STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TERRACE CARE CENTER	1900 ANDREW AVE LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00435794, IN00435885, and IN00436047. Complaint IN00435794 - Federal/state deficiencies related to the allegations are cited at F609. Complaint IN00435885 - Federal/state deficiencies related to the allegations are cited at F609. Complaint IN00436047 - Federal/state deficiencies related to the allegations are cited at F660. Survey date: June 17, 2024 Facility number: 000061 Provider number: 155136 AIM number: 100288620 Census Bed Type: SNF/NF: 135 Total: 135 Census Payor Type: Medicare: 10 Medicaid: 101 Other: 24 Total: 135 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/19/24.	F 0000	**Brickyard Terrace Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **Brickyard Terrace Care Center respectfully requests consideration for a desk review.**	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Shepperd	Executive Director	07/03/2024

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

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	the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, record review and interview, the facility failed to ensure all covered individuals (anyone who was an owner, operator, employee, manager, agent, or contractor of the facility) was notified annually of their obligation and requirement to comply with the reporting of reasonable suspicion of crimes against a resident, related to an allegation of sexual abuse for 1 of 2 residents reviewed for abuse. (Resident B) Finding includes:	F 0609	F609 Reporting of Alleged Violations **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Executive Director informed contractors/covered entities of their obligation and requirements to comply with the Elder Justice	07/01/2024

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	During an observation on 6/17/24 at 9:40 a.m., Resident B was observed in bed and awake. At that time, she was able to confirm she was going home soon and no longer need hemodialysis. During an interview at the time, the resident indicated that she did not remember any male nurse forcing her to take her medications or asking her for sexual favors. The resident indicated she remembered on one night, the room was very dark, and a male came into her room and that scared her. She did not know who he was, but the room was so dark, it had just startled her. The record for Resident B was reviewed on 6/17/24 at 11:20 a.m. The resident was admitted to the facility on 5/13/24 and was on hemodialysis. Diagnoses included, but were not limited to, stroke, cardiac arrest, respiratory failure, atrial fibrillation, anemia, end stage renal disease, anoxic brain damage, alcohol abuse, cocaine abuse, heart failure, high blood pressure, and altered mental status. The Admission Minimum Data Set (MDS) assessment, dated 5/19/24, indicated the resident was not cognitively intact for daily decision making and was dependent on staff for toileting and transfers in and out of bed. The 5 day Medicare MDS assessment, dated 6/1/24, indicated the resident was not cognitively intact for daily decision making. A Care Plan, dated 5/22/24, indicated the resident had impaired cognition and dementia related to a stroke. The approaches were to explain all procedures and reason before performing them. A Nurses' Note, dated 5/27/24 at 2:05 p.m.,		Act of reporting reasonable suspicion of crimes against a resident. No ill effect from alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents alleging a crime have the potential to be affected by this alleged deficient practice. · A full house audit completed and sent to covered individuals to inform them of their obligation to report to the facility any suspicion of a crime. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All staff and covered individuals educated on the Elder Justice Act and reporting requirements. ·Executive Director/designee will audit entrances/exits 5x weekly x 6 mos to ensure that signage for covered individuals is in place. ·All audits will include all shifts and units and weekends. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Executive	

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	indicated the resident had arrived back to the facility from the hospital where she was treated for an urinary tract infection with Vancomycin-Resistant Enterococci (an organism that was resistant to powerful antibiotics). A Nurses' Note, dated 5/27/24 at 9:53 p.m., indicated the resident refused to take her medications and sent the nurse away. The nurse explained the importance of taking the medications, but the resident declined. A Nurses's Note, dated 5/28/24 at 12:19 a.m., indicated the resident refused a bolus enteral feeding through the peg tube. The nurse explained the importance of taking the feeding, but the resident declined. . A Pre/Post Dialysis Evaluation, dated 5/28/24 at 6:31 a.m., indicated the resident was chronically confused. A Nurses' Note, dated 5/29/24 at 7:54 p.m., indicated the resident refused the enteral feedings through the peg tube. The resident continued to state "she doesn't like the nurse (this writer)." The 5/2024 Medication Administration Record indicated the resident had refused all of her 8:00 p.m. medications on 5/27/24 and the 6:00 a.m. medications on 5/28/24. A Hemodialysis Patient Note, dated 5/28/24 at 11:10 a.m., indicated "Pt [patient] came in to facility talking and asked another pt to use her phone to call her daughter. Pt was alert and was speaking on phone. When pt came back to treatment floor pt stated she was not feeling well and that she was sick, at this time patient was refusing to get into the treatment chair. She		Director/designee will complete audit tool to reflect proper signage is in place using attached audit sheet. ·The Executive Director/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	seemed scared, anxious, and was very tearful. Vitals were stable 124/90 Heart Rate 77 Pulse Ox 99%. Writer accessed [sic] pt, lungs diminished with edema to the abdomen. Pt feeding tube has yellow tint to it, and pt had a Hoyer lift under her but it was completely tangled and criss crossed. Writer called [doctor name] to please come and access [sic] the patient.... In the meantime, pt reported to a teammate that last night a male nurse stood over her and was trying to force her to take medicine. The patient states she refused the medication and that she felt as if the RN was trying to give her medication so he can do 'something' to her. Pt states the male nurse said to her 'take your clothes off and bend over so I can get in that bootyhole' pt states she refused and states RN then said 'then take your clothes off and spread your legs' pt states she refused again and told the RN that she is 'not allowed to do that.' Pt states she stayed up all night trying to make sure the RN did not come back." During a phone interview on 6/17/24 at 9:52 a.m., the Dialysis Nurse indicated she was the charge nurse the day the resident made the allegation of sexual abuse. She reported the incident to the Dialysis Facility Administrator at the dialysis center. The Social Worker (SW) and the patient's daughter were also notified. The Dialysis Nurse indicated she did not notify the long term care facility where the resident resided, but the Dialysis Administrator tried contacting them. During a phone interview on 6/17/24 at 10:08 a.m., the Dialysis Facility Administrator indicated she was made aware of the situation on the day the allegation was made. She notified the SW who then notified APS (Adult Protective Service). She tried calling the nursing home for 3 days in a row on 5/28, 5/29 and 5/30/24, and was told the			

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	Director of Nursing (DON) was not available. On 5/28/24 at 11:48 a.m., she spoke with someone, asked for the DON, and they told her she was not available. She called again at 12:38 p.m. and was directed to the DON's voicemail, which was full so she was not able to leave a message. She tried calling on 5/29 and 5/30/24, each time asking for the DON and was directed to voicemail where the mail box remained full, so therefore, she was not able to leave a message. The SW tried calling the nursing home several times and was not able to leave a message because the DON's mailbox was full. The Dialysis Administrator indicated in circumstances like these, she has always notified the DON, she would never speak to the patient's nurse as that was not appropriate because that nurse could have been the perpetrator. She had never received any information on how to report the incident to the facility and only learned of the DON's name the first day she called the facility. The local police were not notified of the allegation of sexual abuse. During an interview on 6/17/24 at 10:45 a.m., the administrator was informed of the allegation of sexual abuse. She was not aware of the allegation and indicated she would start an investigation right away. At 11:10 a.m., the administrator indicated there was a male nurse who worked on 5/27 and 5/28/24 on the resident's unit. The nurse was notified they were suspended pending an investigation. The 5/27 and 5/28/24 nurses' notes were documented by the male RN who worked with the resident those nights. The Administrator indicated no one from the dialysis center had notified her of any allegation of abuse. During an interview on 6/17/24 at 1:01 p.m., the Vice President of Operations indicated there have been no annual letters sent to covered individuals			

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	regarding their obligation and the facility's protocol for reporting a suspicious crime. This citation relates to Complaints IN00435794 and IN00435885. 3.1-28(c)			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the			

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	discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the			

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	resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on record review and interview, the facility failed to ensure continuity of care was provided after a resident was discharged home with orders for intravenous (IV) antibiotic medications and the care of a PICC (a peripherally inserted central catheter) line for continued treatment for a bone infection for 1 of 3 residents reviewed for discharge. (Resident C) Finding includes: The closed record for Resident C was reviewed on 6/17/24 at 2:05 p.m. The resident was admitted to the facility on 5/7/24 and discharged to home on 5/30/24. Diagnoses included, but were not limited to, osteomyelitis (bone infection) of the left ankle and foot, type 2 diabetes, abscess of the left lower limb, heart disease, acute kidney failure, high blood pressure, and obesity. The Admission Minimum Data Set (MDS) assessment, dated 5/14/24, indicated the resident was cognitively intact for daily decision making. A Nurses' Note, dated 5/7/24 at 6:40 p.m., indicated the resident was admitted to the facility from the hospital. He recently had surgery for an incision and drainage of the left foot and ankle, and was on IV antibiotic therapy for 6 weeks. The resident had a single lumen PICC line to the right upper extremity.	F 0660	F660 Discharge Planning Process **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident C discharged from facility. No ill effect from alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents discharging home have the potential to be affected by this alleged deficient practice. · A full house audit completed of all planned discharges to the community completed to ensure resources have been set up and services initiated as needed. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All staff nursing staff and SW educated on discharge planning for residents.	07/01/2024

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	Physician's Orders, dated 5/7/24, indicated IV-PICC change transparent dressing on admission, then weekly and prn thereafter every night shift on Sunday. Give Piperacillin Sod-Tazobactam (an antibiotic medication) Intravenous solution reconstituted 4.5 (4-0.5) grams (gm). Use 4.5 gram intravenously every 8 hours for osteomyelitis until 6/9/24. The Medication Administration Record for 5/2024 indicated the transparent dressing for the PICC line was last completed on 5/26/24. The Piperacillin was scheduled to be administered at 6:00 a.m., 2:00 p.m., and 8:00 p.m. The last dose administered to the resident was on 5/30/24 at 2:00 p.m., before he was discharged home. A Discharge Summary, dated 5/28/24, indicated the resident was to be discharged to home and was living with his parents. The resident had a wound that was in need of daily skin treatments. The resident would be going home with the PICC line to continue IV antibiotic therapy until 6/9/24. The resident wanted to leave the nursing facility and return home to finish up the IV antibiotics, and also wanted a new home health agency, as he was not happy with his previous one. A new (incorrect) home health agency was listed with a telephone number as well as follow up physician appointments. A Nurses' Note, dated 5/30/24 at 3:42 p.m., identified as a late entry with unknown date, indicated the resident finished therapy and was able to be discharged home. The resident left the facility with his mother and was given the transfer discharge order, bed hold policy, and medication list. An IDT (Interdisciplinary Team) Note, dated		·Social Services/designee will audit all discharges weekly x6 mos. to ensure community resources are set up for all residents that are discharging. ·All audits will include all shifts and units and weekends. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Social Worker/designee will complete audit tool to reflect proper signage is in place using attached audit sheet. ·The Social Worker/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	5/31/24 at 12:01 p.m. and documented as a late entry on 6/1/24, indicated "Writer went to talk with resident regarding discharge planning and resident was informed that Writer would call previous home care agency and to resume services with the intent of continuing IV treatment at home per request of resident. Writer called [name of home health agency] this day and confirmed referral sent and confirmed resuming IV treatment to resume at home with services. Writer called pharmacy [name] stated they contracted with and Writer confirmed that [pharmacy name] is contracted with [home health agency name] and would continue IV treatment. Resident and family aware. Resident was also given phone contacts to each agency if there were any questions or concerns. Resident did not state any further concerns with the facility or discharge. An IDT Note, dated 6/4/24 at 3:11 p.m., indicated followed up with home health agency and spoke with their Director of Nursing regarding the post discharge follow up on 5/30/24. The home health agency confirmed they would be able to help with the IV medication. On 5/30/24 the home health pharmacy was notified regarding the IV antibiotics for the resident. The pharmacy indicated they needed a flush order and a line report to complete the referral. Both were faxed over to the pharmacy by the end of the day on 5/30/24. A confirmation was not received from either the home health agency or the home health pharmacy. A follow up phone call was made on 6/4/24 to the pharmacy home health agency and they informed the facility they did not receive any of the information that was requested and did not communicate any further information. On day of discharge, the resident and his parents were provided phone numbers for the home health agencies and the pharmacy home health.			

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	Both IDT notes were written and documented by the facility's Social Worker (SW). The resident was discharged home on 5/30/24. The discharge instructions, dated 5/28/24, did not have the current home health agency or the pharmacy home health agency contact names or phone numbers. There were 2 fax cover sheets, both dated 5/30/34, one with the home health agency contact and telephone number and one for the pharmacy home health agency. The SW had checked urgent on the cover sheets and also checked please reply back. There was no follow up by the SW with either the pharmacy or home health agency the next day on 5/31/24, to confirm the resident would be able to receive the IV antibiotics at home every 8 hours and for the care of PICC line. During an interview on 6/17/24 at 3:06 p.m., the SW indicated the resident told her the first week he was at the facility that he did not want to be there, but each time she had talked him into staying to complete the IV antibiotic therapy. He also told her he would like a new home health agency because the one he had used before had many problems. She was informed on 5/28/24 that the physician gave the ok to discharge the resident to home and to continue the IV antibiotics there. She reached out to several home health agencies for a referral, however, none of them would take his commercial insurance, so she ended having to go back to his previous home health agency. She phoned the home health agency and was given a verbal consent they would be able to provide the IV antibiotics, pump			

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	155136	A. BUILDING 00 B. WING	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TERRACE CARE CENTER	1900 ANDREW AVE LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and take care of the PICC line. She also faxed all of the information to both the home health and the pharmacy home health agencies. The pharmacy replied back to her and indicated they needed an order for the flushes and a line report for the PICC line. The SW indicated she faxed all of that information back to them, but did not hear anything from either agency. She did not follow up with either home health agency on 5/31/24, which was a Friday, before the weekend. The Administrator called her on Saturday 6/1/24 and wanted some information about the discharge because the resident did not have the antibiotics. The discharge instructions were not updated and had a different home health agency listed with contact names and numbers. The SW indicated she had given the resident a post-it note with the phone numbers of both agencies. She came back to work after the weekend and on 6/3/24, there was no report from the home health agencies. On 6/4/24 she called both agencies to see why the IV antibiotics had not been started. During an interview on 6/17/24 at 3:10 p.m., the Administrator indicated she was notified by the on call manager on Saturday 6/1/24 the resident had called in and indicated he did not have his antibiotics yet. She called the SW right away to get the resident's history. She indicated she told the on call manager to call him back and tell him to go the emergency room (ER) for treatment. During an interview on 6/17/24 at 3:25 p.m., the MDS Coordinator indicated she was the manager on duty on 6/1/24. The resident had called the facility and informed her he had not received his IV antibiotics. She notified the on call nursing supervisor and also notified the administrator. The administrator called back and told her to call the resident back and tell him to go to the ER, so			

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	she did. The resident was very mad and upset and asked if the facility was going to pay for his ER bill once he was treated. This citation relates to Complaint IN00436047. 3.1-12(a)(3)			