PRINTED:	08/15/2022
FORM AP	PROVED
OMB NO. (	938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE. IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE TAG F 0000 Bldg. 00 This visit was for a Recertification and State F 0000 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 0554 483.10(c)(7) SS=D Resident Self-Admin Meds-Clinically Approp Bldg. 00 §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 F 0554 Facility requests paper 08/04/2022 interview, the facility failed to ensure residents compliance/ Desk review had Physician's Orders for medications and an assessment to self-administer their own medications for 3 of 3 residents reviewed for F-554 self-administration of medication. (Residents 44, What corrective action(s) will be 60 and 263) accomplished for those residents LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
	Findings include:			found to have been affected by deficient practice?	y the	
	p.m., Resident 44 y time, he had 2 tube table. There was a Aspercreme and a On 7/722 at 9:45 a were observed on the The record for Res at 9:30 a.m. The facility on 4/14/21 hospital on 5/26/22 facility on 6/1/22.	n observation on 7/5/22 at 2:15 was observed in bed. At that as of ointments on the over bed tube of over the counter tube of Bacitracin ointment. , both tubes of ointments he over bed table. 		Residents 44, 60, and 263 wer assessed and noted to have no injury from medications left at bedside. Residents, families, a physicians updated. A medication self-administration assessment was completed or residents 44, 60, and 263 for self-administration of medication Orders obtained from physician as indicated.	o Ind n Dn. ns	
	the urine, COPD, n the bladder, and m The 6/8/22 Quarter assessment indicat intact and had an in There was no Care	euromuscular dysfunction of ajor depressive disorder. Iy Minimum Data Set (MDS) ed the resident was cognitively ndwelling catheter. Plan for the resident to		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potentia be affected. A house sweep o resident's rooms was complete	l to f all ∋d	
	There were no Phy Aspercreme or the	or ointments or medications. sician's Orders for the Bacitracin ointments. There istration of medication for the resident.		to identify any other medication that were at the bedside. No c medications were noted.		
	7/7/22, indicated the self- administer or self-administer his	B-Wing Unit Manager on he resident had no orders to an assessment to own medications. There were spercreme or Bacitracin		What measure will be put into place or what systemic change will be made to ensure that the deficient practices does not red The DEC educated nursing sta	e cur: aff,	
	2. During an inter	view with Resident 60 on 7/5/22		Letters were mailed and reside on medication administration.	ents	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE C A. BUILDING B. WING	00 00	(X3) DATE S COMPLE 07/12/2	ETED
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368		
X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	INAL	DATE
	at 11:16 a.m., a bo	ttle of an over the counter		Residents and families wer	е	
	medication of Pep	to Bismol was observed on the		educated that if they want	a	
	resident's over bed	table. The resident indicated		medication to inform nursir	ig, so	
	he would take the	medication when his stomach		that we may contact physic	cian to	
	was upset.			obtain an order. All educati	on will	
				be completed by 8-4-22. A	ny	
	On 7/6/22 11:45 a	m., and 2:00 p.m., the bottle of		resident who wishes to		
		ained on the resident's over bed		self-administer will have a		
table while he was		at dialysis.		medication self-administrat	ion	
				assessment completed. S	taff will	
On 7/7/	On 7/7/22 at 9:45	a.m., the bottle of Pepto Bismol		determine if the resident is	safe to	
	was observed on the	ne resident's over bed table.	t's over bed table. self-administer based on the	ie		
				results of the assessment.		
	The record for Res	sident 60 was reviewed on 7/8/22				
	at 1:10 p.m. Diag	noses included, but were not				
	limited to, muscle	wasting, abdominal pain, end				
	stage renal disease	, chronic kidney disease, major		How the corrective action(s	s) will be	
	depressive disorde	r, chronic pain, urine retention,		monitored to ensure the de	ficient	
	stroke, heart failur	e, anemia, anxiety, and high		practice will not recur:		
	blood pressure.					
				Resident advocates/desigr	nee will	
	The Quarterly Mir	nimum Data Set (MDS)		audit residents' rooms for		
	assessment, dated	6/30/22 indicated the resident		medications left at bedside	5	
	was cognitively in	tact.		times a week x 6 months.	lf	
				medication noted		
		Plan for the resident to		advocates/designee will		
		y medications. There were no		immediately report to nurse		
		for the Pepto Bismol and there		Audits will occur on all shift	is and	
		istration of medication		weekends.		
	assessment noted t	for the resident.				
				Any negative trends will be		
		B-Wing Unit manager on 7/7/22		reviewed in Monthly QAPI		
		cated she was unaware the		program.		
		le of Pepto Bismol on his over			.	
	bed table.			Any concerns will be monit		
	<b>.</b>			through the QAPI process		
		Director of Nursing on 7/8/22 at		minimum of six months and		
		d residents were not to have		95% compliance is achieve	ed.	
		bedside. If they wanted to				
	self-administer the	ir own medications, they				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	A. BUILDING B. WING	B. WING		DMB NO. 0938-039 TE SURVEY IPLETED 12/2022
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175 LA	ADDRESS, CITY, STATE, ZIP C ANCER ST AGE, IN 46368	COD	
X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	do so.3. On 7/5/22 cream 2.5%, an un and a package of F on Resident 263's					
	an unlabeled bottle	p.m., hydrocortisone cream 2.5%, e of antacid tablets, and a ryl capsules were noted on the table.				
	1:20 p.m. Diagnos	ord was reviewed on 7/6/22 at es included, but were not limited gh blood pressure, and diabetes				
		inimum Data Set (MDS) 6/24/22, indicated the resident tact.				
	indicated hydrocor	er, dated 7/5/22 at 3:00 p.m., rtisone cream 2.5% apply to vevery shift for rash and p at bedside.				
	indicated Benadry	er, dated 7/3/22 at 12:15 p.m., l allergy capsule 25 milligram ery four hours as needed for				
	The record lacked	an order for antacid tablets.				
	The record lacked medications assess	a self-administration of sment.				
	7/8/22 at 2:48 p.m have had a self-add assessment comple	Director of Nursing (DON) on ., indicated the resident should ministration of medications eted and corresponding orders dent to self-administer				

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

Event ID:

**KDD611** Facility ID: 000098

If continuation sheet Page 4 of 73

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					ORM APPROVED MB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/12/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD ANCER ST		
BRICKY	ARD HEALTHCAR	E – PORTAGE CARE CENTER		AGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	medications.					
	3.1-11(a)					
F 0623 SS=B Bldg. 00	Before a facility tresident, the facil (i) Notify the resider representative(s) and the reasons a language and r facility must send representative of Long-Term Care (ii) Record the re- discharge in the re- discharge in the re- accordance with section; and (iii) Include in the in paragraph (c)(s) §483.15(c)(4) Tim (i) Except as spe and (c)(8) of this transfer or dischar section must be re- 30 days before the discharged. (ii) Notice must be practicable before (A) The safety of would be endang (i)(C) of this section (B) The health of would be endang (i)(D) of this section	ents Before ge tice before transfer. ransfers or discharges a lity must- dent and the resident's of the transfer or discharge for the move in writing and in manner they understand. The d a copy of the notice to a the Office of the State Ombudsman. asons for the transfer or resident's medical record in paragraph (c)(2) of this e notice the items described 5) of this section. ning of the notice. cified in paragraphs (c)(4)(ii) section, the notice of arge required under this made by the facility at least he resident is transferred or e made as soon as e transfer or discharge when- individuals in the facility gered under paragraph (c)(1) ion; individuals in the facility gered, under paragraph (c)(1)				

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

Event ID: K

KDD611 Facility ID: 000098

If continuation sheet

sheet Page 5 of 73

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 KDD611

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

Event ID:

Facility ID: 000098

If continuation sheet

Page 6 of 73

08/15/2022 PRINTED: FORM APPROVED

NTERS FC	T OF HEALTH AND HU R MEDICARE & MEDIC		(¥2) MI II TID	LE CONSTRUCTION	F	INTED: 08/15/202 ORM APPROVED MB NO. 0938-039 E SURVEY
	N OF CORRECTION	IDENTIFICATION NUMBER		(x2) multiple construction a. building <u>00</u> b. wing		PLETED 2/2022
	PROVIDER OR SUPPLIEF	E – PORTAGE CARE CENTER	31	REET ADDRESS, CITY, STATE, ZIP COD 75 LANCER ST DRTAGE, IN 46368		
X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION DATE
	protection and ad mental disorder e Protection and Ad Individuals Act.	ency responsible for the vocacy of individuals with a stablished under the vocacy for Mentally III				
	If the information to effecting the tra facility must upda notice as soon as	anges to the notice. In the notice changes prior Insfer or discharge, the the recipients of the practicable once the on becomes available.				
	closure In the case of faci who is the admini- provide written no impending closure Agency, the Office Care Ombudsman and the resident r the plan for the tra	ice in advance of facility lity closure, the individual strator of the facility must tification prior to the e to the State Survey e of the State Long-Term h, residents of the facility, epresentatives, as well as ansfer and adequate esidents, as required at §				
	Based on record rev failed to ensure a re Responsible Party of to a transfer to the l	vere notified in writing related nospital for 4 of 5 residents	F 0623	Facility Requests paper compliance/ desk review		08/04/2022
	reviewed for hospit 68, and 97) Findings include:	alization. (Residents 39, 163,		What corrective action(s) accomplished for those re found to have been affected deficient practice?	sidents	
	1. The record for R	esident 39 was reviewed on		Residents/families of resid	lents 39,	

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)

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

Event ID:

KDD611

Facility ID: 000098

163, 68, and 97 were provided with

the state transfer forms from

recent hospitalizations.

If continuation sheet

Page 7 of 73

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULT A. BUILI B. WING	DING	NNSTRUCTION C 00	x3) date : compl 07/12/	ETED
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3	3175 LA	ADDRESS, CITY, STATE, ZIP COD ANCER ST GE, IN 46368		
X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	Т	'AG	DEFICIENCY)		DATE
		6/20/22, indicated the resident					
	was cognitively in	tact for daily decision making.			How other residents having the		
					potential to be affected by the		
		ed 4/7/22 at 8:42 a.m., indicated			same deficient practice will be		
		omplaining of acute pain to the			identified and what corrective		
		area. The resident had a			action(s) will be taken:		
		issues. The Physician was					
		sident was transported to the			All residents have the potential	to	
	hospital.				be affected. A house audit was		
					completed to identify any reside	ent	
4/14/22.	eadmitted to the facility on			who was sent to hospital in 30			
	4/14/22.				days. A State transfer form was	s	
					mailed to all families of those		
	There was no documentation indicating the resident received a copy of his transfer form.			residents who were identified.			
	Interview with the	Director of Nursing on 7/11/22					
		ated there was no documentation			What measure will be put into		
	indicating the resid	dent received a copy of his			place or what systemic changes	S	
	transfer form when	n he was sent to the hospital.			will be made to ensure that the deficient practices not recur:		
	2. The record for	Resident 163 was reviewed on					
	7/11/22 at 9:43 a.m	n. Diagnoses included, but were			Nursing staff by the		
		nentia with behavior disturbance			DCE/designee, on completion of	of	
	and disorganized s	chizophrenia.			the State transfer form with all		
					transfers/discharges. Education	n	
	· ·	nimum Data Set (MDS)			included sending a copy to		
		6/21/22, indicated the resident			hospital, copy to family/resident	t	
		term memory problems and			and original to be placed in		
	was severely impa	ired for daily decision making.			resident chart. Social Services mail copy to family.	to	
	Nurses' Notes, date	ed 5/27/22 at 4:19 p.m.,					
		ent was walking with staff in					
		her legs collapsed and she fell					
	U U	d slid down. The CNA assisted			How the corrective action(s) wil		
		floor. This had occurred at 9:20			monitored to ensure the deficie	nt	
		was unresponsive to stimuli for			practice will not recur:		
		eyes not focusing. The					
		ported to the hospital via 911.			Unit managers/designee will au		
	The resident was t	ransferred to the inpatient			all transfer/discharges that occu	ur 5	

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet Page 8 of 73

PORTAGE CARE CENTER TEMENT OF DEFICIENCIE MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION lowing her hospital ed to the facility on 6/14/22. Attation indicating the Party had received written tertansfer form. ector of Nursing on 7/11/22 d the state transfer form ed to the resident's The record for Resident 68 2 at 9:21 a.m. The resident spital on 5/17/22 and	317	TX PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	ORRECTION I SHOULD BE E APPROPRIATE APPROPRIATE Atths, then 5 ek x 2 a month for nonths. Any be reviewed in am. monitored pocess for a hs and until
MUST BE PRECEDED BY FULL <u>C IDENTIFYING INFORMATION</u> lowing her hospital ed to the facility on 6/14/22. thation indicating the Party had received written e transfer form. ector of Nursing on 7/11/22 d the state transfer form ed to the resident's The record for Resident 68 2 at 9:21 a.m. The resident spital on 5/17/22 and	PREFI	IX       PROVIDES PLAN OF CC         G       (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)         times a week x 2mon times every other we months then 5 times the completion of 6 m negative trends will b Monthly QAPI progra         Any concerns will be through the QAPI programinimum of six month	order how     COMPL       E APPROPRIATE     DAT       oths, then 5     DAT       ek x 2     a month for       nonths. Any     Dereviewed in       or     monitored       occess for a     hs and until
C IDENTIFYING INFORMATION lowing her hospital ed to the facility on 6/14/22. thation indicating the Party had received written e transfer form. ector of Nursing on 7/11/22 d the state transfer form ed to the resident's The record for Resident 68 2 at 9:21 a.m. The resident spital on 5/17/22 and		times a week x 2mon times a week x 2mon times every other we months then 5 times the completion of 6 m negative trends will b Monthly QAPI progra Any concerns will be through the QAPI pro minimum of six mont	a month for nonths. Any be reviewed in am. monitored pocess for a hs and until
ed to the facility on 6/14/22. ntation indicating the Party had received written transfer form. ector of Nursing on 7/11/22 1 the state transfer form ed to the resident's The record for Resident 68 2 at 9:21 a.m. The resident spital on 5/17/22 and		times every other we months then 5 times the completion of 6 m negative trends will b Monthly QAPI progra Any concerns will be through the QAPI pro minimum of six mont	ek x 2 a month for nonths. Any be reviewed in am. monitored pocess for a hs and until
cility on 5/19/22. She had sion on 6/23/22 and was at were not limited to, low ith behaviors, homicidal sorder with delusions, atrial betes, osteomyelitis of the ongestive heart failure, ease, high blood pressure, roke, anxiety disorder, der, and anemia. Data Set (MDS) he resident was severely naking. The resident was appetite, and was easily cted care 1 to 3 days during The resident was an person physical assist with personal hygiene, and (17/22 at 7:15 p.m., had been complaining of			
in some recent of the recent o	th behaviors, homicidal order with delusions, atrial etes, osteomyelitis of the ngestive heart failure, ease, high blood pressure, toke, anxiety disorder, ler, and anemia. Data Set (MDS) ne resident was severely taking. The resident was ppetite, and was easily ted care 1 to 3 days during The resident was an person physical assist with personal hygiene, and 17/22 at 7:15 p.m., ad been complaining of d bilateral lower nt was crying and indicated	th behaviors, homicidal order with delusions, atrial etes, osteomyelitis of the ngestive heart failure, asse, high blood pressure, toke, anxiety disorder, ler, and anemia. Data Set (MDS) ne resident was severely taking. The resident was ppetite, and was easily ted care 1 to 3 days during The resident was an person physical assist with personal hygiene, and 17/22 at 7:15 p.m., ad been complaining of d bilateral lower nt was crying and indicated	th behaviors, homicidal order with delusions, atrial etes, osteomyelitis of the ngestive heart failure, aase, high blood pressure, toke, anxiety disorder, ler, and anemia. Data Set (MDS) ne resident was severely taking. The resident was ppetite, and was easily ted care 1 to 3 days during The resident was an person physical assist with personal hygiene, and 17/22 at 7:15 p.m., ad been complaining of d bilateral lower nt was crying and indicated

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. KDD611 Event ID: Facility ID: 000098 Page 10 of 73 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

				FORM APPROVED
				OMB NO. 0938-039
		· /		(X3) DATE SURVEY
F CORRECTION			00	COMPLETED
	155187	B. WING		07/12/2022
OVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COD	
OVIDER OR SUFFLIEF	< compared with the second sec	3175 L/	ANCER ST	
RD HEALTHCARE	E – PORTAGE CARE CENTER	PORTA	GE, IN 46368	
SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
A Progress Note, da indicated the reside hospital and report The record lacked of transfer form being resident or to the re Interview with the I 7/8/22 at 2:48 p.m. any further docume transfer form. 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii) 3.1-12(a)(6)(A)(iii) 483.21(a)(1)-(3) Baseline Care Pla §483.21(a)(1)-(3) Baseline Care Pla §483.21(a)(1)-(3) Base	ated 7/6/22 at 8:42 p.m., nt was transferred to the was called to the hospital. documentation of the State sent in writing with the sident's representative. Director of Nursing (DON) on indicated she could not provide entation regarding the State an hensive Person-Centered ne Care Plans e facility must develop and line care plan for each des the instructions needed e and person-centered care at meet professional ity care. The baseline care within 48 hours of a ion. himum healthcare isary to properly care for a , but not limited to- ased on admission orders. ers. S.			
	MEDICARE & MEDIC OF DEFICIENCIES F CORRECTION OVIDER OR SUPPLIEN RD HEALTHCARE SUMMARY (EACH DEFICIEN REGULATORY OF A Progress Note, di indicated the reside hospital and report The record lacked of transfer form being resident or to the re Interview with the I 7/8/22 at 2:48 p.m. any further docume transfer form. 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii) 3.1-12(a)(6)(A)(iii) 483.21(a)(1)-(3) Baseline Care Pla §483.21(a)(1)-(3) Baseline Care Pla §483.21(a)(1) The implement a base resident that inclu to provide effectiv of the resident that standards of quali plan must- (i) Be developed of resident including (A) Initial goals ba (B) Physician orde (C) Dietary orders (D) Therapy servic (E) Social service	F CORRECTION       IDENTIFICATION NUMBER 155187         OVIDER OR SUPPLIER         RD HEALTHCARE – PORTAGE CARE CENTER         SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION         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)         A83.21(a)(1)-(3)         Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §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	MEDICARE & MEDICAID SERVICES       X1) PROVIDER/SUPPLIER/CLIA       X2) MULTIPLE CA         GO F DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA       X2) MULTIPLE CA         F CORRECTION       IDENTIFICATION NUMBER       A. BUILDING         B. WING	WEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       NJ PROVIDERSUPPLIER CLIA         SUBMICIENCIES       ABUILDING         DENTIFICATION NUMBER       A. BUILDING         OUDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP COD         RD HEALTHCARE – PORTAGE CARE CENTER       STREET ADDRESS, CITY, STATE, ZIP COD         SIMMARY STATEMENT OF DEFICIENCIE       ID         (EACH DEFICIENCY MIST BE PRECEDED BY FULL       PORTAGE, IN 46368         SIMMARY STATEMENT OF DEFICIENCIE       ID         (EACH DEFICIENCY MIST BE PRECEDED BY FULL       PREGULATORY OR LSC DENTIFYING INFORMATION         REGULATORY OR LSC DIENTIFYING INFORMATION       TAG         Despital and report was called to the hospital.       TAG         The record lacked documentation of the State transfer form.       TAG         3.1-12(a)(6(A)(ii))       AB2.21(a)(1)-(3)         Baseline Care Plan       State transfer form.         3.1-12(a)(6(A)(iii))       AB3.21(a)(1)-(3)         Baseline Care Plan       State transfer form.         Stata 21(a) Baseline Care Plans       State transfer form.         Stata 21(a) (1) The facility must develop and implement abseline care plan for each resident was fan fore schores         resident that meet professional standards of quality care. The baseline care plan must-         (i) Be developed within 48 hours of a

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

Event ID: KDI

KDD611 Facility ID: 000098

00098 If c

If continuation sheet Page

Page 11 of 73

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155187		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	comprehensive c baseline care pla plan- (i) Is developed y resident's admiss (ii) Meets the req paragraph (b) of f paragraph (b)(2)( §483.21(a)(3) Th resident and their summary of the b includes but is not (i) The initial goa (ii) A summary o and dietary instru (iii) A summary o and dietary instru (iii) Any services administered by t acting on behalf of (iv) Any updated details of the com necessary. Based on record re failed to develop a hours of admission care plans were rev Finding includes: Resident 97's recon 3:31 p.m. The resid on 5/26/22. Diagno limited to, parapleg neurogenic bladder anxiety, depression The Admission Mi	uirements set forth in this section (excepting i) of this section). The facility must provide the representative with a baseline care plan that of limited to: Is of the resident. If the resident's medications ctions. and treatments to be he facility and personnel	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.	s	

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

Event ID: KDD611 Facility ID: 000098

If continuation sheet Page 12 of 73

		CAID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 07/12/2022
BRICKY	1	E – PORTAGE CARE CENTER	3175 L PORT <i>A</i>	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIEVING DIEORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	<ul> <li>was cognitively int assistance for most including bed mobi and toileting.</li> <li>The record lacked of Care Plan created w</li> <li>Interview with the 7/8/22 at 2:48 p.m.</li> </ul>	R LSC IDENTIFYING INFORMATION act and required extensive activities of daily living ility, transfer, personal hygiene, documentation of a baseline within 48 hours of admission. Director of Nursing (DON) on indicated she could not provide entation regarding the baseline	TAG	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 change will be made to ensure that the deficient practices does not red Licensed nursing staff were educated by the DCE/designed completing the base line care p within 48 hours of admission. How the corrective action(s) wi monitored to ensure the deficient practice will not recur: Unit managers will audit all admissions to ensure that baseline care plans are complet within 48 hours. This practice to be ongoing Any negative trends will be reviewed in Monthly QAPI program.	es sur: e on plan Il be ent

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet Page 13 of 73

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE	<sup>R</sup> E – PORTAGE CARE CENTER	3175	i address, city, state, zip cod LANCER ST FAGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		
				Any concerns will be monito through the QAPI process for minimum of six months and 95% compliance is achieved	or a until	
F 0657 SS=E Bldg. 00	<ul> <li>§483.21(b)(2) A dimust be-</li> <li>(i) Developed wit of the comprehending of the comprehending of the comprehending of the comprehending of the representative of the resident.</li> <li>(C) A nurse aide resident.</li> <li>(D) A member of staff.</li> <li>(E) To the extent participation of the representative of the representative of the representative is for the developming of the representative is for the developming of the representative of the repr</li></ul>	and Revision prehensive Care Plans comprehensive care plan hin 7 days after completion asive assessment. In interdisciplinary team, that it limited to physician. hurse with responsibility for with responsibility for the food and nutrition services practicable, the e resident and the resident's . An explanation must be dent's medical record if the e resident and their resident determined not practicable ent of the resident's care riate staff or professionals in ermined by the resident. revised by the eam after each assessment, a comprehensive and assessments. view and interview, the facility	F 0657	Facility request paper compl	liance/ 08/04/20	

IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONGTRUCTION	
OF CORRECTION		$(\Lambda 2)$ MULTIPLE C		X3) DATE SURVEY
		A. BUILDING	00	COMPLETED
	155187	B. WING		07/12/2022
DOVIDED OD SUDDI IE	D	STREET	ADDRESS, CITY, STATE, ZIP COD	
PROVIDER OR SUPPLIE	ĸ	3175 L	ANCER ST	
ARD HEALTHCAR	E – PORTAGE CARE CENTER	PORT	AGE, IN 46368	
SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E COMPLETION
		TAG	DEFICIENCY)	DATE
Responsible Party	were invited to attend and		F-657 What corrective action(s	s)
participate in care	planning conferences for 7 of 7		will be accomplished for those	
residents reviewed	for participation in care		residents found to have been	
planning. (Resider	nts 10, 39, 84, 44, 60, 90, and 16)		affected by the deficient	
			practice? Resident # 84, 10, 39	),
Findings include:			60, 90, 44, and 16 and respons	sible
			parties if applicable were invite	
1. Interview with	Resident 10 on 7/8/22 at 8:28		attend a care plan to be held in	
a.m., indicated he l	had not participated in any care		July 2022.	
	-		How other residents having the	e
			•	
The record for Res	ident 10 was reviewed on 7/7/22		-	
at 2:52 p.m. Diagr	noses included, but were not			
				be
			-	
The Annual Minim	num Data Set (MDS)			
			coordinator and invitations were	e
			sent out with dates and times o	of
			scheduled care plan meetings	to
The resident's Qua	rterly MDS assessments, dated		residents and families. What	
	-		measure will be put into place of	or
	-			
			made to ensure that the deficie	ent
A General Note, da	ated 4/21/22 at 4:15 p.m.,			
	-			
				·
				s
	-			
			-	
_			-	
			-	nd
There was no docu	mentation indicating if the			
	e			
conference.			_	ina
Interview with the	Director of Nursing on 7/11/22			are
	-			
	ARD HEALTHCAR SUMMARY (EACH DEFICIE) REGULATORY O Responsible Party participate in care presidents reviewed planning. (Resident Findings include: 1. Interview with 1 a.m., indicated he leconferences and he invited to a care conditional to a care conditicare to a care conditional to care. The resid	ARD HEALTHCARE – PORTAGE CARE CENTER         SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION         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	ARD HEALTHCARE - PORTAGE CARE CENTER       3175 I         PORT.       SUMMARY STATEMENT OF DEFICIENCIE       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         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.         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 an 0/21/22 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 11:3	3175 LANCER ST       PORTAGE, IN 46368       SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION     D       Responsible Party were invited to attend and participate in care planning conferences for 7 of 7     F-657 What corrective action(% will be accomplished for those residents reviewed for participation in care planning. (Resident 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.     How other residents having the potential to be affected by the same deficient practice? Resident # 84, 10, 35 60, 90, 44, and 16 and response parties if applicable were invite attend a care plan to be held in July 2022.       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.     How other residents having the potential to be affected by the same deficient practice will be same deficient practice will be residents have the potential to affected. Upcoming care plan dates reviewed with MDS coordinator and invitations were was cognitively intact.     How other residents have the potential to plate the potential to affected. Upcoming care plan dates reviewed with MDS coordinator and invitations were sent out with dates and times or scheduled care plan meetings. What measure will be put into place or what systemic changes will be made to ensure that the deficie and residents 2 weeks prior to care plan attened as ble, forme plans are needed to be held sooner families and residents and/or his family attended the care conference.       A General Note, dated 4/21/22 at 4:15 p.m., in

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet Page 15 of 73

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CC A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 07/12/2022
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368	
BRICKY (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O just his family. 2. Interview with a.m., indicated he meetings. The record for Res 7/11/22 at 11:47 a. were not limited to overactive bladder The Quarterly Mir assessment, dated was cognitively in A General Note, d indicated the Interva a Care Plan meetir of care. The reside invitation via mail reviewed and upda was completed on There was no docu resident and/or his conference. Interview with the at 3:50 p.m., indicate conferences. She o	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Resident 39 on 7/6/22 at 10:54 was not invited to his Care Plan bident 39 was reviewed on .m. Diagnoses included, but o, cerebral palsy, low back pain, ., and neurogenic bladder. timum Data Set (MDS) 6/20/22, indicated the resident tact for daily decision making. ated 3/18/22 at 5:16 p.m., disciplinary Team (IDT) met for ng to review the resident's plan ent's family was sent an . The resident's Care Plan was ted as needed. The same entry 10/5/21. umentation indicating if the family attended the care Director of Nursing on 7/11/22 ated the resident should have	ID PREFIX TAG	AGE, IN 46368 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) minutes tool in PCC to document. How the correct action(s) will be monitored to ensure the deficient practice not recur: The DON/Design Audit the care plan schedule times a week x 6 months to ensure that invitations are ar correct documentation is bei completed. Any negative tre will be reviewed in Monthly O program. Any concerns will to monitored through the QAPI process for a minimum of six months and until 95% compl is achieved.	ive will ee will two ad ng ands QAPI be
	9:51 a.m. Diagnos	rd was reviewed on 7/7/22 at ses included, but were not limited aut behavior disturbance and ive.			

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			INSTRUCTION		TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155187	A. BUILDING <u>00</u> B. WING			_	COMPLETED 07/12/2022	
		155187	B. V	VING		_ 077	12/2022	
NAME OF	PROVIDER OR SUPPLIEF	ł			ADDRESS, CITY, STATE, ZIP C	OD		
					ANCER ST			
BRICKY	ARD HEALTHCARE	E – PORTAGE CARE CENTER		PORTA	GE, IN 46368			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLET	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		mum Data Set (MDS)						
		/15/22, indicated the resident						
		g term memory problem and red for daily decision making.						
	was severery impai	red for daily decision making.						
	A General Note, da	ted 6/9/22 at 2:55 p.m.,						
	indicated the Interd	isciplinary Team (IDT) met for						
	a Care Plan meeting	g to review the resident's plan						
		nt's family was sent an						
	invitation via mail.	The resident's Care Plan was						
	reviewed and updat	ed as needed. The same entry						
	was completed on 1	/7/22.						
	There was no docur	mentation indicating if the						
		ended the care conference.						
	Interview with the	Director of Nursing on 7/11/22						
		ated documentation should						
		ed if the resident's wife had						
	-	lan meeting. 4. During an						
		at 2:10 p.m., Resident 44						
		t been invited to attend a care						
	planning conferenc	е.						
	The record for Pee	dent 44 was reviewed on 7/7/22						
		esident was admitted to the						
		He was admitted to the						
		and returned back to the						
	-	Diagnoses included, but were						
		riplegia, bacteremia, ESBL in						
	-	euromuscular dysfunction of						
		jor depressive disorder.						
		jor depressive disorder.						
	The 6/8/22 Quarter	ly Minimum Data Set (MDS)						
	assessment, indicat							
	cognitively intact a	nd had an indwelling catheter.						
	A Social Service Pr	ogress Note, dated 8/19/21 at						
		l "IDT (Interdisciplinary Team)						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	CON	te survey Mpleted 12/2022
	PROVIDER OR SUPPLIE	E – PORTAGE CARE CENTER	3175 LA	ADDRESS, CITY, STATE, ZIP C ANCER ST GE, IN 46368	COD	
X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION neeting to review resident plan	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	of care. Resident f Resident currently Resident code stat Resident care plar needed]. Will foll A Social Service I 4:17 p.m., indicate to review resident sent invitation via planned long term place as FULL CC	amily sent invitation via mail. planned long term care. us in place as Full Code. Is reviewed and updated prn [as				
	2:27 p.m., indicate to review resident sent invitation via planned long term place as FULL CC	Progress Note, dated 6/2/22 at ed "IDT met for care plan meeting plan of care. Resident family mail. Resident currently care. Resident code status in DDE. Resident care plans ated prn. Will follow up prn."				
	regarding the Care	umentation in the clinical record Plan meeting, if the resident content that was reviewed.				
	at 11:25 a.m., indi	Director of Nursing on 7/11/22 cated there was no e resident attended the Care				
		view on 7/5/22 at 11:02 a.m., ated he had not been invited or an conference				
		sident 60 was reviewed on 7/8/22 noses included, but were not				

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

Event ID: KDD611 Facility ID: 000098

If continuation sheet Page 18 of 73

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 7/11/22at 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 KDD611 Event ID: Facility ID: 000098 Page 19 of 73 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/15/2022 PRINTED: FORM APPROVED

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION		TE SURVEY IPLETED
		155187	B. WING	<u></u>	07/12/2022	
	PROVIDER OR SUPPLIE		3175 L	ADDRESS, CITY, STATE, ZIP CO ANCER ST	D	
BRICKY	ARD HEALTHCAR	E – PORTAGE CARE CENTER	PORTA	AGE, IN 46368		
X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	to a care conference time.	e or attended one in a long				
	at 10:55 a.m. Diag limited to, type 2 c limb, peripheral va pressure, end stag heart failure, angin	ident 90 was reviewed on 7/7/22 gnoses included, but were not liabetes, cellulitis of left lower iscular disease, high blood e renal disease, congestive ia, neuromuscular dysfunction ne retention, anxiety disorder, ve disorder.				
	assessment, indica cognitively intact,	erly Minimum Data Set (MDS) ted the resident was had an indwelling catheter and In the last 7 days the resident times.				
	4:55 p.m., indicate met for care plan n of care. Resident fa Resident currently Resident code state	rogress Note, dated 12/14/21 at d "IDT (Interdisciplinary Team) neeting to review resident plan amily sent invitation via mail. planned long term care. Is in place as DNR. Resident d and updated prn. Will follow				
	1:11 p.m., indicate to review resident sent invitation via care plan and decis Resident currently Resident code state	rogress Note, dated 4/14/22 a d "IDT met for care plan meeting plan of care. Resident family mail. Resident involved with sions regarding care plans. planned long term care. as in place as DNR Resident d and updated prn. Will follow				
	regarding the Care	mentation in the clinical record Plan meeting, if the resident ontent that was reviewed.				

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet

ion sheet Page 2

Page 20 of 73

	T OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	È Í	JILDING	DINSTRUCTION 00	(X3) DATE COMP 07/12	
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER		3175 LA	ADDRESS, CITY, STATE, ZIP COD ANCER ST IGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	at 11:25 a.m., indic	Director of Nursing on 7/11/22 cated there was no resident attended the Care					
	12:45 p.m., indicat Service Director, v and informed her t meetings and the c During an interview	Administrator on 7/11/22 at ed he had spoken to the Social who was new to Long Term Care, o document who attended the ontent that was reviewed. 7. w on 7/5/22 at 11:35 a.m., ted she had not been invited to					
	1:09 p.m. Diagnos	rd was reviewed on 7/7/22 at ses included, but were not ood pressure, depression, and ementia.					
		imum Data Set (MDS) 6/11/22, indicated the resident itively impaired.					
	indicated the Intero a Care Plan meetin	ted 4/18/22 at 1:10 p.m., disciplinary Team (IDT) met for g to review the resident's plan ident's family was sent an					
	indicated the IDT in review the resident	ted 6/9/22 at 3:44 p.m., met for a Care Plan meeting to 's plan of care and the 'as 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.

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet

Page 21 of 73

08/15/2022

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE	<sup>R</sup> E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 0677 SS=D Bldg. 00	<ul> <li>7/11/22 at 11:33 a. were generic and cresident or resident meeting.</li> <li>3.1-35(a)</li> <li>483.24(a)(2)</li> <li>ADL Care Provid §483.24(a)(2) Are carry out activitie necessary servic nutrition, groomir hygiene;</li> <li>Based on observat interview, the facilit residents received (activities of daily care for 3 of 4 resi (Residents 49, 98, Findings include:</li> <li>1. On 7/5/22 at 11 her lunch. She wa not receive a magin nor a health shake. not eaten any of he provided cueing of On 7/6/22 at 11:34 served a pureed direceive a magic cu health shake. At 1 eaten any or her for cueing or assistance.</li> </ul>	:30 a.m., Resident 49 was served s served a pureed diet. She did c cup nutritional supplement At 11:45 a.m., the resident had er food and had not been assistance by staff. • a.m., the resident was again et for lunch. She did not p nutritional supplement nor a 1:45 a.m., the resident had not od and had not been provided	F 0677	Facility Requests paper compliance/ Desk review F-677 What corrective action(s) will be accomplished for those resident found to have been affected by deficient practice? Residents 49 and 98 were place together at a table for meals and staff have been assigned to ass 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	ts the ed d ist d	

	NT OF DEFICIENCIES OF CORRECTION	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CO A. BUILDING B. WING	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/12/2022
	PROVIDER OR SUPPLIE	E – PORTAGE CARE CENTER	3175 LA	ADDRESS, CITY, STATE, ZIP COD ANCER ST GE, IN 46368	
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG		PR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	noses included, but were not obstructive pulmonary disease		identified and what corrective action(s) will be taken:	
		entia without behavior		( )	
	disturbance.			An audit of all residents' finge	ernails
				was completed and any need	
	The Quarterly Mir	nimum Data Set (MDS)		or wanting their nails cut or	0
	assessment, dated	5/6/22, indicated the resident		cleaned were addressed at th	ne
		ired for daily decision making.		time of the audit. An audit of	
	She required exter	sive assist for bed mobility and		residents receiving suppleme	ents at
	transfers and super	rvision with eating.		meals was completed no othe	er
				deficiencies noted. An audit o	of
	The Care Plan, dat	ted $5/3/22$ , indicated the resident		residents needing assistance	with
	had a physical fun	ctioning deficit related to		eating was identified. All need	ding
	impaired cognition	and weakness. Interventions		to be assisted will be assisted	d to
	included, but were	not limited to, provide		dining room for meals as	
	cues and physical	ing as needed. Provide verbal assistance as needed to		tolerated. If then staff will as rooms.	sist in
	complete the task.				
	T	$\mathbf{D}_{investorn} = \mathbf{f} \mathbf{N}_{investorn} = \mathbf{r} \cdot 7 / 11 / 22$		What measure will be put into	
		Director of Nursing on 7/11/22		place or what systemic change	
	-	ated the resident should have e and/or cueing with her meal.		will be made to ensure that th deficient practices not recur:	le
	2. On 7/5/22 at 11	:30 a.m., Resident 98 was served		Dietary staff were in serviced	bv
		at was cut up by staff at that		dietary double checking tray	
		ew bites of her food and then		for all supplements that are to	
		at any more. At 11:45 a.m., the		provided for meals. Nursing	
	-	ved no cueing and/or assistance		were in serviced, by the chec	
	from staff.	-		the tray card when the meal i	-
				delivered to ensure ordered	
	On 7/6/22 at 11:30	a.m., the resident was served		supplements are on the tray.	If the
	her lunch. She too	k a few bites of her food and		supplement is not on the tray	,
	then proceeded to	not eat anymore. At 11:45 a.m.,		they are to call the kitchen to	get
		ceived no cueing and/or		it. Education will be complete	ed by
	assistance from sta	aff.		7-30-22. Table arrangement	s have
				been reworked to place those	
		sident 98 was reviewed on		need assistance with feeding	
		n. Diagnoses included, but were		together and staff assigned to	
		blaced fracture of the right		assist them. Shower sheets	
	femur, Alzheimer	s disease, and dementia without		been modified to include nail	care

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet Page 23 of 73

CENTERS FOR MEDICARE & MEDICAID SERVICES

## PRINTED: 08/15/2022 FORM APPROVED

OMB	NO	0938-039
OMD	110.	0,30-037

ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155187	A. BUILDING B. WING		07/12	leted 2/2022	
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	317	EET ADDRESS, CITY, STATE, ZIP ( 5 LANCER ST RTAGE, IN 46368	COD		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE				PROVIDER'S PLAN OF COI	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFL	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETION	
TAG	1	R LSC IDENTIFYING INFORMATION	TAG			DATE	
	behavior disturban	ce.		which is to be signed of	-		
				providing the shower a	at least 2		
	-	ange Minimum Data Set (MDS)		times weekly.			
		5/2/22, indicated the resident					
	-	paired for daily decision					
		red extensive assist with bed			·· · · · · · ·		
	mobility, transfers,	and eating.		How the corrective act			
	The Core Dian dat	ed 6/1/22, indicated the resident		monitored to ensure th			
		ctioning deficit related to		practice will not recur:			
		ent and recent hip fracture.		Dietary			
		ded, but were not limited to,		manager/dietician/des	ianee will		
		with eating as needed.		audit 10 residents with	-		
	-	s and physical assistance as		supplements 5 times a	•		
	needed to complete			ensure supplements a			
				trays for 2 months, the			
	Interview with the	Director of Nursing on 7/12/22		residents 5 times ever			
		tted the resident should have		week x 2 months then	-		
	been provided assis	stance or cueing with her		residents 5 times a we	ek monthly		
	meals. 3. During an	n interview on 7/6/22 at 10:35		to complete 6 months.			
	a.m., Resident 103	indicated she had asked for her					
		and cut for the last two weeks,		Unit manager/designe	e will audit		
		ot helped her. The resident's		10 residents' fingernai			
	nails were observed	d to be long and dirty.		week x 2 months, ther			
				residents' fingernails 5	-		
		ord was reviewed on 7/7/22 at		other week x 2 months			
	e e	ses included, but were not		residents' fingernails r	nonthly to		
	-	ood pressure, heart failure,		complete 6 months.			
	anxiety, and depres	ssion.		Linit managar/daaigna	o will oudit 5		
	The Admission Mi	nimum Data Set (MDS)		Unit manager/designe residents who require			
		6/1/22, indicated the resident		with eating 5 times a v			
		assistance with personal		months to ensure staff			
	hygiene and bathin			assisting them, then 5			
	., 8	e		every other week x 2 r			
	Interview with the	C-Wing Unit Manager on		5 residents monthly to			
		, indicated nail care was to be		months. The unit mar			
		owers or bathing, but it was not		update the list of resid	-		
	_	er sheet. The C-Wing Unit		needed. All audits wil			
		she would be addressing the		different shifts and inc			

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175	i address, city, state, zip cod LANCER ST FAGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Weekend.	(X5) COMPLETION DATE	
	A Progress Note, c	lated 7/7/22 at 3:35 p.m., ent was provided care to		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 un 95% compliance is achieved.	а	
<sup>-</sup> 0684 SS=E Bldg. 00	applies to all treat facility residents. comprehensive a facility must ensu- treatment and ca professional stan comprehensive p and the residents Based on observat interview, the facil bruising and cellul monitored. The fa rails were padded	a fundamental principle that tment and care provided to Based on the ssessment of a resident, the tre that residents receive re in accordance with dards of practice, the erson-centered care plan, ' choices. ton, record review, and ity failed to ensure areas of itis were assessed and cility also failed to ensure side in a timely manner and	F 0684	Facility requests paper compliance/ desk review F-684	08/04/202	
	ordered for 4 of 4	mpleted and signed out as residents reviewed for skin essure related). (Residents 112,		What corrective action(s) will b accomplished for those reside found to have been affected by deficient practice?	nts	
	1. On 7/5/22 at 11	:04 a.m., Resident 112 was		Resident 112 side rails were padded on 7-7-22. Resident 1	12 is	

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/12/2022
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	observed with a dro	essing to her right hand. She		no longer in the facility. Res	ident
	had reddish/purple	bruising to her left hand and		68, and order was obtained for	or
	left and right forear	rms. There was also an area of		treatment to her bi- lower legs	s.
	reddish/purple disc	oloration to the resident's right		Resident 263 was assessed a	and
	temple area.			treatment in place per order,	
				Resident 106 was assessed,	and
		a.m., the resident was observed		treatment was in place per or	der.
		n the dining area. The			
		resident's arms and temple			
	area remained. She	e was wearing a short sleeve			
	shirt at that time.			How other residents having the	ne
				potential to be affected by the	•
		.m. and 10:28 a.m., the resident		same deficient practice will be	e
		r room in bed. Her assist rails		identified and what corrective	
	-	At 11:28 a.m., the resident was ner wheelchair in the unit		action(s) will be taken:	
	dining room. The	resident's eyes were closed.		All residents have the potenti	al to
	She was wearing a	short sleeved shirt and the		be affected. A skin sweep of	
	areas of discolorati	on were visible to her arms and		residents was completed on	
	hands. The resident	t was taken back to her room at		7-14-22 and 7-15-22. No nev	v skin
	11:30 a.m. At 11:3	5 a.m., the resident was sleeping		issues were identified. All cu	rrent
	in her bed. The ass	sist side rails were now padded		areas have orders in place.	AII
	with black foam.			interventions in place.	
		ident 112 was reviewed on			
		Diagnoses included, but were			
	· 1	ated falls, dementia without		What measure will be put into	
	behavior disturband	ce, and anxiety.		place or what systemic change	
	The Original D.C.	mum Data Set (MDS)		will be made to ensure that the	
	· ·	imum Data Set (MDS)		deficient practices do not reci	ur:
		5/24/22, indicated the resident		Lipping nurses have have '	
		paired for daily decision		Licensed nurses have been in	
		red limited assistance with bed ers. The resident was also		serviced on documenting are	
				discoloration immediately, as	
		g skin tears and having		as ensuring the intervention is	
	non-surgical dressi	ngs appneu.		into place immediately. Licer	
	A Change of Cond	ition Note dated 6/26/22 at		nurses have been in serviced	
		ition Note, dated 6/26/22 at ed the resident was found on		ensuring that treatment order	
	-	ht side in the "Coca Cola" room		in place at the time of admiss and/or at the time a wound is	
		in side in the Coca Cola 100III			

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

Event ID: KDD611 Facility ID: 000098

If continuation sheet Page 26 of 73

PRINTED: 08/15/2022 FORM APPROVED

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE S COMPLE 07/12/2	TED
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION
TAG	next to her wheeled touching the wall. I A Change of Cond a.m., indicated the for help. She was a the hallway floor o resident was comple with movement. T arms and hands rent to the emergency rent The Weekly Skin A indicated there was discoloration to the A Change of Cond p.m., indicated the bruise measuring 3 right temple. The I and yellow in color have had two recern leaned to the right positioning would I Physician's Orders, bruise to the reside monitored every shi be padded. Interview with the at 9:39 a.m., indicated have been completed the assist rails show the order was recein Resident 68 was of by her bed. There	Assessment, dated $7/4/22$ , s no documentation related to	TAG	<ul> <li>DEFICIENCY)</li> <li>noted. Licensed nurses in soon completion and document of all treatments as well as of treatments. Education we given to Licensed nurses represent to assess or dress any wounds. Educt will be completed by 7-30-24.</li> <li>How the corrective action(sononitored to ensure the definition of the ensure the definition of the ensure the definition of the ensure treatments are in plat this will be an ongoing procord unit managers/designee will of 5 residents with active treatments 5 times a week for months then 5 residents even other week x 2 months there residents monthly until the completion of 6 months to ensure treatments are completed a ordered. Audits will occur of shifts and include the week All risk management will be an ongoing process.</li> <li>Any negative trends will be an ongoing process.</li> </ul>	erviced ntation refusal as ggarding make ss and ation 2 ) will be ficient audit unds to ace ess. Il audit for 2 ery 5 ensure s n all ends. DT g. IDT ion is is are bing	DATE

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

Event ID: KDD611 Facility ID: 000098

If continuation sheet Page 27 of 73

PRINTED: 08/15/2022 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				ON	AB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A.B	UILDING	00	COMP	LETED
		155187	B. W	ING		07/12	2/2022
				STREET A	ADDRESS, CITY, STATE, ZIP CO	D	
NAME OF P	ROVIDER OR SUPPLIER	Ł.		3175 LA	NCER ST		
BRICKYA	RD HEALTHCARE	– PORTAGE CARE CENTER		PORTA	GE, IN 46368		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ver her shin. The bandage on			program.		
	her left leg was soll	ed with dried bloody drainage.			A		
	0				Any concerns will be mo		
	-	.m., the resident was seated in			through the QAPI proces		
		er room. Both lower legs were ame soiled ace bandages as			minimum of six months		
		e right bandage was around			95% compliance is achie	eved.	
		ame open and red areas noted					
		leg bandage remained soiled					
	with dried bloody d						
	with affed blobdy a	runiuge.					
	On 7/8/22 at 7:45 a.	.m., the resident was observed					
		s closed. Both lower legs were					
	observed out from u	inder the sheets. The same					
	ace bandages were	in place as previously					
	observed.						
		B-Wing Unit Manager on					
		n., indicated the resident had					
		eatments and would not allow					
	anyone to observe h	ner skin.					
	The record for Resi	dent 68 was reviewed on 7/8/22					
		sident was admitted to the					
		and returned back to the					
	-	She had another hospital					
		22 and was readmitted on					
	7/5/22.						
	D' ' 1 1 1	1					
	-	, but were not limited to, low					
	-	with behaviors, homicidal					
		be disorder with delusions, atrial					
	• •	liabetes, osteomyelitis of the , congestive heart failure,					
	-	disease, high blood pressure,					
		i, stroke, anxiety disorder,					
	major depressive di	-					
	major acpressive ar	server, una unennia.					
	The 5/28/22 Minim	um Data Set (MDS)					
		ed the resident was severely					
	•	·					<u> </u>
RM CMS-2567(02	-99) Previous Versions Ob	osolete Event ID:	KDD611	Facility I	D: 000098 If contin	nuation sheet Pa	age 28 of 73

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

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. Event ID: KDD611 Facility ID: 000098 Page 29 of 73 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 Event ID: KDD611 Facility ID: 000098 Page 30 of 73 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/15/2022 PRINTED: FORM APPROVED

EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						RM APPROVED 1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175 L/	ADDRESS, CITY, STATE, ZIP CO ANCER ST AGE, IN 46368	D	
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	was received for a Nurses' Notes, data indicated the bilate day shift with daug Physician's Orders indicated to apply on bilateral lower I dressing, and wrap There were no Phy treatment for the corresident had been r was no continued of nursing staff trying and/or treat the res The Treatment Ad the month of 7/202	ed 7/10/22 at 6:14 p.m., eral leg treatment was done via ghter present. , dated 7/10/22 at 8:47 a.m., Silvadene cream to open areas legs, cover with non adherent o with kerlix every shift. resician's Orders for any type of ellulitis prior to 7/10/22 after the readmitted to the facility. There documentation regarding g every day and shift to assess ident's cellulitis. ministration Record (TAR) for 22 indicated an order, dated				
	symptoms of infect warm, discharge, co of significant findi assessment was sig 7/6-7/10/22. Interview with the 7/12/22 at 10:30 a. many times during treat the resident's treatments for the of readmitted. Now, done every shift, so the next shift woul Interview with the 1:40 p.m., indicate	skin/wounds for signs and tion such as swelling, redness, odor and to notify the physician ngs every shift. The gned out as being completed B-Wing Unit Manager on m., indicated she had tried so the day shift to assess and/or cellulitis. There were no cellulitis when the resident was the current treatment must be o if the resident refused then d try. Director of Nursing on 7/8/22 at d there were no Physician's ulitis, however, the resident had				

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet

ion sheet Page 31 of 73

]	DEPARTMENT OF HEALTH AND HUN	MAN SERVICES	
	CENTERS FOR MEDICARE & MEDIC.	AID SERVICES	
	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL

	F OF HEALTH AND HU					F	INTED: 08/15/2022 ORM APPROVED MB NO. 0938-039
NTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         IDENTIFICATION NUMBER         155187		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DAT COM	(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	•	3175 L/	ADDRESS, CITY, STATE, ZIP C ANCER ST .GE, IN 46368	DD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF not allowed any nu since she had been to assess the area e resident's lower leg bacterial infection 263's record was re Diagnoses included	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> rsing staff to assess her legs back. There was no treatment very day or to even look at the gs due to the diagnosis of of the lower legs. 3. Resident eviewed on 7/6/22 at 1:20 p.m. d, but were not limited to, heart pressure, and diabetes mellitus.		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	The Admission Mi assessment, dated ( was cognitively int	nimum Data Set (MDS) 5/24/22, indicated the resident					

	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,					
FORM CMS-2567	(02-99) Previous Versions Obsolete Event ID:	KDD611	Facility ID:	000098	If continuation sheet	Page 32 of 73

	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
	STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155187			DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/12/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD ANCER ST		
BRICKY	ARD HEALTHCAR	E – PORTAGE CARE CENTER		AGE, IN 46368		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	assessment, dated ( was cognitively int Physician's Orders, cleanse bilateral he apply kenalog crea	imum Data Set (MDS) 5/21/22, indicated the resident act. dated 6/14/22, indicated els with normal saline, pat dry, m, cover with polymem foam, kerlix every day shift every				
	June 2022, indicate	ninistration Record (TAR) for ed the bilateral heel treatment as completed on 6/16/22, 2.				
	-	dated 6/14/22, indicated apply ilateral feet every evening shift.				
	June 2022, indicate cream to bilateral f	ninistration Record (TAR) for ed the application of Eucerin eet was not signed out as (22, 6/21/22 and 6/26/22.				
	7/8/22 at 2:48 p.m. provide any further	Director of Nursing (DON) on , indicated she could not information regarding the lateral heels and feet.				
	3.1-37(a)					
F 0686 SS=D Bldg. 00	Ulcer §483.25(b) Skin I §483.25(b)(1) Pre Based on the con a resident, the fac					

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet

Page 33 of 73

PRINTED: 08/15/2022 FORM APPROVED

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155187 B. WING 07/12/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE. IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 F 0686 Facility requests paper 08/04/2022 interview, the facility failed to ensure a resident compliance/ desk review with pressure ulcers received the necessary F-686 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) What corrective action(s) will be accomplished for those residents Finding includes: found to have been affected by the deficient practice? On 7/6/22 at 11:44 a.m., Resident 68 was observed sitting in a wheelchair by her bed. There were Resident 68 has current treatment white ace bandages noted to both lower legs. The orders for areas to bi- heels. right bandage was around her ankle and there Treatments are rendered as were open and red blistered areas all over her resident allows. Attempts are shin. The bandage on her left leg was soiled with made on all shifts if she refuses. dried bloody drainage. Skin assessment completed. 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 How other residents having the before. The right bandage was around her ankle potential to be affected by the with the same open and red areas. The left leg same deficient practice will be bandage remained soiled with dried bloody identified and what corrective drainage. . action(s) will be taken: On 7/8/22 at 7:45 a.m., the resident was observed All residents have the potential to

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.

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

Event ID:

KDD611

Facility ID: 000098

be affected. A list of residents

with wounds was identified. Those residents were audited. and all

If continuation sheet

Page 34 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155187		(X2) MULTIPLE C A. BUILDING B. WING	00	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLII	<sup>ER</sup> RE – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O Interview with the 7/12/22 at 10:00 a refused all of her t anyone to observe	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION P-Wing Unit Manager on m., indicated the resident had treatments and would not allow ther skin.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) were noted to have current treatment orders in place. What measure will be put into	
	hospital on 5/17/2 facility on 5/19/22 admission on 6/23 7/5/22. Diagnoses include	resident was admitted to the 2 and returned back to the 2. She had another hospital 1/22 and was readmitted on 24, but were not limited to, low		place or what systemic chang will be made to ensure that the deficient practices does not re- Licensed nurses were in servi- by the DCE to obtain treatment orders for residents with wour	e ecur: icced nt nds
	ideations, psychot fibrillation, type 2 right ankle and for peripheral vascula cellulitis, chest pa major depressive of	tia with behaviors, homicidal ic disorder with delusions, atrial diabetes, osteomyelitis of the ot, congestive heart failure, rr disease, high blood pressure, in, stroke, anxiety disorder, disorder, and anemia.		timely. In servicing included t completion of treatments per of and documentation of comple or refusals. Education include attempting dressing changes each shift if resident refuses. Education completed by 7-30-	order tion ed on
	assessment, indica impaired for decis depressed, had a p annoyed. She had the assessment pe extensive assist w bed mobility, dres toilet use. She had vascular ulcers. The Care Plan, da ulcer, actual, due	mum Data Set (MDS) ated the resident was severely ated the resident was severely ated the resident was severely ated to appetite, and was easily aterestication of the resident was an aterestication of the re		How the corrective action(s) w monitored to ensure the defici practice will not recur: Wound nurse/designee will au and assess new admissions to ensure treatment orders are in place this will be an ongoing process. Wound nurse/design will audit 5 residents with wou 5 times a week x 2 months to ensure dressings are in place	ient udit o n nee inds
	left heel and a Sta heel. The Nursing signs and sympton redness, warm, an	ge 2 pressure ulcer to the right g approaches were to monitor for ns of infection such as swelling, d discharge, and skin check bathing and treatments as		then 5 residents every other w x 2 months, then 5 residents monthly for the duration of 6 months. Unit managers/desig will audit TAR's/skin assessm	nee

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet Page 35 of 73

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/12/2022		
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE – PORTAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3175 LANCER ST PORTAGE, IN 46368				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C ordered. Weekly Skin Revi resident refused of Weekly Skin Revi documented Week was on 6/7/22, wh not allow nurse to see necrotic area t allow this nurse to see necrotic area t allow this nurse to A Weekly Skin Rev 6/10/22, indicated palpation of bulla. surrounding mass. and the area was f to monitor for cha measured 11.5 cer centimeters in leng serous fluid. The next Weekly S indicated the resid this time. Nurses' Notes, dat staff attempted 3 t feet for open areas to encourage the r her. Nurses' Notes, dat the resident appro- narcotics, stating s after breakfast. Sh without an order f very angry and lef to go to the hospit	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION ew Assessments indicated the in 4/26/22. There were no ews for 5/2022. The next cly Skin Review Assessment ich indicated "Resident would assess skin, was only able to o left heel. Resident would not o measure or treat." eview Assessment, dated the resident felt no pain upon No redness or irritation There was no foul odor noted irm to touch. Staff will continue nge in size and color. Bulla atimeters in depth and 13.9 gth and was filled with clear Skin Review was on 6/24/22 and ent remained hospitalized at ed 6/3/22 at 4:33 p.m., indicated imes to assess the resident's is with refusal. Staff will continue esident to let a nurse assess ed 6/5/22 at 2:59 p.m., indicated ached the nurse while counting she wanted to go to the hospital e was told she could not go from the physician. She became it the unit. Later, she requested al because her feet were noles in them. Upon	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) of 5 residents with active treatments 5 times a week fo months then 5 residents ever other week x 2 months then 5 residents monthly until the completion of 6 months to en treatments and skin assessm are completed as ordered. Au will include all shifts and weekends. Any negative trer will be reviewed in Monthly Q program. Any concerns will be monitore through the QAPI process for minimum of six months and u 95% compliance is achieved.	r 2 y 5 sure leents udits hds JAPI ed r a intil		

TAG     REGULATORY OR LSC IDENTIFYING INFORMATION     TAG     Distribution       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 an 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 left was a 0.5 cm by 0.5 cm scabbed area		OF CORRECTION			DNSTRUCTION 00	COM	te survey Mpleted 12/2022
PRETX TAG       (EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION A necrotic area on the heal with no bleeding, the right foot was swollen with no bleeding, but had a small dry red area.       PREFX       Constrained to the second to the second particular to the second to the second to the second to the second the resident may propelling hersel 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 fool yesterday but it is much better and thar'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 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 ack had necrotic area measuring 3 centimeters (cm) by 4 cm. The helwas intact with no redness noted to the would 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 0.5 cm by 0.5 cm seabbed area				3175 L/	ANCER ST	COD	
Intervition of the heal 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 hen 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 for wound care, however, the resident for measuring 3 centimeters (cm) by 4 cm. The left heel had a hard here or of as 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 helw as 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 seabbed area	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC DATE
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		a necrotic area on right foot was swo small dry red area. Nurses' Notes, date the resident was pr with socks and sho the resident and as feet, as the nurses area to her heels. S reason to be lookin swollen [pointed to is much better and had an area on her be notified to get a refused an assessm was notified and in identified a necroti- resident's declinati- order was obtained assess. Nurses' Notes, date therapy attempted wound care, howe Nurses' Notes, date indicated the Dired assess and measure left heel had a dark centimeters (cm) b no redness noted to heel, identified as open area surround skin. There was a to the side of the o made aware and no the right heel.	the heel with no bleeding, the llen with no bleeding, but had a ed 6/6/22 at 8:30 a.m., indicated ropelling herself in the hallway bes on. The writer approached ked if she could look at her were concerned she had an the responded "There is no ng at my feet. This one was to her right foot] yesterday but it that's it." Staff explained if she foot, the doctor would need to the reatment. The resident again thent of her feet. The physician offormed that the nurse had ic area on her left heel and the on of an assessment. A new and continue to attempt to ed 6/6/22 at 10:08 a.m., indicated to assess the resident for ver, the resident refused. ed 6/6/22 at 12:30 p.m., ctor of Nursing was able to e the areas on both feet. The c hard necrotic area measuring 3 y 4 cm. The heel was intact with to the wound bed. The right a Stage 2, had a 1 cm by 1 cm led by hard colored peeling 0.5 cm by 0.5 cm scabbed area pen area. The physician was ew treatments were obtained for				

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 Event ID: KDD611 Facility ID: 000098 Page 38 of 73 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/15/2022 PRINTED: FORM APPROVED

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 Event ID: KDD611 Facility ID: 000098 Page 39 of 73 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

**CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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)Event ID: KDD611 Facility ID: 000098 Page 40 of 73 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/15/2022 PRINTED: FORM APPROVED

	T OF HEALTH AND HU R MEDICARE & MEDIC			FORM APPROVED OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155187	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIEI	R E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
= 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Ind §483.25(e) Incont §483.25(e) Incont §483.25(e)(1) The resident who is co bowel on admissi assistance to mai or her clinical con that continence is §483.25(e)(2)For incontinence, bas comprehensive as ensure that- (i) A resident who an indwelling cath unless the residen demonstrates tha necessary; (ii) A resident who indwelling cathete one is assessed f as soon as possit clinical condition of catheterization is (iii) A resident wh receives appropri to prevent urinary restore continence, §483.25(e)(3) For incontinence, bas comprehensive as ensure that a resi bowel receives ap services to restor function as possit Based on observati interview, the facility	continence, Catheter, UTI inence. a facility must ensure that on receives services and ntain continence unless his dition is or becomes such not possible to maintain. a resident with urinary ed on the resident's assessment, the facility must enters the facility without heter is not catheterized ht's clinical condition t catheterization was b enters the facility with an er or subsequently receives or removal of the catheter ble unless the resident's demonstrates that necessary; and o is incontinent of bladder ate treatment and services tract infections and to e to the extent possible. T a resident with fecal ed on the resident's assessment, the facility must dent who is incontinent of opropriate treatment and e as much normal bowel	F 0690	Facility requests paper compliance/ Desk review	08/04/2022	

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

Event ID: KDD611 Facility ID: 000098

If continuation sheet Page 41 of 73

DEPARTMENT OF HEALTH AND HUMAN SERVICES	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155187 B. WING 07/12/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE. IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE changed on a monthly basis and nursing staff F-690 provided foley catheter care every shift for 2 of 2 residents reviewed for catheters. (Residents 44 and 90) Findings include: What corrective action(s) will be accomplished for those residents 1. During an interview on 7/5/22 at 2:11 p.m., found to have been affected by the Resident 44 indicated foley catheter care was not deficient practice? being done. The resident pulled down the bed sheet and lifted up his abdomen. He was Catheter care orders were observed with a suprapubic foley catheter. There obtained for both resident 44 and was a large amount of dried blood and crusty skin 90. Catheter care was given. around the stoma. The resident indicated it had Appointments made for residents not been cleaned or changed in "a while." 44 and 90 to have their suprapubic catheter changed in July. 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 How other residents having the indicated no staff had cleaned the catheter. potential to be affected by the same deficient practice will be On 7/8/22 at 12:40 p.m., the B-Wing Unit Manager identified and what corrective went into the resident's room for an assessment of action(s) will be taken: the resident's stoma and suprapubic catheter. The linens were removed and the stoma was observed. Residents who have catheters There was a moderate amount of dried blood and were identified, and an audit was crusty skin surrounding the stoma and catheter. completed with no other The resident informed the Unit Manager no staff deficiencies noted. had cleaned it or placed a gauze sponge around it for quite some time. The record for Resident 44 was reviewed on 7/7/22What measure will be put into at 9:30 a.m. The resident was admitted to the place or what systemic changes facility on 4/14/21. He was admitted to the will be made to ensure that the hospital on 5/26/22 and returned back to the deficient practices does not recur: facility on 6/1/22. Diagnoses included, but were not limited to, quadriplegia, bacteremia, ESBL in The DCE educated Licensed the urine, COPD, neuromuscular dysfunction of nurses to ensure that all new the bladder, and major depressive disorder. admissions/readmissions who have catheters have orders for The 6/8/22 Quarterly Minimum Data Set (MDS) catheter care, including catheter KDD611

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

Event ID:

Facility ID: 000098

If continuation sheet

Page 42 of 73

PRINTED: 08/15/2022 FORM APPROVED

OMB NO. 0938-039

#### CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE assessment, indicated the resident was change per physician orders. cognitively intact and had an indwelling catheter. Nursing education included setting up appointments for residents to A Care Plan, revised on 6/10/22, indicated the get to the physician's office. resident had suprapubic catheter in place and was Education will be completed by at risk for complications. 7-30-22 A Care Plan, revised on 6/10/22, indicated the resident was at risk for complications related to use of suprapubic catheter. The nursing How the corrective action(s) will be approaches were to provide catheter care per monitored to ensure the deficient staff. practice will not recur: An Urinalysis, collected on 5/30/22, indicated Unit managers/designee will audit large amount of leukocytes and WBC (white all new admissions/readmissions blood cells, indicative of infection). The final with those residents who have culture results, on 6/2/22, indicated greater than catheters to ensure catheter care 100,000 Escherichia Coli ESBL (bacterial organism) orders and change orders are in and greater than 100,000 of Providencia Stuarti place this will be on ongoing (bacterial organism). process. Unit managers will audit 5 with catheters 5 weekly x 2 Physician's Orders, dated 6/6/22, indicated contact months, then 5 residents every isolation for ESBL in urine. other week, then 5 residents monthly until the completion of six There were no orders for suprapubic foley months to ensure that catheter catheter care or orders when to change the foley care is completed as ordered. catheter. Audits will be completed on different shifts and will include the weekends. Any negative trends Physician's Orders, dated 6/29/22, indicated Cefdinir (an antibiotic) capsule 300 milligrams will be reviewed in monthly QAPI (mg). Give 1 capsule by mouth two times a day for program. infection for 7 days. This was discontinued on 7/7/22. Any Concerns will be monitored through QAPI process for a The 6/2022 and 7/2022 Treatment Administration minimum of six months and until Record (TAR) indicated there was no treatment 95% compliance of achieved. ordered to do suprapubic catheter care every shift.

An Urology consult, dated 5/27/22 while the

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

KDD611 Event ID:

Facility ID: 000098

If continuation sheet

Page 43 of 73

08/15/2022 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 7/11/22at 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 Event ID: KDD611 Facility ID: 000098 Page 44 of 73 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/15/2022 PRINTED: FORM APPROVED

OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE	E – PORTAGE CARE CENTER		3175 LA	ddress, city, state, zip NCER ST GE, IN 46368	, COD	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION icated the area was pink with no ind the catheter.		TAG	DEPICIENCY		DATE
	at 10:55 a.m. Diag limited to, type 2 d limb, peripheral va pressure, end stag heart failure, angin of the bladder, urin and major depress The 5/31/22 Quart assessment indicat intact, had an indv dialysis. A Care Plan, upda alteration in elimin	sident 90 was reviewed on 7/7/22 gnoses included, but were not diabetes, cellulitis of left lower ascular disease, high blood e renal disease, congestive na, neuromuscular dysfunction ne retention, anxiety disorder, ive disorder. erly Minimum Data Set (MDS) ed the resident was cognitively velling catheter and received ted 6/2/22, indicated an nation and had a suprapubic nosis of neuromuscular					
	dysfunction of his disease. The nurs	bladder and end-stage renal ing approaches were to provide theter site as per order.					
	discontinued on 3/ suprapubic cathete every shift and as symptoms of infect	a, dated 6/23/21 and 3/22, indicated to provide or care with soap and water needed, monitor for signs and tion, odor, and color. Staff may al saline every shift and as y and occlusion.					
	assess the suprapu orders to provide f	visician's Orders to monitor or bic catheter site every shift or oley cath care every shift at the on from the hospital on 3/7/22.					
	3/2022 from 3/7 to	ministration Record (TAR) for 9 3/31/22, 4/2022, 5/2022, 6/2022 icated suprapubic cath care was					

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 7/12/22at 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 483.25(g)(1)-(3) SS=D Nutrition/Hydration Status Maintenance Bldg. 00 §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 KDD611

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

Event ID:

Facility ID: 000098

If continuation sheet

Page 46 of 73

FORM APPROVED

PRINTED:

08/15/2022

DEPARTMENT	OF HEALTH	I AND HUN	IAN SERVIC	CES

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155187 B. WING 07/12/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE. IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 F 0692 Facility Requests paper 08/04/2022 interview, the facility failed to ensure supplements compliance/ Desk Review were provided as ordered for 1 of 4 residents reviewed for nutrition. (Resident 49) F-692 Finding includes: What corrective action(s) will be On 7/5/22 at 11:30 a.m., Resident 49 was served accomplished for those residents her lunch. She was served a pureed diet. She did found to have been affected by the not receive a magic cup nutritional supplement deficient practice? nor a health shake. Resident 49 was given her magic On 7/6/22 at 11:34 a.m., the resident was again cup supplement at meals, her

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

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

Event ID:

KDD611 Facility ID: 000098

med pass was changed to be

meals.

given with medication instead of

How other residents having the

potential to be affected by the same deficient practice will be

identified and what corrective

All residents have the potential to

be affected. An audit of residents who receive supplements with

meals was completed with no

other deficiencies noted.

action(s) will be taken:

If continuation sheet

Page 47 of 73

PRINTED:

08/15/2022

STATEMEN	Γ OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLET	ED
		155187	B. WING		07/12/20	22
NAME OF PI	ROVIDER OR SUPPLIEI	2	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF T	COVIDER OR SOLLEIE			ANCER ST		
BRICKYA	RD HEALTHCARE	E – PORTAGE CARE CENTER	PORT	AGE, IN 46368		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	C C	OMPLETI
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	transfers and super-	vision with eating.				
				What measure will be put into		
	A Care Plan, dated	5/5/22, indicated the resident		place or what systemic chang	es	
	had a diet alteration	related to receiving a		will be made to ensure that th	e	
	therapeutic, mechai	nically altered diet.		deficient practices does not re	ecur:	
	Interventions include	led, but were not limited to,				
	diet as ordered.			Dietary manager the dietary		
				department on double checkin	na	
	A Physician's Orde	r, dated 2/1/22, indicated the		tray cards for all supplements	-	
		eive 2 cal supplement 120 cubic		are to be provided with meals		
		vith meals for supplement.		DCE nursing check tray cards		
		ini menio foi supprement.		supplements and instructed th		
	A Physician's Orde	r, dated 4/19/22, indicated the		supplement is not on meal tra		
	-	eive a magic cup with meals for			y lo	
				call the kitchen to get it.		
	a house supplement	L.		Education will be completed b 7-30-22	ру	
	The July 2022 Med	ication Administration Record		1 00 22		
	(MAR), indicated t	he 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.		How the corrective action(s) w	vill be	
				monitored to ensure the defic		
	Interview with the	Director of Nursing on 7/11/22		practice will not recur:		
		ted the resident should have		·····		
	-	magic cup with her meals and it		Dietary		
		sent from the kitchen. She		manager/dietician/designee w	/ill	
	~ ~	hanged the 2 cal order to be		audit 10 residents with dietary		
		ass instead of meals.		supplements 5 times a week		
	5. ven during med p	ass moteau of meals.		months to ensure supplement		
	3.1-46(a)(1)					
	5.1-40(a)(1)			are on meal trays, then 5	r.)	
				residents every other week for		
				months then 5 residents month	niy	
				for the duration of 6 months.	:a.	
				Audits will include different sh		
				and weekends. Any negative		
				trends will be reviewed in mor	nthly	
				QAPI program.		
				Any concerns will be monitore	ed	
				through the QAPI process for		
				minimum of six months and u		

STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155187		(X2) MULTIPLE ( A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/12/2022		
	PROVIDER OR SUPPLIE	<sup>R</sup> E – PORTAGE CARE CENTER	3175	t address, city, state, zip cod LANCER ST FAGE, IN 46368	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) 95%compliance is achieved.	COMPLETION DATE
F 0698 SS=D Bldg. 00	require dialysis re consistent with p practice, the com care plan, and th preferences. Based on record re failed to complete assessment for 2 o dialysis. (Residen Findings include: 1. The record for 1 7/7/22 at 10:55 a.m not limited to, type lower limb, periph pressure, end stag heart failure, angir of the bladder, urin and major depressi The 5/31/22 Quart assessment, indica cognitively intact, received dialysis. A Care Plan, upda resident had an alto to end	ensure that residents who eccive such services, rofessional standards of prehensive person-centered e residents' goals and eview and interview, the facility a pre and post dialysis f 2 resident's reviewed for ts 90 and 72) Resident 90 was reviewed on n. Diagnoses included, but were e 2 diabetes, cellulitis of left eral vascular disease, high blood e renal disease, congestive na, neuromuscular dysfunction ne retention, anxiety disorder,	F 0698	<ul> <li>Facility request paper complete Desk review</li> <li>F-698</li> <li>What corrective action(s) will accomplished for those reside found to have been affected deficient practice?</li> <li>were assessed and noted to no adverse reactions related deficient practice.</li> <li>Pre and post dialysis forms wadded to residents 90 and 72 dialysis binders.</li> <li>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</li> </ul>	l be lents by the o have to the vere 2 the e e

PRINTED: 08/15/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION X	3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING	00	COMPLETED
155187		B. WING		07/12/2022	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP COD	
	1	E – PORTAGE CARE CENTER		AGE, IN 46368	
(X4) ID		A STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
IAU		o monitor for edema in	IAG	action(s) will be taken:	DAIL
	**	port any increase to Physician,			
		ost-dialysis weights at dialysis		All residents who go to dialysis	
		r post-dialysis hang over - vital		have the potential to be affected.	
		s, excessive weight gain		A list of all dialysis residents was	
	-	s, nausea, vomiting, weakness,		compiled. was completed and th	
	headache, and sev	ere leg cramps.		corrected pre and post dialysis	
				forms were added to residents'	
	Physician's Orders	s, dated 3/10/22, indicated		dialysis binders.	
	monitor post dialy	sis dressing for bleeding. If			
	bleeding noted, ap	ply pressure dressing for 10			
mir	minutes and notify	v doctor.			
			What measure will be put into		
	Physician's Orders, dated 3/10/22, indicated to			place or what systemic changes	
	monitor the bruit a	and thrill every shift.		will be made to ensure that the	
				deficient practices not recur:	
	-	sician's Orders for a pre-dialysis			
	assessment.			The DCE/designee Licensed	
	DI CLOI			Nurses on completion of the pre	
		s, dated 3/29/22, indicated on Tuesdays, Thursdays and		and post dialysis forms with ever	У
	Saturdays.	on Tuesdays, Thursdays and		dialysis day. Education will be completed by 7-30-22	
	Saturdays.			completed by 7-30-22	
	The 6/2022 Medic	ation Administration Record			
	(MAR) indicated t	he bruit and thrill was blank and			
	-	day shift on 6/2, 6/11, 6/16, 6/21,		How the corrective action(s) will	be
	and 6/28/22			monitored to ensure the deficient	
				practice will not recur:	
		B-Wing Unit Manager on			
		.m., indicated a pre-dialysis		Unit managers will audit dialysis	
		be completed by nursing staff		binders of residents receiving	
		tion forms that were sent with		dialysis 3 times a week for the	
	the resident to the	dialysis center.		duration of 6 months to ensure	
				that pre and post assessments	
		rvation Communication Forms		are being completed. Any negativ	ve
		sment of the resident's status		trends will be reviewed in QAPI	
		e and output last 24 hours, any		program.	
		changes, vital signs including			
		eaten, access site, mental		Any concerns will be monitored	
	status, neart, lungs	s, edema, skin, and date of		through the QAPI process for a	

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet Page 50 of 73

	R MEDICARE & MEDIC.						OMB NO. 0938-0
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	A. BUILDING <u>00</u> COMP		ATE SURVEY DMPLETED 7/12/2022		
	PROVIDER OR SUPPLIER			3175 L	ADDRESS, CITY, STATE, ZIP	COD	
BRICKY	ARD HEALTHCARE	- PORTAGE CARE CENTER		PORTA	AGE, IN 46368		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLET
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	COVID-19 test and signed and dated by	results. The form was to be the nurse.			minimum of six month 95% compliance is ac		
	<ul> <li>6/7, and 6/14/22, the information of weig mental status, heart, concerns. On 6/18/2 information of accellungs, and edema or assessment had no corresident's weight, accedema, and skin. The documentation regatemperature, weight mental status, heart, was not completed.</li> <li>Interview with the I at 10:30 a.m., indicate forms were to be condialysis. The pre-dimension of the pre-dimension of the second status of the second status of the second status of the second status of the second second status of the second status of the second se</li></ul>	c, pain, meal eaten, access site, , edema and skin. The 7/7/22 Director of Nursing on 7/11/22 ated the pre and post-dialysis mpleted prior to and after alysis forms were ent 72's record was reviewed Diagnoses, included but high blood pressure, renal llitus, hyperlipidemia, anxiety ssion.					
	on Tuesday, Thursd	alysis treatments at 8:30 a.m. lay, and Saturday each week. dated 5/7/22, indicated to					
	complete a pre-dial	ysis assessment and s site for any signs and					

PRINTED: 08/15/2022

CAID SERVICES		
X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION
IDENTIFICATION NUMBER	A. BU	ILDING <u>00</u>
155187	B. WI	NG
R	•	STREET ADDRESS, CITY, STATE, ZIP COD 3175 LANCER ST
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	X1) PROVIDER/SUPPLIER/CLIA X2) MU IDENTIFICATION NUMBER A. BU 155187 B. WI

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155187	A. BU B. W		00	COMPLETED 07/12/2022	
	PROVIDER OR SUPPLI ARD HEALTHCAF	<sup>ER</sup> RE – PORTAGE CARE CENTER		3175 LA	.ddress, city, state, zip coi NCER ST GE, IN 46368	)	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
	complete a post-d	s, dated 5/7/22, indicated to ialysis assessment including beding at the access site.					
	(MAR), indicated	edication Administration Record the pre-dialysis assessments ed as ordered on 6/18/22, 6/25/22, /22.					
	(MAR), indicated	edication Administration Record the post-dialysis assessments ed as ordered on 6/9/22.					
	(DON) on 7/5/22 "Hemodialysis," i assure residents re would be monitor after dialysis treat would communic telephonic commu- including, but not administration by	I from the Director of Nursing at 11:00 a.m., titled ndicated the facility would ecceiving dialysis treatment ed for complications before and ments. The licensed nurse ate to the dialysis facility via unication or written format limited to, timely medication the nursing home and/or nd physician/treatment orders, and vital signs.					
	indicated the pre-	e DON on 7/8/22 at 2:48 p.m., dialysis and post-dialysis ld have been completed as					
	3.1-37(a)						
<sup>=</sup> 0740 SS=D Bldg. 00	Each resident m must provide the	th Services oral health services. ust receive and the facility e necessary behavioral health as to attain or maintain the					

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155187 B. WING 07/12/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE. IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. Facility request paper compliance/ Based on record review and interview, the facility F 0740 08/04/2022 failed to follow up with a resident's family Desk review regarding the continuation of behavioral health services for a resident with behaviors. (Resident F-740 29) Finding includes: What corrective action(s) will be accomplished for those residents Resident 29's record was reviewed on 7/8/22 at found to have been affected by the 11:44 a.m. Diagnoses included, but were not deficient practice? limited to hemiplegia affecting the left side, high blood pressure, renal insufficiency, Resident 29 son was called and non-Alzheimer's dementia, seizure disorder, returned call to the facility and depression, bipolar disorder, and anxiety disorder. declined for his father to have Psych services. His GP was The Quarterly Minimum Data Set (MDS) updated with recent behaviors. assessment, dated 4/19/22, indicated the resident was cognitively intact. The resident had physical How other residents having the and verbal behavioral symptoms that occurred 1 potential to be affected by the to 3 days during the assessment period. same deficient practice will be identified and what corrective Physician's Orders, dated 8/6/20, indicated action(s) will be taken: behavior health services may evaluate and treat. All residents have the potential to A Social Service Note, dated 5/21/22, indicated the be affected. Residents with resident was seen by behavioral health services. behaviors were identified and no other deficiency noted. 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

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

Event ID:

Facility ID: 000098

If continuation sheet

Page 53 of 73

KDD611

What measure will be put into

place or what systemic changes

CENTERS FOR MEDICARE & MEDICAID SERVICES

0938-039
0,00 00,

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155187	A. BUILDING B. WING	<u>00</u>	COMPLETED 07/12/2022
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368	
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG	shaking the bed rai threatening to harm resident was placed	R LSC IDENTIFYING INFORMATION ls. The resident was n self without ideation. The l on 15 minute checks.	TAG	will be made to ensure that the deficient practices does not rect DON SS director and SS design	nee
	indicated this was previous behaviors and talking with th along with 15 minu was offered drinks	ted 6/3/22 at 3:58 a.m., a follow up on the resident's . A staff member was sitting e resident as an intervention ite interval checks. The resident and snacks. The interventions		on 7-25-22 on timely follow up v families related to psych services.	
	and shout, cuss at s	the resident continued to yell staff, shake the bed rails, and de to kick the staff member.		How the corrective action(s) will monitored to ensure the deficien practice will not recur:	
	indicated social set representative rega behavior health set representative voic and after spending	tote, dated 6/7/2022 at 4:42 p.m., rvices spoke with the resident's rding the resident resuming vices. The resident's ed wanting to come in to visit time with him, then he would regarding the resident receiving vices.		DON will audit the report for behavior charting 5 times a wee to ensure all residents with behaviors have/or are offered psych services timely. This practice will be ongoing.	۰ĸ
	indicated the residu the hospital with a COVID-19 test, br calling, and spit on	ted 6/18/22 at 5:25 p.m., ent returned to the facility from gitation. He refused to take a eaking multiple swabs with name a paramedic. The resident m himself and was cursing at		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 unt 95% compliance is achieved.	il
	indicated the reside and was using inap	ted 6/21/22 at 9:06 a.m., ent was combative with care propriate language. tempted, but was unsuccessful nued.			
	indicated the reside	ted 7/6/22 at 11:34 p.m., ent was cursing and making gestures at staff and throwing			

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIEF	– PORTAGE CARE CENTER	3175 L/	ADDRESS, CITY, STATE, ZIP C ANCER ST AGE, IN 46368	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF food and water.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
	the resident's repres health services.	cumentation of a follow up to entative to resume behavior Social Service Director (SSD)				
	on 7/11/22 at 10:36 representative had r longer see behavior but there were no ne decision. The facilit the resident to see b	a.m., indicated the resident's equested the resident no al health services previously, otes in the chart reflecting that y was in the process of getting ehavioral health services re of where they were at in the				
	indicated the facility the resident's represent determine if he would behavioral health set	SSD on 7/12/22 at 10:22 a.m., y should have reached out to entative at an earlier time to ld allow the resident to receive rvices.				
: 0757 SS=D Bldg. 00	Drugs §483.45(d) Unnec Each resident's dr	Free from Unnecessary essary Drugs-General. ug regimen must be free drugs. An unnecessary /hen used-				
	§483.45(d)(1) In e duplicate drug the	xcessive dose (including rapy); or				
		excessive duration; or nout adequate monitoring;				

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

Event ID: KDD611 Facility ID: 000098

If continuation sheet Page 55 of 73

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	î î	ILDING	ONSTRUCTION	X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIEF	E – PORTAGE CARE CENTER		3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPL	
	§483.45(d)(4) Wit for its use; or	hout adequate indications					
	consequences wh	ne presence of adverse iich indicate the dose d or discontinued; or					
	reasons stated in (5) of this section.						
	failed to ensure insu administered as ord for unnecessary me	view and interview, the facility alin and oral medication were ered 2 of 5 residents reviewed dications. (Residents 90 and	F 07	/5/	Facility Requests paper compliance/ Desk review F-757	08/04	/202
		esident 90 was reviewed on . Diagnoses included, but were			What corrective action(s) will be accomplished for those residen found to have been affected by deficient practice?	its	
	lower limb, periphe pressure, end stage heart failure, angina	2 diabetes, cellulitis of left ral vascular disease, high blood renal disease, congestive a, neuromuscular dysfunction e retention, anxiety disorder, ye disorder.			90 and 72 were assessed and noted to have no adverse react from the deficient practice. wer updated for both residents. Resident 90 insulin orders		
	The 5/31/22 Quarte assessment, indicate	rly Minimum Data Set (MDS)			changed. Resident 72 Coreg order changed. How other residents having the		
	received insulin 7 ti	n the last 7 days the resident imes. ed $6/2/22$ , indicated the			potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:		
	resident had and alt to diabetes mellitus	eration in blood glucose due . The nursing approaches, ere to administer medications			A list of residents who attend dialysis was obtained. Any resident who to Dr.		
	Physician's Orders,	dated 3/10/22, indicated			Appointments or with family course be affected also. Orders were	na	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Novolog Flex Pen Solution Pen-injector 100 obtained for residents to hold Unit/Milliliters (ml) (Insulin Aspart). Inject as per medication while out of the sliding scale: id 71 - 180 = 0 units ; 181 - 230 = 2building and /or may give late upon units; 231 - 280 = 4 units; 281 - 330 = 6 units; 331 return 350 = 8 units; 351 - 352 = 8 units subcutaneously (under the skin) three times a day. Physician's Orders, dated 3/10/22, indicated What measure will be put into Levemir Solution 100 Unit/ml (Insulin Detemir). place or what systemic changes Inject 16 unit subcutaneously in the morning. will be made to ensure that the deficient practices does not recur: Physician's Orders, dated 3/29/22, indicated dialysis treatment on Tuesdays, Thursdays and The DCE licensed nursing staff to Saturdays. make sure that medication orders are correct and can be held while The 6/2022 Medication Administration Record out of building or given to the (MAR) indicated the Novolog Flex Pen was not resident upon return. Education administered as ordered on 6/2, 6/11, 6/16, 6/21 will be completed by 7-30-22 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 How the corrective action(s) will be on 6/11, 6/21, 6/28, and 6/30/22. An "X" or "N/A" monitored to ensure the deficient was in the box for the 8:00 a.m. and 12:00 p.m. practice will not recur: 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 Unit managers/designee will audit administered. 5 residents 3 times a week for 2 months to ensure that they The 6/2022 MAR for the Levemir Insulin indicated received medication per order. the scheduled time to be administered was at 7:00 then 5 residents weekly for 2 a.m. There was no documentation on 6/11, 6/16months, then 5 residents monthly and 6/21/22. A "5" indicating LOA was coded on for the duration of 6 months. 6/7 and 6/18/22. Audits will be completed on all shifts and will include the The 7/2022 MAR indicated the 12:00 p.m., weekends. Any negative trends Novolog insulin was coded with a N/A on 7/2, 7/5, will be reviewed in the monthly and 7/7/22. QAPI program. Interview with the Director of Nursing on 7/8/22 at Any concerns will be monitored 1:50 p.m., indicated the resident does to go through the QAPI process for a dialysis on Tuesdays, Thursdays, and Saturdays. minimum of six months and until He was not in the facility for 12:00 p.m. blood 95% compliance is achieved.

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

Event ID:

KDD611

Facility ID: 000098

If continuation sheet

Page 57 of 73

08/15/2022 PRINTED: FORM APPROVED

STATEME	NT OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	IB NO. 0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED 07/12/2022	
		155187	B. WING			
NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
BRICKY	ARD HEALTHCAR	E – PORTAGE CARE CENTER		ANCER ST AGE, IN 46368		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF	E	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	Resident 72's recon 11:04 a.m. Diagno limited to, high blo	sulin administration.2. rd was reviewed on 7/8/22 at ses, included but were not ood pressure, renal failure, nyperlipidemia, anxiety disorder,				
		inimum Data Set (MDS) 5/13/22, indicated the resident tact.				
	resident received d	, dated 5/24/22, indicated the lialysis treatments at 8:30 a.m. day, and Saturday each week.				
		, dated 5/7/22, indicated Coreg ns by mouth two times a day.				
		, dated 5/6/22, indicated to hold of Coreg (a blood pressure lysis days.				
		cord (MAR) indicated the . dose of Coreg at 8:00 a.m. on				
		Director of Nursing (DON) on indicated the medication should dialysis days.				
	3.1-48(a)					
0760 S=D Idg. 00	The facility must §483.45(f)(2) Res significant medica	sidents are free of any ation errors.				
	Based on observat	ion, record review, and ity failed to ensure a resident	F 0760	Facility requests paper compliance/Desk review		08/04/202

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

Event ID:

KDD611 Facility ID: 000098

Page 58 of 73

PRINTED: 08/15/2022

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE ( A. BUILDING B. WING	<u>00</u>	COME	e survey pleted 2/2022		
	PROVIDER OR SUPPLIE	<sup>R</sup> E – PORTAGE CARE CENTER	3175	T ADDRESS, CITY, STATE, ZIP LANCER ST FAGE, IN 46368	COD			
(X4) ID					ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLETIC		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
	-	ificant medication errors related						
		ninistration of insulin for 2 of 6		F-760				
		during medication pass.						
	(Residents 274 and	126)						
				What corrective action	. ,			
	Findings include:			accomplished for thos				
	1 0 07/11/20			found to have been af	fected by the			
		8:47 a.m., Agency RN 1 was		deficient practice?				
		g to administer insulin to						
		resident's blood sugar was 285		Residents 274 and 26				
		e 9 units of insulin. The RN		assessed and noted to				
		sulin kwik pen from the drawer e resident's room. She dialed		adverse reactions related to the deficient practice. Agency RN 1 was immediately educated on				
	-	nd removed the cap from the e pen to the resident to						
	-	lin into his abdomen. The RN		priming of insulin pens	5.			
	did not prime the r							
		•						
	The record for Res	ident 274 was reviewed on		How other residents h	aving the			
	7/12/22 at 11:00 a.	m.		potential to be affecte	-			
				same deficient practic	e will be			
	Physician's Orders	, dated 7/5/22, indicated Insulin		identified and what co	orrective			
	Lispro (1 Unit Dia	l) 100 Unit/milliliter solution		action(s) will be taken	:			
		t as per sliding scale: if $0 - 199 =$						
	3 units; 200 - 250 -	= 6 units; 251 - 300 = 9 units; 301		All residents who rece	eive insulin			
	-350 = 12 units; 3	51+ 351+, Call MD.,		have the potential to b	be affected.			
	subcutaneously be	fore meals and at bedtime.		A list of diabetic reside	ents who			
				receive insulin via per				
		:09 a.m., Agency RN 1 was		compiled. Instructions				
		g to administer medications and		those orders to prime	pen prior to			
		26. She decided to administer		administration.				
		the nurse before already had						
		nt's blood sugar. She removed						
		pen from the medication cart						
		e resident's room. She dialed		What measure will be	•			
	-	and indicated she was to		place or what systemi	-			
		dose of insulin several times a		will be made to ensure				
		e resident's thigh with an		deficient practices doe	es not recur:			
	-	ministered the insulin. The RN						
	did not prime the r	eedle prior to use.		The DCE licensed nu	rsing staff on			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	A. BUILDING <u>00</u> COM		(X3) DATE SURVEY COMPLETED 07/12/2022
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Interview with Ag she had never prin and was unaware s	ency RN 1 at that time, indicated ned an insulin pen prior to use she needed to do so. sident 26 was reviewed on		how to administer insulin usin insulin pen, including priming pen prior to administration per Insulin Pen policy. Return demonstration was completed Education completed by 7-30-	g the the r the d.
	Insulin Aspart Sol Unit/Milliliters.	, dated 12/6/21, indicated ution Pen-injector 100 utaneously three times a day.		How the corrective action(s) v monitored to ensure the defici practice will not recur:	
	1:15 p.m., indicate before use. The current 2022, by the Nurse Cons indicated "prime the turning the dose see needle pointing up to see that at least	Nurse Consultant on 7/11/22 at ad insulin pens were to be primed "Insulin Pen" policy, provided ultant on 7/11/22 at 1:15 p.m., he insulin pen: dial 2 units by elector clockwise. With the push the plunger and watch one drop of insulin appears on le. If not repeat until at least		Unit managers/DCE/DON/designe audit insulin administration to residents who receive insulin insulin pen 5 times a week x 2 months then, 5 residents ever other week x 2 months then 5 residents monthly for the dura of 6 months. Audits will be completed on all shifts and wi include the weekend. Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitore through the QAPI process for minimum of six months and u 95% compliance is achieved.	5 via 2 ry ation II
0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/A Temp §483.60(d) Food	ppear, Palatable/Prefer and drink			

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

Event ID:

KDD611 Facility ID: 000098

If continuation sheet Page 60 of 73

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	A. BL	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE ARD HEALTHCAR	R E – PORTAGE CARE CENTER		3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E	(X5) COMPLETION DATE
	provides- §483.60(d)(1) Fo conserve nutritive appearance; §483.60(d)(2) Fo palatable, attracti appetizing tempe Based on observati failed to ensure for temperature for 4 c (Residents 10, 39, Finding includes: Interview with Res indicated most of t resident would eat Interview with Res indicated the food eat in his room and Interview with Res indicated the food at in his room.	tion and interview, the facility bod was served at a palatable of 6 residents reviewed for food. 44, and 90) dident 10 on 7/6/22 at 10:40 a.m., he time the food was cold. The his meals in his room. dident 39 on 7/6/22 at 10:55 a.m., was cold. The resident would the main dining room. dident 44 on 7/5/22 at 2:15 p.m., was always cold. The resident	F 08	304	Facility request paper complian Desk review F-804 What corrective action(s) will be accomplished for those residen found to have been affected by deficient practice? Residents 10, 39, 44, and 90 w assessed and noted to have no adverse reactions to the deficie practice. Residents were all offered the chance to get up an come to the dining room for meals. Resident 39 comes to to dining room for most meals.	e ths the ere o ent nd he	08/04/202
	indicated the food ate in his room. On 7/8/22 at 8:00 a arrived on the B w CNA started passin beverages. At 8:36 a.m., the se	ident 90 on 7/6/22 at 11:16 a.m., was always cold. The resident a.m., the first breakfast cart ing at 8:00 a.m. At 8::06 a.m., a ng trays as well as serving econd cart was delivered. The d at 9:00 a.m., and temperatures			Residents 10, 44, and 90 have declined to eat meals in the din room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	ing	

NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/12/2022
PROVIDER OR SUPPLIEF ARD HEALTHCARE	E – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368	
ARD HEALTHCARE SUMMARY (EACH DEFICIEN REGULATORY OF from the test tray w -scrambled eggs 11 -hash browns 113 d Interview with the A 12:50 p.m., indicate well the last couple residents up for bre to the dining room. had not been getting them down to the d agency staff on both been a challenge with passed right away w Interview with the B 7/11/22 at 12:55 p.1	<ul> <li>PORTAGE CARE CENTER</li> <li>STATEMENT OF DEFICIENCIE</li> <li>CY MUST BE PRECEDED BY FULL</li> <li>LSC IDENTIFYING INFORMATION</li> <li>ere taken at that time:</li> <li>7 degrees Fahrenheit</li> </ul>			DATE
			How the corrective action(s) we monitored to ensure the defice practice will not recur: Dietary manager/dietician/designee we temp the last room tray serve different units 3 times a week months, then 3 times every of week x 2 months then monthl the duration of 6 months. An	/ill d on x 2 ther y for

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	СОМ	e survey pleted <b>2/2022</b>
	PROVIDER OR SUPPLIE	E – PORTAGE CARE CENTER	3175	T ADDRESS, CITY, STATE, ZIP LANCER ST TAGE, IN 46368	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
= 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Sto §483.60(i) Food The facility must §483.60(i)(1) - Pl approved or cons federal, state or I (i) This may inclu directly from loca applicable State regulations. (ii) This provision facilities from usi gardens, subject applicable safe g practices. (iii) This provision from consuming facility. §483.60(i)(2) - State State	ore/Prepare/Serve-Sanitary safety requirements. - rocure food from sources sidered satisfactory by		will occur on different include the weekend. trends will be reviewe monthly QAPI program Any concerns will be n through the QAPI pro- minimum of six month 95% compliance is ac	Any negative d in the m. monitored cess for a ns and until	DATE

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	ì í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/12/2022
	PROVIDER OR SUPPLIE	E – PORTAGE CARE CENTER		3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	(X5) COMPLETIC
TAG	<ul> <li>standards for food Based on observati failed to serve, stor sanitary conditions when opened in the bowls stored impro- open to air in the for facility also failed conditions related to with dirty, bare han affect 116 residents kitchen. (Main Kitchen, (Main Kitchen, Findings include:</li> <li>1. During the brief 7/5/22 at 9:33 a.m. the following was of a. Four large bowl on a storage rack.</li> <li>b. In the deep free observed with no late c. In the deep free was observed with</li> </ul>	on and interview, the facility e, and prepare food under related to food not dated e freezer, dirty ice machine lid, perly on storage rack, and food ood preparation area. The to serve food under sanitary to touching resident's food ids. This had the potential to to who received food from the then) 'kitchen sanitation tour, on with the Dietary Food Manager, observed: s were observed stored upright ze, a package of egg rolls were abel or open date. te, a package of used butter no label or open date.	F 08	<u>TAG</u> 312	<ul> <li>Facility requests paper compliance/ Desk review</li> <li>F-812</li> <li>What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice?</li> <li>No residents were affected by deficient practice.</li> <li>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:</li> <li>All residents have the potentia be affected. A house audit of residents was completed with other residents identified. Dief aid 1 was immediately on hand hygiene and glove wearing what touching food.</li> </ul>	be nts y the the e I to no tary d
		6 a.m., while observing the staff iet meal, the following was			What measure will be put into place or what systemic change will be made to ensure that the deficient practices not recur:	
	containing pork ch uncovered. The sta	ation counter, a baking sheet ops was observed to be ff were not observed to be chops at this time. The pork			Education was provided by die manager/dietician/designee or dating food when opened, sanitation of equipment, bowl	•

	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 07/12/2022
	PROVIDER OR SUPPLI	<sup>ER</sup> RE – PORTAGE CARE CENTER	3175 L	ADDRESS, CITY, STATE, ZIP COD ANCER ST AGE, IN 46368	
(X4) ID PREFIX	(EACH DEFICII	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETIO
TAG	<ul> <li>chops were placed a.m.</li> <li>3. On 7/7/22 at 11 preparing plates a observed:</li> <li>a. Dietary Aide 1 with bare hands, than other meal. She and reached unde She opened a pace reached in the pace then covered a coordinate burger burs with burger burs with burger burs with burger patties proceeded to reace hamburger patties proceeded to reace two pieces of che placed those onto 4. On 7/7/22 at 11 observed in the de a. A clear bag coordinate with no lab. A clear bag of observed opened the package.</li> <li>Interview with the Registered Dietic indicated the food have been propertial.</li> </ul>	:45 a.m., the following was	TAG	storage, keeping food covere preparation of food begins, ar hand hygiene/glove wearing w handling food. Education will completed by 7-30-22 How the corrective action(s) w monitored to ensure the defice practice will not recur: Dietary manager/dietician/designee w audit the kitchen for clean equipment, proper storage of dishes including bowls, food preparation including food coverage and hand hygiene a glove wearing of dietary staff times a week for 2 months, the times a week for 2 months, the times a week for 2 months, the times a week x 2 months ther monthly for the duration of 6 months. Audits will occur on different shifts and include weekends. Any negative tren will be reviewed in the monthe QAPI program. Any concerns will be monitored through the QAPI process for minimum of six months and u 95% compliance is achieved.	vill be ient ind f vill be ient vill be vill be ient vill be vill be

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		CO	(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE	<sup>R</sup> E – PORTAGE CARE CENTER	3175 L/	ADDRESS, CITY, STATE, ZIP ANCER ST AGE, IN 46368	COD		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO	
F 0880 SS=D Bldg. 00	in use, bowls shou prevent contamina should be cleaned. performed hand hy and opening packa touched food with 3.1-21(i)(3) 483.80(a)(1)(2)(4 Infection Prevent §483.80 Infection The facility must infection prevent designed to prov comfortable envi the development communicable di §483.80(a) Infect program. The facility must prevention and c must include, at a elements: §483.80(a)(1) A s identifying, repor controlling infect diseases for all re visitors, and othe services under a based upon the f conducted accorr following accepted §483.80(a)(2) We and procedures f include, but are r	)(e)(f) ion & Control c Control establish and maintain an on and control program de a safe, sanitary and conment and to help prevent and transmission of seases and infections. ion prevention and control establish an infection ontrol program (IPCP) that a minimum, the following system for preventing, ting, investigating, and ons and communicable esidents, staff, volunteers, r individuals providing contractual arrangement acility assessment ding to §483.70(e) and ed national standards; itten standards, policies, or the program, which must	TAG			DATE	

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TATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	A. BUILI B. WING	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			OMB NO. 0938-039           (X3) DATE SURVEY           COMPLETED           07/12/2022	
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3	175 LA	ddress, city, state, zip c NCER ST GE, IN 46368	OD		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF COR	RECTION	(X5)	
REFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A	IOULD BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE	
		communicable diseases or						
		they can spread to other						
	persons in the fac	-						
		vhom possible incidents of						
		sease or infections should						
	be reported;							
	(iii) Standard and							
	precautions to be							
	of infections;	visalation abould be used						
	· ,	v isolation should be used luding but not limited to:						
	(A) The type and							
	depending upon t							
	organism involved	-						
	-	t that the isolation should be						
		e possible for the resident						
	under the circums	•						
	(v) The circumsta	nces under which the facility						
	must prohibit emp	bloyees with a						
	communicable dis	sease or infected skin						
		t contact with residents or						
		t contact will transmit the						
	disease; and							
		ene procedures to be						
		nvolved in direct resident						
	contact.							
	\$483 80(a)(4) A a	system for recording						
		d under the facility's IPCP						
		e actions taken by the						
	facility.	,						
	§483.80(e) Linen							
		andle, store, process, and						
	of infection.	o as to prevent the spread						
	§483.80(f) Annua	l review.						
		nduct an annual review of						
	Lits IPCP and und	ate their program, as						

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

Event ID: KDD611 Facility ID: 000098

If continuation sheet Page 67 of 73

PRINTED: 08/15/2022 FORM APPROVED

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155187	(X2) MULT A. BUILD B. WING	iple construction ding <u>00</u>	COMI	te survey 1pleted 12/2022	
NAME OF PROVIDER OR SUPPL BRICKYARD HEALTHCA	IER RE – PORTAGE CARE CENTER	3	TREET ADDRESS, CITY, STATE 175 LANCER ST PORTAGE, IN 46368	E, ZIP COD		
· · ·	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL		D PROVIDER'S PLAN (EACH CORRECTIVE AC (EACH CORRECTIVE AC	CTION SHOULD BE	(X5) COMPLETIO	
TAG REGULATORY	OR LSC IDENTIFYING INFORMATION	T	AG CROSS-REFERENCED T		DATE	
necessary.         Based on random         and interview, th         infection control         implemented, inc         contain COVID-         hygiene before at         incorrect disposa         residents observer         (Residents 274, 2)         Findings include         1. On 7/11/22 at         pair of clean glow         room. She did m         was to going to c         by the way of the         insulin if needed         room, wiped his         pricked it with a         the strip. She inf         need insulin and         much. She walk         used gloves to be         alcohol pad and         paper bag on the         the same gloved         resident was to row         walked back into         gloves and admin         out of the room a         threw them away         medication cart.         the medication cart.	a observations, record review, e facility failed to ensure guidelines were in place and duding those to prevent and/or 19, related to not performing hand and after glove use and the l of used lancets for 3 of 9 d during medication pass. 26, and 275)	F 0880	<ul> <li>Facility Requests compliance/ Desk F-880</li> <li>What corrective a accomplished for found to have bee deficient practice?</li> <li>Residents 274, 20 assessed and no outcome related to practices were no 1 and Agency LP immediately educt when to perform I handwashing and gloves as well as lancets in SHARF</li> <li>How other resider potential to be aff same deficient pr identified and what action(s) will be ta</li> <li>All residents have be affected. All re being monitored a signs and sympto COVID-19/respirat</li> </ul>	Action(s) will be those residents en affected by the ? 6, and 275 were adverse to the deficient oted. Agency RN N 1 were cated on how and hand hygiene and d when to don/doff disposal of used Ps container ints having the fected by the actice will be at corrective aken: the potential to esidents are at least daily for ons of atory infection, no oted to have been	08/04/202	

NTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155187		(X2) MULTIPLE CON A. BUILDING B. WING	struction 00	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/12/2022	
	ROVIDER OR SUPPLIE	<sup>R</sup> E – PORTAGE CARE CENTER	3175 LAN	DDRESS, CITY, STATE, ZIP COD NCER ST SE, IN 46368	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	At 9:09 a.m., she c gloves to both ham medication cart in insulin pen and inh into the room. Wi handed the inhaler herself and then a Wearing the same resident's thigh win administered the in room wearing the g medication cart. S sharp's container a threw them away. hygiene. Agency I resident's oral med she still had not per Interview with the 7/11/22 at 4:45 p.m.	lonned another pair of clean ds whiled standing at the the hallway. She removed an haler for Resident 26 and walked th the same gloved hands, she to the resident to administer cup of water to rinse her mouth. gloves, she wiped the th an alcohol wipe and hsulin. She walked out of the gloves and over to the he threw the needle into the nd removed her gloves and She did not perform hand RN 1 proceeded to prepare the ications at that time, however, rformed hand hygiene. Director of Nursing (DON) on n., indicated hand hygiene was ifore donning and after doffing		place or what systemic chang will be made to ensure that th deficient practices does not re The DCE/DNS/designee educ all licensed nursing staff with return demonstration related t facility policies and procedure and CDC guidelines for PPE of related to Transmission Based Precautions, PPE donning an doffing, hand hygiene, infection control practiced regarding glucometer use and appropriate SHARPs disposal after use. A education will be completed p to 8-4-22 How the corrective action(s) w monitored to ensure the defici- practice will not recur:	es ecur: cated to the es use d d d on ate All vrior
	Agency LPN 1 wa pouring a medicati administered throu inserted into the st The Agency LPN Propranolol (a bloc crushed it and pour plastic cup. She entered the roo The LPN donned a hands and at that ti she threw it away a and obtained anoth other hand. She di prior to donning th	on pass on 7/11/22 at 4:30 p.m., s observed preparing and on for Resident 275 to be gh a peg tube (a tube directly omach to provide nutrition). removed the medication of od pressure medication) and red the medication into a om and identified the resident. a clean pair of gloves to both ime, one of the gloves tore so and walked towards the door her glove and donned it to her d not perform hand hygiene e gloves. The LPN medication through the peg tube,		The Regional Director of Clini Operations (RDCO), IP/DCE/DNS/Designee will au random licensed nursing staff members, to include all units shifts daily or more often as necessary for 6 weeks and ur compliance is maintained, the times per week x 2 months the weekly x 2 months to ensure to is donned/doffed appropriately hand hygiene is performed per policy and CDC guidelines, as as that all sharps are dispose properly in a SHARPs contain after use. The RDCO/IP/DCE/DNS will perfor daily visual rounds throughour	udit 5 ntil en 3 en PPE y, er s well d of ner

KDD611 Facility ID: 000098

If continuation sheet Page 69 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155187		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 07/12/2022	
	PROVIDER OR SUPPLIE	R E – PORTAGE CARE CENTER	3175	et address, city, state, zip cod LANCER ST TAGE, IN 46368	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	soap and water. Interview with Agr indicated she thoughy hygiene prior to do she did not and wa water for the flush The current 5/2022 provided by the Do indicated hand hyg applying and after equipment, includi Interview with DO indicated there was lancets, however, in	2 "Hand Hygiene" policy, DN on 7/12/22 at 10:00 a.m., iene was to performed before removing personal protective ng gloves. N on 7/12/22 at 10:00 a.m., s no policy for disposal of used t was a nursing practice that all dles were to be disposed of in		<ul> <li>facility to include all units and shifts including weekends, to ensure licensed nursing staff a practicing appropriate Infectior Control Practices and compliant is maintained for a least 6 wee and until compliance is maintained, then 3 times per w x 2 months then weekly x 2 months. Any negative trends w be reviewed in the monthly QA program.</li> <li>Any concerns will be monitored through the QAPI process for a minimum of six months and un 95% compliance is achieved.</li> </ul>	n nce ks /eek /ill .PI d
F 0921 SS=E Bldg. 00	§483.90(i) Other The facility must sanitary, and con residents, staff an Based on observat failed to ensure the clean and in good marred walls, door tiles, dusty ceiling	Sanitary/Comfortable Environ Environmental Conditions provide a safe, functional, affortable environment for ad the public. on and interview, the facility residents' environment was repair related to dirty floors, s, and heat registers, stained vents, dirty light covers, and or 2 of 3 units. (The B wing	F 0921	Facility Requests paper compliance / Desk review. F-921 What corrective action(s) will b	e 08/04/202
	Finding includes: During the Environ	nmental Tour with the		accomplished for those resider found to have been affected by deficient practice?	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155187 B. WING 07/12/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Maintenance and Housekeeping Supervisors on Resident rooms: 105, 112, 118, 7/12/22 at 10:00 a.m., the following was observed: 309, 316, 318, 319, 324, 326, and Coca Cola room and dining room 1. The B Wing were addressed immediately by repairing and cleaning all affected a. On 7/7/22 at 9:45 a.m., a large amount of dirt areas. and debris was noted on the side of bed 1 in Room 105. At 2:20 p.m., the dirt remained on the How other residents having the side of the resident's bed. potential to be affected by the same deficient practice will be A large amount of debris was observed on the identified and what corrective floor, underneath the bed, and between the wall action(s) will be taken: and the bed in Room 105 bed 1. Two residents resided in this room. All residents have the potential to be affected by the alleged deficient On 7/8/22 at 7:43 a.m., the dirt remained to the side practice. All Other rooms were of the resident's bed. assessed for needed repairs and cleaning and placed on Building b. The doors and walls were marred in Room 112. Engines (electronic work orders) The floor was dirty in the bathroom. Two for maintenance and residents resided in the room and shared the housekeeping services to prioritize bathroom. and complete. c. The walls were marred in Room 118 and the floors were dirty. Two residents resided in this room. What measure will be put into place or what systemic changes 2. The ACU Unit will be made to ensure that the deficient practices does not recur: a. The heat register in Room 309 was marred on both sides. The closet door was marred at the Staff will be reeducated on the top. The base of the bathroom door was resident rights policy and building scratched and marred. The inside of the toilet engines to ensure they can submit bowl was discolored and there was an work orders effectively. accumulation of dust on the ceiling vent in the bathroom. Two people resided in the room and Housekeeping to be reeducated used the bathroom. on cleaning processes and procedures b. The door frame to Room 316 had areas of chipped paint. The bathroom door frame was Maintenance will be reeducated on

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

Event ID:

KDD611 Facility II

Facility ID: 000098

If continuation sheet Pa

Page 71 of 73

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OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/12/2022 155187 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3175 LANCER ST BRICKYARD HEALTHCARE – PORTAGE CARE CENTER PORTAGE, IN 46368 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE scratched and marred. There was adhesive on the completion of work orders and floor next to bed one from previous non-skid environmental rounding. strips. The floor tile in the bathroom was discolored. Two residents resided in this room and shared the bathroom. How the corrective action(s) will be c. The inside of the bathroom door in Room 318 monitored to ensure the deficient was marred as well as the walls. By the head of practice will not recur: bed 1, the wall was scratched and marred. Two residents resided in the room and shared the An audit will be completed to bathroom. determine areas of concern. The random audit will be completed by d. The base of the heating unit in Room 319 was Maintenance or designee to scratched and marred. The wall behind the head include 5 rooms weekly for 2 of bed 2 was scratched and marred. The months, bimonthly for 2 months, baseboard was pulling away from the wall in the and monthly for 2 months. This bathroom. Two residents resided in this room and audit will be reviewed in QAPI for 6 shared the bathroom. months and at the end of 6 months of 90% compliance is e. The base of the heat register in Room 324 had achieved the audits will be areas of chipped paint. The floor tile was complete. If compliance is not discolored in the bathroom behind the toilet and achieved in 6 months, then the there was an accumulation of dust on the QAPI Committee will continue to bathroom ceiling vent. Two residents resided in monitor monthly until 90% this room and shared the bathroom. compliance is achieved. 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. Facility ID: 000098 Event ID: KDD611 Page 72 of 73 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

NTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155187		A. BL	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		X3) DATE SURVEY COMPLETED 07/12/2022			
	PROVIDER OR SUPPLIEF	2 E – PORTAGE CARE CENTER		3175 LA	ADDRESS, CITY, STATE, ZIP COD ANCER ST GE, IN 46368	-		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF h. The floor in the and dull in appeara chipped paint and w chair in the room ha and legs and fabric Interview with the I time, indicated the Interview with the I	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION "Coca Cola" room was dusty nce. The walls had areas of were marred in sections. A ad scratched and marred arms hanging from underneath. Maintenance Director at that chair needed to be thrown out. Housekeeping Supervisor at all of the above were in need of air.		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPP DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	3.1-19(f)							

KDD611 Facility ID: 000098