 11:34 a.m., the resident was again served a pureed diet for lunch. She did not receive a magic cup nutritional supplement nor a health shake. On 7/7/22 at 11:28 a.m., the resident was served juice while waiting for her meal. At 11:44 a.m., she was served her lunch. She did not receive a magic cup nor a health shake. The record for Resident 49 was reviewed on 7/7/22 at 8:47 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 5/6/22, indicated the resident was severely impaired for daily decision making. She required extensive assist for bed mobility and	F 0692	Facility Requests paper compliance/ Desk Review F-692 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 49 was given her magic cup supplement at meals, her med pass was changed to be given with medication instead of meals. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. An audit of residents who receive supplements with meals was completed with no other deficiencies noted.	08/04/2022

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	transfers and supervision with eating. A Care Plan, dated 5/5/22, indicated the resident had a diet alteration related to receiving a therapeutic, mechanically altered diet. Interventions included, but were not limited to, diet as ordered. A Physician's Order, dated 2/1/22, indicated the resident was to receive 2 cal supplement 120 cubic centimeters (cc's) with meals for supplement. A Physician's Order, dated 4/19/22, indicated the resident was to receive a magic cup with meals for a house supplement. The July 2022 Medication Administration Record (MAR), indicated the 2 cal and the magic cup had been signed out as being given three times a day on 7/5, 7/6, and 7/7/22. Interview with the Director of Nursing on 7/11/22 at 3:50 p.m., indicated the resident should have been receiving her magic cup with her meals and it was supposed to be sent from the kitchen. She also indicated she changed the 2 cal order to be given during med pass instead of meals. 3.1-46(a)(1)		What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: Dietary manager the dietary department on double checking tray cards for all supplements that are to be provided with meals. DCE nursing check tray cards for supplements and instructed that if supplement is not on meal tray to call the kitchen to get it. Education will be completed by 7-30-22 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Dietary manager/dietician/designee will audit 10 residents with dietary supplements 5 times a week x 2 months to ensure supplements are on meal trays, then 5 residents every other week for 2 months then 5 residents monthly for the duration of 6 months. Audits will include different shifts and weekends. Any negative trends will be reviewed in monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until	

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			95%compliance is achieved.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to complete a pre and post dialysis assessment for 2 of 2 resident's reviewed for dialysis. (Residents 90 and 72) Findings include: 1. The record for Resident 90 was reviewed on 7/7/22 at 10:55 a.m. Diagnoses included, but were not limited to, type 2 diabetes, cellulitis of left lower limb, peripheral vascular disease, high blood pressure, end stage renal disease, congestive heart failure, angina, neuromuscular dysfunction of the bladder, urine retention, anxiety disorder, and major depressive disorder. The 5/31/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact, has an indwelling catheter and received dialysis. A Care Plan, updated 6/2/22, indicated the resident had an alteration in kidney function due to end stage renal disease and dialysis. The nursing	F 0698	Facility request paper compliance/ Desk review F-698 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? were assessed and noted to have no adverse reactions related to the deficient practice. Pre and post dialysis forms were added to residents 90 and 72 dialysis binders. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/04/2022

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	155187	A. BUILDING 00 B. WING	07/12/2022

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

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	approaches were to monitor for edema in extremities and report any increase to Physician, pre-dialysis and post-dialysis weights at dialysis center, observe for post-dialysis hang over - vital signs, mental status, excessive weight gain between treatments, nausea, vomiting, weakness, headache, and severe leg cramps. Physician's Orders, dated 3/10/22, indicated monitor post dialysis dressing for bleeding. If bleeding noted, apply pressure dressing for 10 minutes and notify doctor. Physician's Orders, dated 3/10/22, indicated to monitor the bruit and thrill every shift. There was no Physician's Orders for a pre-dialysis assessment. Physician's Orders, dated 3/29/22, indicated Dialysis treatment on Tuesdays, Thursdays and Saturdays. The 6/2022 Medication Administration Record (MAR) indicated the bruit and thrill was blank and not completed for day shift on 6/2, 6/11, 6/16, 6/21, and 6/28/22 Interview with the B-Wing Unit Manager on 7/11/22 at 10:00 a.m., indicated a pre-dialysis assessment was to be completed by nursing staff on the communication forms that were sent with the resident to the dialysis center. The Dialysis Observation Communication Forms indicated an assessment of the resident's status such as fluid intake and output last 24 hours, any order medication changes, vital signs including weight, pain, meal eaten, access site, mental status, heart, lungs, edema, skin, and date of		action(s) will be taken: All residents who go to dialysis have the potential to be affected. A list of all dialysis residents was compiled. was completed and the corrected pre and post dialysis forms were added to residents' dialysis binders. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices not recur: The DCE/designee Licensed Nurses on completion of the pre and post dialysis forms with every dialysis day. Education will be completed by 7-30-22 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Unit managers will audit dialysis binders of residents receiving dialysis 3 times a week for the duration of 6 months to ensure that pre and post assessments are being completed. Any negative trends will be reviewed in QAPI program. Any concerns will be monitored through the QAPI process for a	

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	COVID-19 test and results. The form was to be signed and dated by the nurse. The pre-dialysis assessment indicated on 5/26, 6/7, and 6/14/22, the forms were lacking information of weight, meal eaten, access site, mental status, heart, lungs, edema, and skin concerns. On 6/18/22 the assessment was lacking information of access site, mental status, heart, lungs, and edema or skin concerns. The 7/2/22 assessment had no documentation regarding the resident's weight, access site, mental status, heart, edema, and skin. The 7/5/22 assessment had no documentation regarding the resident's temperature, weight, pain, meal eaten, access site, mental status, heart, edema and skin. The 7/7/22 was not completed. Interview with the Director of Nursing on 7/11/22 at 10:30 a.m., indicated the pre and post-dialysis forms were to be completed prior to and after dialysis. The pre-dialysis forms were incomplete.2. Resident 72's record was reviewed on 7/8/22 at 11:04 a.m. Diagnoses, included but were not limited to, high blood pressure, renal failure, diabetes mellitus, hyperlipidemia, anxiety disorder, and depression. The Admission Minimum Data Set (MDS) assessment, dated 5/13/22, indicated the resident was cognitively intact. Physician's Orders, dated 5/24/22, indicated the resident received dialysis treatments at 8:30 a.m. on Tuesday, Thursday, and Saturday each week. Physician's Orders, dated 5/7/22, indicated to complete a pre-dialysis assessment and assessment of access site for any signs and symptoms of bleeding or infection.		minimum of six months and until 95% compliance is achieved.	

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	Physician's Orders, dated 5/7/22, indicated to complete a post-dialysis assessment including monitoring for bleeding at the access site. The June 2022 Medication Administration Record (MAR), indicated the pre-dialysis assessments were not completed as ordered on 6/18/22, 6/25/22, 6/28/22, and 6/30/22. The June 2022 Medication Administration Record (MAR), indicated the post-dialysis assessments were not completed as ordered on 6/9/22. A policy, received from the Director of Nursing (DON) on 7/5/22 at 11:00 a.m., titled "Hemodialysis," indicated the facility would assure residents receiving dialysis treatment would be monitored for complications before and after dialysis treatments. The licensed nurse would communicate to the dialysis facility via telephonic communication or written format including, but not limited to, timely medication administration by the nursing home and/or dialysis facility, and physician/treatment orders, laboratory values, and vital signs. Interview with the DON on 7/8/22 at 2:48 p.m., indicated the pre-dialysis and post-dialysis assessments should have been completed as ordered. 3.1-37(a)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the			

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	highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to follow up with a resident's family regarding the continuation of behavioral health services for a resident with behaviors. (Resident 29) Finding includes: Resident 29's record was reviewed on 7/8/22 at 11:44 a.m. Diagnoses included, but were not limited to hemiplegia affecting the left side, high blood pressure, renal insufficiency, non-Alzheimer's dementia, seizure disorder, depression, bipolar disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 4/19/22, indicated the resident was cognitively intact. The resident had physical and verbal behavioral symptoms that occurred 1 to 3 days during the assessment period. Physician's Orders, dated 8/6/20, indicated behavior health services may evaluate and treat. A Social Service Note, dated 5/21/22, indicated the resident was seen by behavioral health services. The facility was unable to provide the behavioral health services note dated 5/21/22. A Nurses' Note, dated 6/2/22 at 10:27 p.m., indicated the resident was in bed yelling and	F 0740	Facility request paper compliance/ Desk review F-740 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 29 son was called and returned call to the facility and declined for his father to have Psych services. His GP was updated with recent behaviors. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. Residents with behaviors were identified and no other deficiency noted. What measure will be put into place or what systemic changes	08/04/2022

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	shaking the bed rails. The resident was threatening to harm self without ideation. The resident was placed on 15 minute checks. A Nurses' Note, dated 6/3/22 at 3:58 a.m., indicated this was a follow up on the resident's previous behaviors. A staff member was sitting and talking with the resident as an intervention along with 15 minute interval checks. The resident was offered drinks and snacks. The interventions were ineffective as the resident continued to yell and shout, cuss at staff, shake the bed rails, and an attempt was made to kick the staff member. A Social Service Note, dated 6/7/2022 at 4:42 p.m., indicated social services spoke with the resident's representative regarding the resident resuming behavior health services. The resident's representative voiced wanting to come in to visit and after spending time with him, then he would make the decision regarding the resident receiving behavior health services. A Nurses' Note, dated 6/18/22 at 5:25 p.m., indicated the resident returned to the facility from the hospital with agitation. He refused to take a COVID-19 test, breaking multiple swabs with name calling, and spit on a paramedic. The resident made threats to harm himself and was cursing at staff. A Nurses' Note, dated 6/21/22 at 9:06 a.m., indicated the resident was combative with care and was using inappropriate language. Redirection was attempted, but was unsuccessful as behaviors continued. A Nurses' Note, dated 7/6/22 at 11:34 p.m., indicated the resident was cursing and making inappropriate hand gestures at staff and throwing		will be made to ensure that the deficient practices does not recur: DON SS director and SS designee on 7-25-22 on timely follow up with families related to psych services. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: DON will audit the report for behavior charting 5 times a week to ensure all residents with behaviors have/or are offered psych services timely. This practice will be ongoing. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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	food and water. The record lacks documentation of a follow up to the resident's representative to resume behavior health services. Interview with the Social Service Director (SSD) on 7/11/22 at 10:36 a.m., indicated the resident's representative had requested the resident no longer see behavioral health services previously, but there were no notes in the chart reflecting that decision. The facility was in the process of getting the resident to see behavioral health services again, but was unsure of where they were at in the process. Interview with the SSD on 7/12/22 at 10:22 a.m., indicated the facility should have reached out to the resident's representative at an earlier time to determine if he would allow the resident to receive behavioral health services. 3.1-43(a)(1)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or			

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	§483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure insulin and oral medication were administered as ordered 2 of 5 residents reviewed for unnecessary medications. (Residents 90 and 72) Findings include: 1. The record for Resident 90 was reviewed on 7/7/22 at 10:55 a.m. Diagnoses included, but were not limited to, type 2 diabetes, cellulitis of left lower limb, peripheral vascular disease, high blood pressure, end stage renal disease, congestive heart failure, angina, neuromuscular dysfunction of the bladder, urine retention, anxiety disorder, and major depressive disorder. The 5/31/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact, had an indwelling catheter and received dialysis. In the last 7 days the resident received insulin 7 times. A Care Plan, updated 6/2/22, indicated the resident had and alteration in blood glucose due to diabetes mellitus. The nursing approaches, initiated 11/4/21, were to administer medications as ordered. Physician's Orders, dated 3/10/22, indicated	F 0757	Facility Requests paper compliance/ Desk review F-757 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 90 and 72 were assessed and noted to have no adverse reaction from the deficient practice. were updated for both residents. Resident 90 insulin orders changed. Resident 72 Coreg order changed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: A list of residents who attend dialysis was obtained. Any resident who to Dr. Appointments or with family could be affected also. Orders were	08/04/2022

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	Novolog Flex Pen Solution Pen-injector 100 Unit/Milliliters (ml) (Insulin Aspart). Inject as per sliding scale: id 71 - 180 = 0 units ; 181 - 230 = 2 units; 231 - 280 = 4 units; 281 - 330 = 6 units; 331 - 350 = 8 units ; 351 - 352 = 8 units subcutaneously (under the skin) three times a day. Physician's Orders, dated 3/10/22, indicated Levemir Solution 100 Unit/ml (Insulin Detemir). Inject 16 unit subcutaneously in the morning. Physician's Orders, dated 3/29/22, indicated dialysis treatment on Tuesdays, Thursdays and Saturdays. The 6/2022 Medication Administration Record (MAR) indicated the Novolog Flex Pen was not administered as ordered on 6/2, 6/11, 6/16, 6/21 6/28 and 6/30 for the 12:00 p.m. dose. All of those days were blank. The 8:00 a.m., dose was blank on 6/11, 6/21, 6/28, and 6/30/22. An "X" or "N/A" was in the box for the 8:00 a.m. and 12:00 p.m. doses on 6/4, 6/7, 6/9, 6/13, 6/14, 6/18, 6/22, 6/23, and 6/25/22, all indicating the insulin was not administered. The 6/2022 MAR for the Levemir Insulin indicated the scheduled time to be administered was at 7:00 a.m. There was no documentation on 6/11, 6/16 and 6/21/22. A "5" indicating LOA was coded on 6/7 and 6/18/22. The 7/2022 MAR indicated the 12:00 p.m., Novolog insulin was coded with a N/A on 7/2, 7/5, and 7/7/22. Interview with the Director of Nursing on 7/8/22 at 1:50 p.m., indicated the resident does to go dialysis on Tuesdays, Thursdays, and Saturdays. He was not in the facility for 12:00 p.m. blood		obtained for residents to hold medication while out of the building and /or may give late upon return What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: The DCE licensed nursing staff to make sure that medication orders are correct and can be held while out of building or given to the resident upon return. Education will be completed by 7-30-22 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Unit managers/designee will audit 5 residents 3 times a week for 2 months to ensure that they received medication per order, then 5 residents weekly for 2 months, then 5 residents monthly for the duration of 6 months. Audits will be completed on all shifts and will include the weekends. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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	sugar and/or the Insulin administration.2. Resident 72's record was reviewed on 7/8/22 at 11:04 a.m. Diagnoses, included but were not limited to, high blood pressure, renal failure, diabetes mellitus, hyperlipidemia, anxiety disorder, and depression. The Admission Minimum Data Set (MDS) assessment, dated 5/13/22, indicated the resident was cognitively intact. Physician's Orders, dated 5/24/22, indicated the resident received dialysis treatments at 8:30 a.m. on Tuesday, Thursday, and Saturday each week. Physician's Orders, dated 5/7/22, indicated Coreg tablet 25 milligrams by mouth two times a day. Physician's Orders, dated 5/6/22, indicated to hold the morning dose of Coreg (a blood pressure medication) on dialysis days. The June and July 2022 Medication Administration Record (MAR) indicated the resident received a dose of Coreg at 8:00 a.m. on 6/4/22 and 7/2/22, prior to dialysis. Interview with the Director of Nursing (DON) on 7/8/22 at 2:48 p.m. indicated the medication should have been held on dialysis days. 3.1-48(a)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure a resident	F 0760	Facility requests paper compliance/Desk review	08/04/2022

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	was free from significant medication errors related to the incorrect administration of insulin for 2 of 6 residents observed during medication pass. (Residents 274 and 26) Findings include: 1. On 07/11/22 at 8:47 a.m., Agency RN 1 was observed preparing to administer insulin to Resident 274. The resident's blood sugar was 285 so he was to receive 9 units of insulin. The RN obtained Lispro Insulin kwik pen from the drawer and walked into the resident's room. She dialed the pen to 9 units and removed the cap from the pen and handed the pen to the resident to administer the insulin into his abdomen. The RN did not prime the needle prior to use. The record for Resident 274 was reviewed on 7/12/22 at 11:00 a.m. Physician's Orders, dated 7/5/22, indicated Insulin Lispro (1 Unit Dial) 100 Unit/milliliter solution pen-injector. Inject as per sliding scale: if 0 - 199 = 3 units; 200 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351+ 351+, Call MD., subcutaneously before meals and at bedtime. 2. On 7/11/22 at 9:09 a.m., Agency RN 1 was observed preparing to administer medications and insulin to Resident 26. She decided to administer the insulin first, as the nurse before already had checked the resident's blood sugar. She removed a Novolog Insulin pen from the medication cart and walked into the resident's room. She dialed the pen to 35 units and indicated she was to receive a standard dose of insulin several times a day. She wiped the resident's thigh with an alcohol pad and administered the insulin. The RN did not prime the needle prior to use.		F-760 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 274 and 26 were assessed and noted to have no adverse reactions related to the deficient practice. Agency RN 1 was immediately educated on priming of insulin pens. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who receive insulin have the potential to be affected. A list of diabetic residents who receive insulin via pen was compiled. Instructions added to those orders to prime pen prior to administration. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: The DCE licensed nursing staff on	

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	Interview with Agency RN 1 at that time, indicated she had never primed an insulin pen prior to use and was unaware she needed to do so. The record for Resident 26 was reviewed on 7/12/22 at 11:10 a.m. Physician's Orders, dated 12/6/21, indicated Insulin Aspart Solution Pen-injector 100 Unit/Milliliters. Inject 35 unit subcutaneously three times a day. Interview with the Nurse Consultant on 7/11/22 at 1:15 p.m., indicated insulin pens were to be primed before use. The current 2022, "Insulin Pen" policy, provided by the Nurse Consultant on 7/11/22 at 1:15 p.m., indicated "prime the insulin pen: dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger and watch to see that at least one drop of insulin appears on the tip of the needle. If not repeat until at least one drop appears." 3.1-48(c)(2)		how to administer insulin using the insulin pen, including priming the pen prior to administration per the Insulin Pen policy. Return demonstration was completed. Education completed by 7-30-22 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Unit managers/DCE/DON/designee will audit insulin administration to 5 residents who receive insulin via insulin pen 5 times a week x 2 months then, 5 residents every other week x 2 months then 5 residents monthly for the duration of 6 months. Audits will be completed on all shifts and will include the weekend. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink			

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	155187	A. BUILDING 00 B. WING	07/12/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure food was served at a palatable temperature for 4 of 6 residents reviewed for food. (Residents 10, 39, 44, and 90) Finding includes: Interview with Resident 10 on 7/6/22 at 10:40 a.m., indicated most of the time the food was cold. The resident would eat his meals in his room. Interview with Resident 39 on 7/6/22 at 10:55 a.m., indicated the food was cold. The resident would eat in his room and the main dining room. Interview with Resident 44 on 7/5/22 at 2:15 p.m., indicated the food was always cold. The resident ate in his room. Interview with Resident 90 on 7/6/22 at 11:16 a.m., indicated the food was always cold. The resident ate in his room. On 7/8/22 at 8:00 a.m., the first breakfast cart arrived on the B wing at 8:00 a.m. At 8::06 a.m., a CNA started passing trays as well as serving beverages. At 8:36 a.m., the second cart was delivered. The last tray was passed at 9:00 a.m., and temperatures	F 0804	Facility request paper compliance/ Desk review F-804 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 10, 39, 44, and 90 were assessed and noted to have no adverse reactions to the deficient practice. Residents were all offered the chance to get up and come to the dining room for meals. Resident 39 comes to the dining room for most meals. Residents 10, 44, and 90 have declined to eat meals in the dining room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	08/04/2022

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	from the test tray were taken at that time: -scrambled eggs 117 degrees Fahrenheit -hash browns 113 degrees Fahrenheit Interview with the Administrator on 7/11/22 at 12:50 p.m., indicated the units were doing very well the last couple of months at getting the residents up for breakfast and taking them down to the dining room. These past weeks, the staff had not been getting the residents up and taking them down to the dining room. There were many agency staff on both B and C Units and it had been a challenge with making sure the trays were passed right away when they arrived to the unit. Interview with the Dietary Food Manager on 7/11/22 at 12:55 p.m., indicated the eggs and hash browns should have been warmer for the breakfast meal. 3.1-21(a)(2)		All residents have the potential to be affected. A house audit was completed cold food. 5 other residents voiced concern about the temperature of the food. Those residents were also offered to be assisted up for all meals. 2 of the 5 agreed. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices not recur: Dietary manager/dietician have re-evaluated the room tray pass to reduce the amount of time it takes to pass trays. The dietary staff will send a smaller quantity of room trays at a time to allow staff to get them passed while maintaining appropriate food temperature. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Dietary manager/dietician/designee will temp the last room tray served on different units 3 times a week x 2 months, then 3 times every other week x 2 months then monthly for the duration of 6 months. Audits	

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			will occur on different shifts and include the weekend. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional			

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	standards for food service safety. Based on observation and interview, the facility failed to serve, store, and prepare food under sanitary conditions related to food not dated when opened in the freezer, dirty ice machine lid, bowls stored improperly on storage rack, and food open to air in the food preparation area. The facility also failed to serve food under sanitary conditions related to touching resident's food with dirty, bare hands. This had the potential to affect 116 residents who received food from the kitchen. (Main Kitchen) Findings include: 1. During the brief kitchen sanitation tour, on 7/5/22 at 9:33 a.m. with the Dietary Food Manager, the following was observed: a. Four large bowls were observed stored upright on a storage rack. b. In the deep freeze, a package of egg rolls were observed with no label or open date. c. In the deep freeze, a package of used butter was observed with no label or open date. d. The ice machine lid contained an unknown brown speckled substance. 2. On 7/7/22 at 9:16 a.m., while observing the staff preparing a puree diet meal, the following was observed: On the food preparation counter, a baking sheet containing pork chops was observed to be uncovered. The staff were not observed to be preparing the pork chops at this time. The pork	F 0812	Facility requests paper compliance/ Desk review F-812 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. A house audit of residents was completed with no other residents identified. Dietary aid 1 was immediately on hand hygiene and glove wearing while touching food. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices not recur: Education was provided by dietary manager/dietician/designee on dating food when opened, sanitation of equipment, bowl	08/04/2022

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	chops were placed in the oven on 7/7/22 at 9:30 a.m. 3. On 7/7/22 at 11:12 a.m., while observing the staff preparing plates at the tray line, the following was observed: a. Dietary Aide 1 was observed touching her face with bare hands, then grabbing a plate to prepare another meal. She proceeded to set the plate down and reached underneath to a shelf containing lids. She opened a package of lids with her bare hands, reached in the package and grabbed a new lid and then covered a container with the lid. b. Dietary Aide 1 was observed to open a bag of hamburger buns with her bare hands. She proceeded to reach into the bag and retrieve two hamburger buns with her bare hands. She placed the buns on two separate plates, and placed the hamburger patties on the buns with tongs. She proceeded to reach into a container and retrieve two pieces of cheese with her bare hands and placed those onto the hamburgers. 4. On 7/7/22 at 11:45 a.m., the following was observed in the deep freezer: a. A clear bag containing cod fish was observed opened with no label or open date on the package. b. A clear bag of breaded fish filets were observed opened with no label or open date on the package. Interview with the Dietary Food Manager and the Registered Dietician on 7/7/22 at 11:45 a.m., indicated the food products in the freezer should have been properly labeled and dated, food on the preparation counter should be covered when not		storage, keeping food covered until preparation of food begins, and hand hygiene/glove wearing when handling food. Education will be completed by 7-30-22 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Dietary manager/dietician/designee will audit the kitchen for clean equipment, proper storage of dishes including bowls, food preparation including food coverage and hand hygiene and glove wearing of dietary staff 5 times a week for 2 months, then 3 times a week x 2 months then monthly for the duration of 6 months. Audits will occur on different shifts and include weekends. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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	in use, bowls should be stored upside down to prevent contamination, and the ice machine lid should be cleaned. The Dietary Aid 1 should have performed hand hygiene after touching her face and opening packages and should not have touched food with her bare hands. 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to			

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

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	necessary. Based on random observations, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not performing hand hygiene before and after glove use and the incorrect disposal of used lancets for 3 of 9 residents observed during medication pass. (Residents 274, 26, and 275) Findings include: 1. On 7/11/22 at 8:47 a.m., Agency RN 1 donned a pair of clean gloves outside of Resident 274's room. She did not perform hand hygiene. The RN was to going to check the resident's blood sugar by the way of the glucometer and administer insulin if needed. She walked into the resident's room, wiped his finger with an alcohol pad, pricked it with a lancet, and obtained the blood on the strip. She informed the resident he would need insulin and left the room to check to see how much. She walked out of the room wearing the used gloves to both hands. She threw the dirty alcohol pad and used lancet in the small brown paper bag on the side of the cart. She opened up the medication drawer and removed the insulin pen and touched the mouse on the computer with the same gloved hands. She indicated the resident was to receive 9 units of insulin. She walked back into the room still wearing the same gloves and administered the insulin. She walked out of the room and removed her gloves and threw them away in trash can on the side of the medication cart. She touched the computer and the medication cart drawer and still had not performed hand hygiene. At 9:01 a.m., she performed hand hygiene with hand sanitizer.	F 0880	Facility Requests Paper compliance/ Desk review F-880 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 274, 26, and 275 were assessed and no adverse outcome related to the deficient practices were noted. Agency RN 1 and Agency LPN 1 were immediately educated on how and when to perform hand hygiene and handwashing and when to don/doff gloves as well as disposal of used lancets in SHARPs container How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. All residents are being monitored at least daily for signs and symptoms of COVID-19/respiratory infection, no residents were noted to have been affected by the deficient practice. What measure will be put into	08/04/2022

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	At 9:09 a.m., she donned another pair of clean gloves to both hands whiled standing at the medication cart in the hallway. She removed an insulin pen and inhaler for Resident 26 and walked into the room. With the same gloved hands, she handed the inhaler to the resident to administer herself and then a cup of water to rinse her mouth. Wearing the same gloves, she wiped the resident's thigh with an alcohol wipe and administered the insulin. She walked out of the room wearing the gloves and over to the medication cart. She threw the needle into the sharp's container and removed her gloves and threw them away. She did not perform hand hygiene. Agency RN 1 proceeded to prepare the resident's oral medications at that time, however, she still had not performed hand hygiene. Interview with the Director of Nursing (DON) on 7/11/22 at 4:45 p.m., indicated hand hygiene was to be completed before donning and after doffing gloves. 2. During medication pass on 7/11/22 at 4:30 p.m., Agency LPN 1 was observed preparing and pouring a medication for Resident 275 to be administered through a peg tube (a tube directly inserted into the stomach to provide nutrition). The Agency LPN removed the medication of Propranolol (a blood pressure medication) and crushed it and poured the medication into a plastic cup. She entered the room and identified the resident. The LPN donned a clean pair of gloves to both hands and at that time, one of the gloves tore so she threw it away and walked towards the door and obtained another glove and donned it to her other hand. She did not perform hand hygiene prior to donning the gloves. The LPN administered the medication through the peg tube,		place or what systemic changes will be made to ensure that the deficient practices does not recur: The DCE/DNS/designee educated all licensed nursing staff with return demonstration related to the facility policies and procedures and CDC guidelines for PPE use related to Transmission Based Precautions, PPE donning and doffing, hand hygiene, infection control practiced regarding glucometer use and appropriate SHARPs disposal after use. All education will be completed prior to 8-4-22 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Regional Director of Clinical Operations (RDCO), IP/DCE/DNS/Designee will audit 5 random licensed nursing staff members, to include all units shifts daily or more often as necessary for 6 weeks and until compliance is maintained, then 3 times per week x 2 months then weekly x 2 months to ensure PPE is donned/doffed appropriately, hand hygiene is performed per policy and CDC guidelines, as well as that all sharps are disposed of properly in a SHARPs container after use. The RDCO/IP/DCE/DNS will perform daily visual rounds throughout the	

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	removed her gloves and washed her hands with soap and water. Interview with Agency LPN 1 at that time, indicated she thought she did perform hand hygiene prior to donning the gloves, then realized she did not and was in the bathroom to obtain the water for the flush. The current 5/2022 "Hand Hygiene" policy, provided by the DON on 7/12/22 at 10:00 a.m., indicated hand hygiene was to performed before applying and after removing personal protective equipment, including gloves. Interview with DON on 7/12/22 at 10:00 a.m., indicated there was no policy for disposal of used lancets, however, it was a nursing practice that all used lancets or needles were to be disposed of in the sharp's container. 3.1-18(b)		facility to include all units and shifts including weekends, to ensure licensed nursing staff are practicing appropriate Infection Control Practices and compliance is maintained for a least 6 weeks and until compliance is maintained, then 3 times per week x 2 months then weekly x 2 months. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to dirty floors, marred walls, doors, and heat registers, stained tiles, dusty ceiling vents, dirty light covers, and loose baseboards for 2 of 3 units. (The B wing and ACU unit) Finding includes: During the Environmental Tour with the	F 0921	Facility Requests paper compliance / Desk review. F-921--- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	08/04/2022

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	Maintenance and Housekeeping Supervisors on 7/12/22 at 10:00 a.m., the following was observed: 1. The B Wing a. On 7/7/22 at 9:45 a.m., a large amount of dirt and debris was noted on the side of bed 1 in Room 105. At 2:20 p.m., the dirt remained on the side of the resident's bed. A large amount of debris was observed on the floor, underneath the bed, and between the wall and the bed in Room 105 bed 1. Two residents resided in this room. On 7/8/22 at 7:43 a.m., the dirt remained to the side of the resident's bed. b. The doors and walls were marred in Room 112. The floor was dirty in the bathroom. Two residents resided in the room and shared the bathroom. c. The walls were marred in Room 118 and the floors were dirty. Two residents resided in this room. 2. The ACU Unit a. The heat register in Room 309 was marred on both sides. The closet door was marred at the top. The base of the bathroom door was scratched and marred. The inside of the toilet bowl was discolored and there was an accumulation of dust on the ceiling vent in the bathroom. Two people resided in the room and used the bathroom. b. The door frame to Room 316 had areas of chipped paint. The bathroom door frame was		Resident rooms: 105, 112, 118, 309, 316, 318, 319, 324, 326, and Coca Cola room and dining room were addressed immediately by repairing and cleaning all affected areas. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. All Other rooms were assessed for needed repairs and cleaning and placed on Building Engines (electronic work orders) for maintenance and housekeeping services to prioritize and complete. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: Staff will be reeducated on the resident rights policy and building engines to ensure they can submit work orders effectively. Housekeeping to be reeducated on cleaning processes and procedures Maintenance will be reeducated on	

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

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	scratched and marred. There was adhesive on the floor next to bed one from previous non-skid strips. The floor tile in the bathroom was discolored. Two residents resided in this room and shared the bathroom. c. The inside of the bathroom door in Room 318 was marred as well as the walls. By the head of bed 1, the wall was scratched and marred. Two residents resided in the room and shared the bathroom. d. The base of the heating unit in Room 319 was scratched and marred. The wall behind the head of bed 2 was scratched and marred. The baseboard was pulling away from the wall in the bathroom. Two residents resided in this room and shared the bathroom. e. The base of the heat register in Room 324 had areas of chipped paint. The floor tile was discolored in the bathroom behind the toilet and there was an accumulation of dust on the bathroom ceiling vent. Two residents resided in this room and shared the bathroom. f. The wall next to bed 1 in Room 326 was scratched and marred. The bathroom floor tile was discolored and the base board was loose. There was an accumulation of dust in the bathroom ceiling vent. Two residents resided in this room and shared the bathroom. g. The walls throughout the unit dining room were scratched and marred. The baseboards were also scratched and marred. The floor was dirty and in need of cleaning. There was also dust in the ceiling vents and debris in the plastic light covers.		completion of work orders and environmental rounding. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: An audit will be completed to determine areas of concern. The random audit will be completed by Maintenance or designee to include 5 rooms weekly for 2 months, bimonthly for 2 months, and monthly for 2 months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	h. The floor in the "Coca Cola" room was dusty and dull in appearance. The walls had areas of chipped paint and were marred in sections. A chair in the room had scratched and marred arms and legs and fabric hanging from underneath. Interview with the Maintenance Director at that time, indicated the chair needed to be thrown out. Interview with the Housekeeping Supervisor at the time, indicated all of the above were in need of cleaning and/or repair. 3.1-19(f)			