STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00431372 and IN00432746. Complaint IN00431372 - No deficiencies related to the allegations are cited. Complaint IN00432746 - No deficiencies related to the allegations are cited. Survey dates: April 15, 16, 17, 18, 19, 22, 2024 Facility number: 000411 Provider number:155384 AIM number: 100275100 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 2 Medicaid: 55 Other: 8 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 6, 2024.	F 0000	Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible. We would like to respectfully request a desk review.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and			

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

Julie Pennington | Executive Director | 05/17/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure each resident	F 0550	What corrective action will be accomplished for those residents	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	was treated with dignity for 2 of 2 residents reviewed for choices. One resident continued to receive styrofoam dishes after a suicide watch was discontinued. A CNA (Certified Nursing Aide) was standing up to feed a resident and asked the nurse "What do you want me to do with her?" when she was done. (Resident 37, Resident 26) Findings include: 1. On 4/17/24 at 8:38 A.M., Resident 37 was observed sitting on the side of her bed while staff were putting TED (Thrombo-Embolic Deterrent) hose on her legs. Her breakfast tray containing Styrofoam dishes was sitting on the bedside table. On 4/17/24 at 8:53 A.M., Resident 37's clinical records were reviewed. Diagnosis included, but were not limited to depression and anxiety. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 1/19/24 indicated Resident 37 was cognitively intact. Progress Notes: 4/16/2024 8:52 A.M. General Note Note Text: "suicide watch over this day. Res [Resident] has not threatened to harm self during watch not attempt [sic] to hurt self. Continue to await final UA [urinalysis] results. No c/o [complaint] voiced this am [sic]." During an interview on 4/17/24 at 8:42 A.M., QMA (Qualified Medication Aide) 19 indicated Resident 37 was receiving Styrofoam dishes because she was on 15 minute checks and suicide watch, but that had been discontinued so we just need to contact dietary to cancel the Styrofoam dishes. During an interview on 4/18/24 at 8:21 A.M.,		found to have been affected by this deficient practice? The dietary department was notified to discontinue use of Styrofoam dishes for Resident #37. The staff member assisting Resident #26 was instructed on protecting and promoting residents' rights and treating each resident with respect and dignity. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Re-Education will be provided by the DNS/Designee to staff members on protecting and promoting residents' rights and treating each resident with respect and dignity. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Audits will be conducted if a resident is placed on suicide watch to ensure the use of Styrofoam dishes is discontinued and the Dietary Department is notified when the resident is taken off of a suicide watch. Audits will be conducted 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month and 1x	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	Resident 37 indicated she didn't like the Styrofoam dishes. 2. On 4/19/24 at 7:30 A.M., Certified Nurse Aide (CNA) 80 was observed in the main dining room standing next to and feeding Resident 26. On 4/19/24 at 7:42 A.M., CNA 80 was observed pushing Resident 26 out of the dining room up to a nurse and asking "What do you want me to do with her?" On 4/18/24 at 10:04 A.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety, weakness and Alzheimer's disease. Resident 26 was admitted on 11/22/23 . The most recent Quarterly MDS Assessment, dated 1/19/24, indicated Resident 26's cognition was severely impaired and she was an extensive assist of 2 staff for bed mobility and toileting, an extensive assist of 1 staff for transfers, and supervision of 1 staff for eating. A Nutritional Assessment Report (NAR), dated 4/4/24 indicated Resident 26 had a significant weight loss and it was recommended the resident would eat meals in the dining room, need assistance to eat, and should be changed to a weekly weight. During an interview on 4/19/24 at 9:03 A.M., the Director of Nursing (DON) indicated she would expect staff to sit when feeding a resident. At that time, she indicated she wouldn't consider the statement made by CNA 80 a dignity concern, but would talk to staff and inservice them on using the proper names and not "her" when discussing the resident's care.		weekly for two months to ensure staff are promoting residents' rights' and treating each resident with respect and dignity. How will the corrective action be monitored to ensure the deficient practice does not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current nondated Promoting/Maintaining Resident Dignity Policy was provided on 4/19/24 at 11:00 A.M., by the Regional Consultant and indicated " ... It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity ... 5. When interacting with a resident, pay attention to the resident as an individual ... 10. Speak respectfully to residents; avoid discussions about residents that may be overheard ... " 3.1-3(t)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	(ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	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 number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to notify the ombudsman of transfer or discharge for 3 of 4 residents reviewed for hospitalizations. (Resident 23, Resident 25, Resident 35)	F 0623	What corrective action will be accomplished for those residents found to have been affected by this deficient practice? The Ombudsman was notified of the transfer and discharge of	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	Findings include: 1. On 4/16/24 at 11:02 A.M., Resident 23's clinical record was reviewed. Resident 23 was sent to the hospital on 4/9/24. Resident 23's clinical record lacked documentation that notification of the hospitalization was sent to the ombudsman. 2. On 4/16/24 at 10:44 P.M., Resident 35's clinical record was reviewed. Resident 35 was sent to the hospital on 12/22/23. Resident 35's clinical record lacked documentation that notification of the hospitalization was sent to the ombudsman. 3. On 4/17/24 at 10:30 A.M., Resident 25's clinical record was reviewed. Diagnoses included, but was not limited to, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and diabetes mellitus type II. Progress Notes indicated Resident 25 was hospitalized 7/7/23 through 7/10/23. A completed Notice of Transfer or Discharge Form was provided by the Director of Nursing (DON) on 4/18/24 at 2:55 P.M., with a transfer or discharge date of 7/7/24 (sic). On 4/19/24 at 9:57 A.M., the Regional Consultant indicated notification to the ombudsman could not be located for Resident 23, Resident 25, or Resident 35. On 4/19/24 at 4:10 P.M., the state ombudsman indicated via email that notification reports for July 2023, December 2023, or any months in 2024 had not been received from the facility.		Residents #23, #25, and #35. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Social Services will be re-educated to notify the Ombudsman of the transfer and discharges of residents from the facility. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Social Services Director/Designee will audit the transfer and discharge notice to the Ombudsman 1x monthly for six months to ensure the notices were sent. How will the corrective action be monitored to ensure the deficient practice does not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 4/22/24 at 8:55 A.M., the Administrator indicated no one at the facility was sending the discharges to the ombudsman. A current, nondated Discharge Planning Policy was provided by the DON on 4/22/24 at 10:44 A.M., and indicated " ... the facility must notify the Office of the State Long-Term Care Ombudsman of all resident discharges from the facility. Social Services will notify the Ombudsman of all discharges, which are not due to an issue of a 30-day notice, by means of a monthly summary containing at minimum: the residents name, discharge date, and discharge location ... " 3.1-12 (a)(6)(A)(iv)			
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure MDS (Minimum Data Set) Assessments were accurate for 4 of 19 residents in the initial sample. The MDS Assessment failed to indicate residents had a PASRR (preadmission screening and resident review) II. The MDS failed to indicate a resident received hospice services. (Resident 1, Resident 31, Resident 39, Resident 51) Findings include: 1. On 4/17/24 at 8:43 A.M., Resident 39's clinical record was reviewed. Diagnosis included, but were not limited to, epilepsy, developmental disorder of speech and language, spastic quadriplegic cerebral palsy, and severe intellectual disabilities.	F 0641	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The MDS assessments for Residents 1, 31, 39 and 51 were updated. How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. The MDS consultant re-educated the MDS coordinator on PASRR screening	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The most recent Annual MDS, dated 7/16/23, indicated Resident 39 did not have the following: "...currently considered by the state level II PASRR [preadmission screening and resident review] process to have serious mental illness and/or intellectual disability or a related condition." On 11/5/21 a PASRR level II was completed by [name of company] and indicated the PASRR was valid for the duration of Resident 39's stay. During an interview on 4/22/24 at 9:23 A.M., the MDS Coordinator indicated social services previously completed that portion of the MDS, and due to the lack of a social services coordinator, it was an entry error. 2. On 4/16/24 at 9:19 A.M., Resident 51's clinical record was reviewed. Diagnoses included, but were limited to, chronic obstructive pulmonary disease (COPD), stroke, and hemiplegia (paralysis) on the left side. The most recent Quarterly MDS Assessment, dated 3/29/24, indicated Resident 51 was not receiving hospice care. Current Physician's Orders included, but were not limited to, the following: (Hospice Company Name), ordered 1/5/2024 Resident 51's clinical record included a current hospice care plan, revised 1/4/24. During an interview on 4/22/24 at 9:25 A.M., the MDS Coordinator indicated hospice should have been marked and she missed it. 3. On 4/16/24 at 10:51 A.M., Resident 31's clinical records were reviewed. Diagnosis included, but		and residents receiving hospice services on assessments. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Audits will be completed 5x weekly for 1 month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month and 1x weekly for two months to ensure assessments accurately reflect the resident's status. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	was not limited to bipolar disorder and major depressive disorder. On 4/19/24 at 8:54 A.M., the most current Annual MDS Assessment, dated 7/1/23, indicated Resident 31 was marked no for having a PASSAR II. On 4/22/24 at 8:15 A.M., the Business Office Manager provided a copy of the PASSAR II that was in Resident 31's chart. During an interview on 4/22/24 at 9:23 A.M., the MDS Coordinator indicated that marking Resident 31 did not have a PASSAR II was an error. She indicated Social Services normally filled that section out, and since the facility currently did not have a Social Worker, she filled it out. 4. On 4/16/24 at 12:54 P.M., Resident 1's clinical records were reviewed. The diagnosis included, but was not limited to paranoid schizophrenia. The most current Annual MDS (Minimum Data Set) Assessment, dated 6/3/23, indicated Resident 1 was marked No for having a PASSAR II. On 4/22/24 at 8:15 A.M., the Business Office Manager provided a copy of the PASSAR II that was in Resident 1's chart. During an interview on 4/22/24 at 9:23 A.M., the MDS Coordinator indicated that marking Resident 1 did not have a PASSAR II was an error on her part. She indicated Social Services normally filled that section out, and since the facility currently did not have a Social Worker, she filled it out. During an interview on 4/22/24 at 9:23 A.M., the MDS Coordinator indicated she did not have an			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	MDS Policy. She indicated she use the RAI (Resident Assessment Instrument) Manual as the policy. 3.1-31(i)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on observation, interview, and record review, the facility failed to ensure care was provided in accordance with the written plan of care for 2 of 2 residents reviewed for smoking. A resident smoked in a non-designated smoking area. Staff failed to lock up residents smoking materials.(Anonymous Resident, Resident 1) Findings include: 1. During an interview on 4/17/24 7:37 A.M., an Anonymous Resident indicated cigarettes are kept in the resident's room and supervision is not needed to smoke. During an observation on 4/19/24 at 1:42 P.M., an Anonymous Resident was unsupervised on the front porch. At that time, the resident lit a cigarette. On 4/16/24 at 10:30 A.M., the Resident's clinical record was reviewed. Diagnoses included, but was not limited to, diabetes mellitus, hypertension, seizure disorder, and chronic	F 0656	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Education was provided to Resident 1 that it is a requirement of the Smoking Policy that all items related to smoking are to be kept at the nurses' station. Resident 1 returned his smoking material to the nurses to be kept at the nurses' desk. Resident 1's care plan was updated to reflect his current status. How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Residents that smoke will be re-educated on the	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	obstructive pulmonary disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 3/10/24, indicated the Anonymous Resident was cognitively intact and had shortness of breath. A current smoking and safety assessment, dated 3/6/24, indicated that the resident used tobacco products and followed the facility's policy on location of smoking. A current at risk for smoking related injury care plan, initiated 7/18/23, included, but was not limited to, the following interventions, "...Assure smoking material is extinguished prior to patient leaving smoking area...Observe patient for unsafe smoking behaviors or attempts to obtain smoking material from outside sources. Immediately inform facility management...Patient not to have cigarettes or smoking material on person...Storage of smoking materials per Living Center policy..." During an interview on 4/22/24 at 8:42 A.M., LPN (Licensed Practical Nurse) 16 indicated Resident's should go out the back door to smoke, and Residents should not smoke on the front porch unless they are supervised. At that time, she indicated the Anonymous Resident could keep possession of the smoking materials. After the care plan was reviewed, LPN 16 indicated the Anonymous Resident's smoking materials must be held by staff. 2. On 4/16/24 at 8:50 A.M., Resident 1 was observed sitting outside to the left of the door smoking, sitting on rollator walker with no smoking apron on and no staff present. On 4/17/24 at 10:02 A.M., Resident 1 was observed ambulating down the hall with a rollator		smoking policy. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Audits will be conducted 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month and 1x weekly for one month to ensure residents that smoke do not have smoking materials in their room. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	walker, stopping at nurse's desk to sign smoking sign out sheet. At that time, he indicated he was going outside to smoke. On 4/22/24 at 8:42 A.M., Resident 1 was observed standing at nurse's desk with rollator walker and coat on signing smoking sign out sheet. He did not ask nurse for cigarettes. Resident 1 was observed getting on the elevator. Resident 1 was observed walking down hall on 1st floor to door to smoking area, putting code in, and walking outside without supervision and without a smoking apron. Resident 1 was observed sitting on rollator walker outside to the left of the door lighting a cigarette. On 4/16/24 at 12:54 P.M., Resident 1's clinical records were reviewed. Diagnosis included, but were not limited to paranoid schizophrenia, dementia, extrapyramidal movement disorder, and epilepsy. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 3/2/24 indicated Resident 1 was moderately cognitively impaired, and needed supervision of one for bed mobility, transfers, eating and toilet use. A current Smoking Care Plan dated 3/19/12 was provided on 4/19/24 at 10:15 A.M. Interventions included, but were not limited to the following: Patient not to have cigarettes or smoking material on person, date initiated 12/3/21 Supervision and wear apron, revision on 5/13/22 During an interview on 4/16/24 at 9:03 A.M., Resident 1 indicated he could go outside to smoke by himself whenever he chose. He indicated he kept his cigarettes in a blue bag in his rollator walker and kept cigars in his dresser.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 4/16/24 at 9:14 A.M., RN 24 indicated there was a sign out sheet at the nurse's desk for smokers to sign out, but they don't have to sign back in. She indicated the smokers go outside to smoke by themselves. During an interview on 4/22/24 at 8:42 A.M., LPN 16 indicated most of the time cigarettes for the smokers were kept at the nurse's desk. She indicated if a resident was cognitively intact they could keep their cigarettes with them. She indicated Resident 1 could keep his cigarettes with him. When asked to look at Resident 1's Smoking Care Plan, LPN 16 indicated the care plan said the resident was not to have cigarettes on his person. On 4/19/24 at 11:00 A.M., a Comprehensive Care Plan Policy, dated February 2023, was provided by the Regional Consultant which indicated "...Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made." 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to provide care plan conferences quarterly for 2 of 5 residents reviewed for unnecessary medications. (Resident 35, Resident 52) Findings include: 1. On 4/18/24 at 12:50 P.M., Resident 35's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and anxiety disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/11/24, indicated a severe cognitive impairment. Resident 35's most recent care plan meeting was held 12/13/23. Resident 35's clinical record lacked a care plan meeting since 12/13/23.	F 0657	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Care plan meetings were held for Resident #52 and #35. How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Social Services/Designee will review the care plan schedule to ensure all residents are notified of their scheduled care plan meeting.	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/15/24 at 12:39 P.M., the Administrator indicated there was no current Social Services Director (SSD) as the most recent one quit in January 2024. She indicated the Activities Director was assuming the role of care plan meeting coordinator until a new SSD could be found. 2. On 4/17/24 at 11:00 A.M., Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, Alzheimer's disease, and anxiety disorder. The most recent Quarterly MDS, dated 1/26/24, indicated a severe cognitive impairment. The clinical record lacked a care plan conference between 9/19/23 and 3/12/24. During an interview on 4/22/24 at 8:55 A.M., the Administrator indicated social services arranged the care plan conferences, but the activity director had been helping set the conferences up due to the facility not having a social services provider. At that time, she indicated she was unsure of how often care plan conferences should be completed. On 4/22/24 at 11:21 A.M., the Regional Consultant provided an undated Care Planning-Resident Participation policy that indicated, "...10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes..." 3.1-35(c)(2)(C) 3.1-35(d)(2)(B)		What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? The Social Services Director/Designee will use the monthly calendar prepared by the MDS Coordinator to schedule care plan meeting timely with residents and families. Audits will be conducted 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for 1 month and 1x weekly for 2 months for timely notification of care plans. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
Bldg. 00	Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with 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, interview, and record review, the facility failed to provide care, consistent with professional standards of practice, to prevent pressure ulcers and promote healing of existing pressure ulcers for 2 of 2 residents reviewed for pressure ulcers. Residents admitted with a deep tissue injury (DTI) and incontinence associated dermatitis (IAD) worsened and resident developed a stage IV pressure ulcer on the right heel. (Resident 64, Resident 23) Findings include: 1. On 4/16/24 at 10:52 A.M., Resident 64's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure, weakness, and atrial fibrillation. Resident 64 was admitted on 2/8/24. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/25/24, indicated Resident 64 was cognitively intact and an extensive assist of 2 staff for bed mobility,	F 0686	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents # 64 and #26 will be placed on turning and repositioning audits. Re-education was provided for CNA 34, QMA 19, CNA 80 and LPN 42 to ensure staff provides professional standard of practice to prevent pressure ulcers, and promote, if applicable, healing of existing pressure ulcers. How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents who have pressure ulcers have the potential to be affected by this deficient practice. Nursing staff was re-educated to ensure staff provide	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	transfers, and toileting. Resident 26 noted to have a foley catheter, colostomy, and 1 unstageable pressure ulcer. Current Physician Orders included, but were not limited to, the following: Cleanse right heel open area with wound cleanser, pat dry, Apply Manuka (honey alginate) cut to size and cover with border dressing every night shift daily, every other day (sic), ordered 4/4/24 Cleanse wound to coccyx with wound cleanser and pat dry. Apply Honey alginate (Manuka) cut to size, cover with bordered foam dressing every night and as needed for soiling or dislodgement, ordered 4/11/24 House shake three times a day for wound care, ordered 3/13/24 Juven oral packet, give 1 packet by mouth two times a day at 7:00 A.M. and 8:00 P.M., ordered 3/13/24 A current Pressure Ulcer Care Plan, dated 3/24/24, included, but was not limited to, the following interventions: juven and house shake for wound healing as ordered, initiated 3/14/24 turning and repositioning every 2 hours and as needed, initiated 3/24/24 Skin and wound notes from admission on 2/8/24 through 4/17/24 were reviewed and indicated the following: Wound 1 On 2/14/24 at 1:30 P.M., Patient was seen today for a DTI (damage of underlying soft tissue of		professional standards of practice, to prevent pressure ulcers and promote, if applicable, healing of existing pressure ulcers. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? DNS/Designee will audit residents with pressure ulcers to ensure professional standards of practice to prevent pressure ulcers and promote, and if applicable, healing of existing pressure ulcers 5x a week for one month, 4x a week for one month, 3x a week for one month, 2 x a week for one month and 1x a week for two months. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	skin from pressure and/or shearing) on her sacrum acquired by the hospital. Location: coccyx (back of body above buttocks). Size: 0 centimeter (cm) x 0 cm x 0 cm. Initial weekly wound assessment of DTI pressure present on admission to sacrum/coccyx area completed 2/14/24 by Wound Nurse Practitioner (NP) and facility Wound Nurse. Wound appears with deep red/purple area. No drainage. Recommended TRIAD (sterile coating used on broken skin to keep it covered and protected from incontinence) cream to area every shift, leave open to air. On 2/21/24 at 11:24 A.M., Patient was seen today for a DTI on her sacrum acquired by the hospital. Location: sacrum. Primary Etiology: Pressure. Stage/Severity: DTI. Wound Status: Improving without complications. Size: 1 cm x 0.5 cm x 0 cm. Recommended cleansing with soap and water, pat dry, apply triad to base of the wound, leave open to air, and change twice daily and as needed. The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. On 2/26/24 at 10:20 A.M., Noted: discolored area to coccyx was being treated with Triad hydrophilic wound dress external paste. Wound noted to open. Wound measurement 2.0 cm x 2.0 cm x < 0.1 cm. Wound cleansed. Wound bed covered with Xeroform cut to size, covered with bordered foam gauze dressing. On 2/28/24 at 9:18 A.M., Patient was seen today for a DTI on her sacrum acquired by the hospital. Deep tissue pressure injury (DTPI) location: coccyx Size: 4 cm x 2 cm x 0.1 cm with moderate			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of sacral wound completed 2/28/24 by Wound NP and facility Wound Nurse. Patient had unstageable (full thickness tissue loss but depth of ulcer can not be determine) DTI to sacrum. Recommended use of Honey alginate (Manuka) to wound bed, secure with silicone border foam dressing related to fragile skin and moderate drainage, change daily. Rest in bed with low air loss mattress, turn and reposition protocol. Heel protector to right foot, heels floated. On 3/6/24 at 3:13 P.M., Patient was seen today for a DTI on her sacrum acquired by the hospital. DTPI location: coccyx Size: 5 cm x 3 cm x 0.1 cm with moderate amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of sacral wound completed 3/6/24 by Wound NP and facility Wound Nurse. Patient had unstageable DTI to sacrum. Recommend continuing the use of Honey alginate (Manuka) to wound bed, secure with silicone border foam dressing related to fragile skin and moderate drainage, change daily. Rest in bed with low air loss mattress, turn and reposition protocol. Heel protector to bilateral feet, heels floated. On 3/13/24 at 9:45 A.M., Patient was seen today for a DTI on her sacrum acquired by the hospital. DTPI location: coccyx Size: 4 cm x 2.5 cm x 0.1 cm with moderate amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of unstageable sacral wound completed 3/13/24 Wound NP and facility Wound Nurse. Recommended continuing the use of Honey alginate (Manuka) to wound bed, secure with silicone border foam dressing related to fragile skin and moderate drainage, change daily.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	Rest in bed with low air loss mattress, turn and reposition protocol. Heel protector to bilateral feet, heels floated. On 3/20/24 at 12:58 P.M., Patient was seen today for a DTI on her sacrum acquired by the hospital. DTPI location: coccyx Size: 3.5 cm x 3 cm x 0.1 cm with moderate amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of unstageable sacral wound completed 3/20/24 by Wound NP and facility Wound Nurse. Wound is stalled with moderate amount of serosanguinous drainage. Recommended continuing the use of Honey alginate (Manuka) to wound bed, secure with silicone border foam dressing related to fragile skin and moderate drainage, change daily. Rest in bed with low air loss mattress, turn and reposition protocol. Heel protector to bilateral feet, heels floated. Reviewed results of prealbumin, dietician notified. Juven and mighty shakes ordered with meals to aid in wound healing. On 3/27/24 at 11:08 A.M., Patient was seen for a DTI on her sacrum acquired by the hospital. This is now an unstageable. She always lays on her bottom. DTPI location: coccyx Size: 4 cm x 3.5 cm x 0.1 cm with moderate amount of serosanguineous drainage. Weekly wound assessment of unstageable sacral wound completed 3/27/24 by Wound NP and facility Wound Nurse. Wound was stalled with moderate amount of serosanguinous drainage, 100% slough to wound bed, wound debrided. Recommended continuing the use of Honey alginate (Manuka HD) to wound bed, secure with silicone border foam dressing related to fragile skin and moderate drainage, change daily. Turn and reposition every 2 hours from side to side. Rest in bed with low air loss			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	mattress, heels floated. Juven twice daily and mighty shakes ordered with meals to aid in wound healing. On 4/2/24 at 11:45 A.M., Patient was seen for a DTI on her sacrum acquired by the hospital. She always lays on her bottom. DTPI location: coccyx Size: 4 cm x 3.5 cm x 1.5 cm with moderate amount of serosanguineous drainage. Community acquired pressure to sacral area. Improving despite measurements. Sacral wound culture showed Staph Aureus (is a type of germ that about 30% of people carry in their noses). Receiving doxycycline 100 (milligrams) mg twice daily for 10 days. PCP noted rectal fistula with drainage upon inspection. Will continue use of Dakin's moistened fluffed gauze to wound bed, secure with bordered gauze, change every shift. On 4/10/24 at 12:35 P.M., Patient was seen for a DTI on her sacrum acquired by the hospital. On 3/27/24, this is now an unstageable. She always lays on her bottom. On 4/10/24, her sacrum was now a stage IV (The Center for Medicare and Medicaid Services defined a Stage 4 pressure ulcer as: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). DTPI location: coccyx Size: 4 cm x 3.3 cm x 1.2 cm with moderate amount of serosanguineous drainage. Improving despite measurements. Continue doxycycline 100 (milligrams) mg twice daily. Wound measurements were done by 2 different nurses which may explain the difference in calculations. Denies any pain. Will change treatment to Manuka (honey alginate) to wound bed, secure with bordered gauze, and change daily.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/17/24 at 1:27 P.M., Patient was seen for a DTI on her sacrum acquired by the hospital. On 3/27/24, this is now an unstageable. She always lays on her bottom. On 4/10/24, her sacrum was a stage IV. DTPI location: Coccyx Size: 4 cm x 3 cm x 1.2 cm with moderate amount of serosanguineous drainage. Improving despite measurements. Denies any pain. Changed treatment to Manuka (honey alginate) to wound bed, secure with bordered gauze, and change daily. Wound 2 On 3/27/24 at 4:34 P.M., Patient noted for new Pressure ulcer. Location: right heel. Size: 2.8 cm x 2 cm x 0.1 cm. Pressure ulcer staging: Stage II (The Center for Medicare and Medicaid Services defined a Stage 2 pressure ulcer as: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister). Recommended xeroform to wound bed, secure with silicone border foam dressing, change every other day (QOD), to wear derma saver boots to bilateral feet while in bed. turn and reposition every 2 hours from side to side. Rest in bed with low air loss mattress, heels floated. Juven twice daily and mighty shakes with meals ordered to aid in wound healing. On 4/2/24 at 11:45 A.M., History of Present Illness (HPI) does not indicate resident has pressure on her right heel, but addresses it in the wound assessment. Pressure ulcer location: right heel. Size: 3 cm x 2 cm x 0.1 cm with scant amount of serous drainage. Unstageable pressure area to right heel. Weekly wound assessment of pressure areas to right heel and sacral area completed 4/3/24 by Wound NP and facility Wound Nurse. Recommended Manuka (honey alginate) cut to size to wound bed, secure with bordered gauze.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	Heels floated, rest in bed with low air loss mattress, turn and reposition protocol. Appetite was good, received supplements and Juven to aid in healing. On 4/10/24 at 10:36 A.M., Patient was seen on 4/10/24, her right heel now a stage IV. Pressure ulcer location: right heel. Size: 2 cm x 1.5 cm x 0.1 cm with scant amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of pressure areas to right heel and sacral area completed 4/10/24 by Wound NP and facility Wound Nurse. Wound measurements were done by 2 different nurses which may explain the difference in calculations. Recommended cleanse with wound cleanser, apply Manuka (honey alginate) cut to size to wound bed, secure with bordered gauze. Heels floated, rest in bed with low air loss mattress, turn and reposition protocol. Appetite is good, received supplements and Juven to aid in healing. On 4/17/24 at 1:27 P.M., Patient was seen on 4/10/24, her right heel now a stage IV. Pressure ulcer location: right heel. Size: 0.8 cm x 1.2 cm x 0.1 cm with scant amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of pressure areas to right heel and sacral area completed 4/17/24 by Wound NP and facility Wound Nurse. Recommended cleanse with wound cleanser, apply Manuka (honey alginate) cut to size to wound bed, secure with bordered gauze. Heels floated, rest in bed with low air loss mattress, turn and reposition protocol. Appetite is good, received supplements and Juven to aid in healing. On 4/17/24 at 10:38 A.M., wound care performed by the facility Wound Nurse and Wound Nurse Practitioner (NP) was observed. The Wound			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	Nurse indicated Resident 26 came to facility with the sacral wound but it was not getting better. She indicated the Primary Care Physician (PCP) recently noticed drainage from rectal fistula and indicated it was "feeding it".The Wound NP indicated the right heel was a facility acquired stage IV pressure ulcer. She measured the wound as length 1.2 x width 1.8cm x depth 0.1 cm, sprayed it with lidocaine and debrided the wound. Then she performed wound care on the sacral wound. She measured it as length 4.5 cm x width 3cm. She indicated it was "looking better", sprayed lidocaine and debrided the wound. Both wounds lacked signs and symptoms of redness, odor, drainage, and swelling and were dressed as ordered prior to and after wound care. The observations at that time did not meet defining criteria for a stage IV wound. On 4/19/24 at 7:30 A.M., Resident 64 was observed laying on her back asleep in her bed. On 4/19/24 at 7:45 A.M., Resident 64 was observed with the head of her bed elevated, sitting in bed, and eating breakfast. At that time, staff indicated her meal ticket did not say Resident 64 was to have any supplements, so she doesn't know if she was supposed to have some or not. Resident noted to have heel protectors on both feet and heels floating. She was covered with sheet and blanket up to her waist. During a continuous observation on 4/19/24 from 8:05 A.M. to 10:15 A.M., the following was observed: On 4/19/24 at 8:05 A.M., Resident 64 was observed sitting in her bed as she was when she was eating breakfast.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/19/24 from 8:39 A.M. to 9:51 A.M., , Resident 64 was observed with her eyes closed, sitting in her bed as she was when she was eating breakfast. On 4/19/24 at 9:51 A.M., Certified Nurse Aide (CNA) 34 went into room and answered the call light of Resident 64's roommate. She did not attend to Resident 64 who was observed sitting in her bed as she was when she was eating breakfast. On 4/19/24 at 9:57 A.M., Qualified Medication Aide (QMA) 19 entered the room and talked to Resident 26's roommate. She did not attend to Resident 64 who was observed sitting in her bed as she was when she was eating breakfast. On 4/19/24 at 10:00 A.M., CNA 34 walked past Resident 64's room. She was observed sitting in her bed as she was when she was eating breakfast. On 4/19/24 at 10:03 A.M., QMA 19 came into Resident 64's room to give roommate medication but did not attend to Resident 64 who was observed sitting in her bed as she was when she was eating breakfast. On 4/19/24 at 10:05 A.M., CNA 34 walked past Resident 64's room who was observed sitting in her bed as she was when she was eating breakfast. On 4/19/24 at 10:07 A.M., CNA 34 and QMA 19 walked past Resident 64's room who was observed sitting in her bed as she was when she was eating breakfast. On 4/19/24 at 10:15 A.M., Resident 64 was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	observed sitting in her bed as she was when she was eating breakfast. During an interview on 4/22/24 at 8:51 A.M., Licensed Practical Nurse (LPN) 16 indicated she came to the facility with the coccyx wound, but it kept getting worse until the PCP found the rectal fistula and they figured out that was where the drainage was coming from. Now it's getting better. The wound on her heel started here possibly from her rubbing her heels on her sheets while she was laying in bed. During an interview on 4/22/24 at 8:56 A.M., CNA 80 indicated she was aware that Resident 64 had pressure ulcers. She wasn't sure what they were doing for them because the nurses provided the treatments. At that time, she indicated she liked to sit in her bed but did get into her wheelchair at times. During an interview on 4/22/24 at 9:12 A.M., the Director of Nursing (DON) indicated Resident 64's wounds would stay staged as stage IV until they heal, despite improvement. At that time, she indicated staff were repositioning her off her wound and keeping heel boots on, and floating her heels while she was in bed. 2. On 4/16/24 at 11:02 A.M., Resident 23's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, traumatic brain injury, and anxiety. The most recent Quarterly and State Optional MDS Assessment, dated 3/24/24, indicated a severe cognitive impairment, and one stage 3 pressure ulcer present on re-entry. Resident 23 required extensive assistance of two staff for bed mobility and transfers. Resident 23 returned from a hospitalization on 4/12/24.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	Physician orders included, but were not limited to: Cleanse sacral area with wound cleanser, pat dry, apply polymem pink (an absorbent dressing) to skin breakdown and redness, cover with sacral border dressing and notify MD of deterioration daily, once a day, dated 4/13/24. Lantiseptic Skin Protectant Ointment 50 % (Skin Protectant) apply to buttocks topically every day and night shift for redness, dated 2/22/24. A current risk for pressure ulcers care plan, updated on 3/5/24 to reflect a current stage 3 sacral pressure ulcer, included but was not limited to, the following interventions: Treatments as ordered, dated 1/11/24. Turning and repositioning every 2 hours and as needed, dated 1/11/24. Skin and wound notes from the Nurse Practitioner (NP) included, but were not limited to, the following: 1/24/24 Bilateral buttocks with IAD. Cleanse with soap and water, apply barrier cream to base of the wound, leave open to air, change twice a day and as needed. 1/31/24 Bilateral buttocks with IAD measuring 0x0x0 (cm). Cleanse with soap and water, apply barrier cream to base of the wound, leave open to air, change twice a day and as needed. 2/7/24 Bilateral buttocks with IAD measuring 0x0x0 (cm). Cleanse with soap and water, apply barrier cream to base of the wound, leave open to air, change twice a day and as needed. 2/14/24 Bilateral buttocks with IAD measuring 0x0x0 (cm). Cleanse with soap and water, apply barrier cream to base of the wound, leave open to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	air, change twice a day and as needed. 2/28/24 Stage 3 pressure ulcer to sacrum measuring 5x5x0.1 (cm). Cleanse with soap and water, apply barrier cream to base of the wound, leave open to air, change twice a day and as needed. (A Stage 3 pressure ulcer as defined by the Center for Medicare and Medicaid Services is full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). The observation at that time did not meet defining criteria for a stage 3 wound. 3/6/24 Stage 3 pressure ulcer to sacrum measuring 6x3x0.1 (cm). Cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered gauze and change twice a day and as needed. 3/13/24 Stage 3 pressure ulcer to sacrum measuring 6x6x0.1 (cm). Cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered gauze and change twice a day and as needed. 3/20/24 Stage 3 pressure ulcer to sacrum measuring 7x6x0.1 (cm). Cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered gauze and change twice a day and as needed. 3/27/24 Stage 3 pressure ulcer to sacrum measuring 6x5x0.1 (cm). Cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered gauze and change twice a day and as needed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	4/17/24 Stage 3 pressure ulcer to sacrum measuring 4x1.5x0.1 (cm). Cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered gauze and change daily and as needed. Skin only evaluations from the wound nurse included, but were not limited to, the following: 2/22/24 Open lesion needs review. Right buttock measuring 3.5x1.3 (cm). 4/4/24 Stage 3 pressure ulcer to buttocks measuring 6x4.5x0.1 (cm). Hospital records dated 4/10/24 indicated Resident 23 was admitted to the hospital on 4/9/24 with an existing sacral pressure ulcer measuring 3x3x<0.1. Resident 23's clinical record lacked a re-entry sacral wound assessment on 4/12/24. On 4/17/24 at 9:34 A.M., the NP and wound nurse were observed to perform a dressing change for Resident 23's sacral pressure ulcer. The area measured 4x1.5 (cm). The wound nurse cleansed the wound with wound cleanser, pat dried the area, applied two medihoney pads that the wound nurse indicated contained calcium alginate also, and applied a foam border. At that time, the NP indicated she wanted the order changed to use medihoney, as the facility did not use polymem dressings that was currently ordered. On 4/18/24 at 9:40 A.M., Licensed Practical Nurse (LPN) 42 was observed to perform a dressing change for Resident 23's sacral pressure ulcer. At that time, she indicated the order had been updated that morning and would be using medihoney on the wound. LPN 42 removed the soiled dressing, dated 4/17/24, cleansed the area			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	with wound cleanser and let air dry. LPN 42 then placed two pads of medihoney dressing on top of each other on the wound bed. The red areas surrounding the wound were not covered with medihoney. A foam border was placed over the entire area. At that time, LPN 42 indicated the medihoney should cover all red areas per the order. At that time, the wound was observed as open with area in the middle beefy red. The surrounding area was pink and very little pink drainage was observed. On 4/18/24 at 10:00 A.M., Resident 23's record was reviewed a second time. Current orders included, but were not limited to, the following: Cleanse sacral area with wound cleanser, pat dry, apply honey alginate to skin breakdown and redness, cover with border foam dressing and notify MD of deterioration daily, dated 4/18/24. On 4/18/24 at 10:50 A.M., the wound nurse indicated she believed Resident 23 has had a recent decline in overall status, although no decline had been identified in any other areas other than the pressure areas. She indicated Resident 23 was totally dependent on staff for all activities of daily living (ADLs) and had been that way for a long time now. She indicated the area on the sacrum had been there for over a year now, and had healed and re-opened. On 4/19/24 at 6:30 A.M., Resident 23 was observed lying on her back in bed. During a continuous observation on 4/22/24, Resident 23 was not turned/repositioned from 4:35 A.M. until 6:50 A.M. On 4/22/24 at 10:25 A.M., a non-dated current Pressure Injury Prevention policy was provided			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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 indicated "Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them" 3.1-40(a)(1) 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent accidents for 1 of 3 residents reviewed for falls. Interventions put into place after falls were not evaluated and modified and interventions were not followed for a resident at risk for falls resulting in multiple falls. (Resident 26) Finding includes: On 4/15/24 at 9:47 A.M., Resident 26 was observed laying in her lowered (but not lowest position)bed. Her call light was wrapped around hook on the wall above the head of bed. Resident 26 indicated she wanted to get out of bed. On 4/15/24 at 9:50 A.M., Resident 26 told staff, " I need to get up. I have a hair appointment at 10." Staff told the resident, "Hang on, let me check."	F 0689	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? CNA 80 was re-educated on fall prevention practices. Fall interventions for resident #26 were evaluated and modified. How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Nursing staff will be re-educated on fall prevention practices.	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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 left the room. Resident uncovered, sat bedside, was restless, and repeating, "I need to get up." On 4/15/24 at 9:54 A.M., staff came back to the room and notified resident that her hair appointment wasn't until the next day and left the resident's room. On 4/15/24 2:14 P.M., Certified Nurse Aide (CNA) 52 was observed putting Resident 26 in bed and telling the resident, "Stay in bed. Try to get some sleep." The call light was not moved from the hook above the head of the bed where it was observed earlier. On 4/15/24 at 2:18 P.M., Resident 26 was observed getting out of her bed, stood by her wheelchair, and started to get in it. Once alerted, CNA 52 came back into the room, helped the resident get back in her wheelchair, and took the resident up to sit by the nurse's station. On 4/18/24 at 1:19 P.M., Resident 26 was observed sleeping in bed and her call light was laying over the raised bedside table with the button laying towards the roommate. On 4/19/24 at 7:49 A.M., CNA 80 was observed taking Resident 26 to her room from the dining room in her wheelchair and laying her down in her bed without toileting the resident. Her call light was laying on the floor between her and her roommate's bed. The bed was in lowered, but not in lowest position. On 4/19/24 at 8:20 A.M., the Director of Nursing entered Resident 26's room, lowered the bed to the lowest position while resident was asleep, and placed her call light in reach.		What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? DNS/Designee will perform audits for 5x a week for one month, 4 x a week for one month, 3 x a week for one month, 2x a week for one month and 1x a week for two months to ensure fall interventions are in place. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

On 4/18/24 at 10:04 A.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety, weakness and Alzheimer's disease. Resident 26 was admitted on 11/22/23.

The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/19/24, indicated Resident 26's cognition was severely impaired and she was an extensive assist of 2 staff for bed mobility and toileting, an extensive assist of 1 staff for transfers. Resident 26 had 2 or more falls, 1 with injury.

A current Falls Care Plan, dated 11/26/23 included, but was not limited to, the following interventions:
15 minute checks x 3 days, initiated 3/21/24

call light within reach, initiated 11/26/23

resident to be in low bed, initiated 12/8/23

Toilet plan: Toilet before and after meals, at bedtime and every 2 hours through night and as needed, 12/1/23

Wearing of appropriate footwear, 11/26/23

Fall Risk Assessments were reviewed from 11/22/23 through 4/16/24 and all of them indicated resident to be a high risk for falls.

Progress notes were reviewed and included, but were not limited to, the following:
On 12/6/23 at 9:47 P.M., Behavior Charting: "Resident got up unassisted and was in hallway. Staff immediately went to get resident and assisted her into w/c [wheelchair]. Resident confused. Brought up by nurses desk. Repeatedly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	asking staff about writing them a check and when she can leave. Repeatedly standing up unassisted. Keeps stating she needs to leave because she has to go to work tomorrow. Unable to redirect. Resident had just been toileted and assisted back to bed ... " On 12/7/23 at 9:41 A.M., Change of Condition: "Resident continues to be restless at night, goes to sleep and does not stay. Has been getting up unassisted and ambulating, gait very unsteady. Resident continues to be irritated in am (morning). Does have dementia ... " On 12/30/23 at 11:30 A.M., Change of Condition: "Resident has been having increased episodes of confusion and anxiety. Has fell several times due anxiousness. When having periods of anxiety has become harder to redirect ... " On 1/7/24 at 6:30 P.M., Behavior Charting: "Resident ambulated into dining room using bedside table for support. Resident attempting to open door to stairwell. Resident spilled liquids and bucket of colored pencils onto the floor while wheeling bedside table through dining room ... " Falls were reviewed from admission on 11/22/23 through 4/18/24. Resident 26 had the following 7 falls: Fall 1 On 12/1/23 at 9:30 A.M. Unwitnessed fall. Resident was sitting on the floor in her room in front of her wheelchair. Resident incontinent of urine at time of fall. Alert with confusion. Noted reddened area, measuring 4 (centimeters) cm x 2.6 cm to right clavicle area. A right clavicle and right shoulder STAT (immediately) x-ray was ordered and showed no fracture. Falls Care Plan was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	updated with an intervention to toilet resident before and after meals, at bedtime and every 2 hours through night and as needed, initiated 12/1/23. Fall 2 On 12/7/23 at 8:30 P.M. Unwitnessed fall. Resident noted to be sitting on the floor on her bottom between her bed and her roommate's bed. When asked what happened, resident stated, "I fell on my butt." Bed was in low bed position at time of fall. Falls Care plan was updated with an intervention to be in low bed, initiated 12/7/24. Fall 3 On 12/29/23 at 6:55 P.M. Unwitnessed fall. Resident noted to be on the floor, barefoot, and on her bottom between resident's bed and roommate's bed. Upon speaking with roommate, roommate states that resident got up and stood next to her bed and then started to fall, grabbing the bedside table and taking it down with her. Resident often stands up without assistance. Confused at all times. Disoriented. Exhibits behaviors often. Intervention: 15 minute checks for 3 days (12/29/23 6:55 P.M. through 1/1/24 6:55 P.M.) 15 minute checks for this fall were reviewed and indicated they were performed every 15 minutes from 7:00 P.M. on 12/29/23 to 6:45 P.M. on 12/31/23. Then they weren't done until 1:15 A.M., 1:30 A.M., and 1:45 A.M., on 1/1/24 then not again until 5:45 A.M. and stopped. Fall 4 On 12/29/23 at 8:20 P.M. Unwitnessed fall. Resident had fallen on the floor between her wheelchair and the side of the bed facing the door. Resident attempts to get up on her own often. Resident has unsteady gait requiring 1 assist with transfers and wheelchair for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	ambulation. Neurological checks provided were reviewed, but started at 8:55 P.M. and then not done again until 9:50 P.M. Falls Care Plan was updated with an intervention for nonskid strips to floor by bed on door side, initiated 12/29/23. Fall 5 On 12/29/24 at 9:50 P.M. Unwitnessed fall. Resident laying barefoot on the floor in front of her wheelchair in front of the door. The wheelchair was not locked. Resident has been restless this night. Standing up and walking without assistance. Falls Care Plan was updated with an intervention for Dycem to wheelchair set, initiated 12/29/23. Fall 6 On 1/24/24 at 8:29 P.M. Unwitnessed fall. Resident was found yelling out for help sitting next to the bed on the floor. Resident stated she attempted to transfer from the wheelchair to her bed. Resident has dementia and history of falls. Falls Care Plan was updated with an intervention not to be alone in room sitting in wheelchair, initiated 1/24/24. Fall 7 On 3/20/24 at 1:55 P.M. Unwitnessed fall. Resident found sitting on the floor barefoot next to bed. Resident stated she rolled out of bed. Falls Care Plan was updated with an intervention of 15 minute checks for 3 days, initiated 3/20/24. Documentation of the 15 minute checks was requested but not provided for this fall. During an interview on 4/22/24 at 8:48 A.M., staff indicated they were not sure why Resident 26 fell often but she did get up by herself a lot and had to go to the bathroom quite often. At that time, they indicated they weren't sure if there was an intervention in place for that. The roommate will			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	use her call light and alert us if she sees her getting up, we keep her bed lowered, and check on her. During an interview on 4/22/24 at 9:03 A.M., the DON indicated she did lower the bed Resident 26 was laying in earlier that morning because the bed was low but not in the lowest position. She expected it to be in the lowest position possible. At that time, she indicated she also laid the call light next to the resident within her reach. She indicated Resident 26 could not use her call light, but it should still be made available to the resident. She indicated she did expect interventions on care plan to be followed. A current Accidents and Supervision Policy, revised February 2023, was provided on 4/22/24 at 10:25 A.M., by the DON and indicated " ... Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s) 2. Evaluating and analyzing hazard(s) and risk(s) 3. Implementing interventions to reduce hazard(s) and risk(s) 4. Monitoring for effectiveness and modifying interventions when necessary ... ensuring interventions are based on results of the evaluation ... consistent with relevant standards, including evidence-based practice ... educating staff ... a. ensuring that interventions are implemented correctly and consistently b. evaluating the effectiveness of interventions c. modifying or replacing interventions as needed d. evaluating the effectiveness of new interventions ... " 3.1-45(a)			
F 0732 SS=C	483.35(g)(1)-(4) Posted Nurse Staffing Information			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
Bldg. 00	§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure posted nurse	F 0732	What corrective action will be accomplished for those residents	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	staffing sheets contained the required information daily for 5 of 5 days reviewed during the survey. Findings include: On 4/15/24 at 8:30 A.M., a staffing sheet was observed posted in the front entrance of the facility on the wall. The posted nurse staffing sheet lacked the facility name and actual hours worked the nursing staff worked was not clear on the posting. On 4/16/24 at 9:30 A.M., a staffing sheet was observed posted in the front entrance of the facility on the wall. The posted nurse staffing sheet lacked the facility name and actual hours worked the nursing staff worked was not clear on the posting. On 4/17/24 at 9:31 A.M., a staffing sheet was observed posted in the front entrance of the facility on the wall. The posted nurse staffing sheet lacked the facility name and actual hours worked the nursing staff worked was not clear on the posting. On 4/18/24 at 3:00 P.M., a staffing sheet was observed posted in the front entrance of the facility on the wall. The posted nurse staffing sheet lacked the facility name, correct census, and actual hours worked the nursing staff worked was not clear on the posting. On 4/19/24 at 11:30 A.M., a staffing sheet was observed posted in the front entrance of the facility on the wall. The posted nurse staffing sheet lacked the facility name and actual hours worked the nursing staff worked was not clear on the posting.		found to have been affected by the deficient practice? The staff scheduler added the facility name and actual hours worked for licensed and unlicensed staff to the posted nurse staffing information. How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. The staff scheduler was re-educated on adding the facility name and actual hours worked for licensed and unlicensed staff to the posted nurse staffing information. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Executive Director/Designee educated scheduler/designee to ensure daily posted staffing includes facility name and staffing information reflects actual hours worked for licensed and unlicensed nursing staff. Administrator/Designee will audit facility name and actual hours worked for posted nurse staffing information 5x per week for one month, 4x a week for one month, 3x a week for one month, 2x a week for one month and 1x a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 4/19/24 at 2:30 P.M., the Scheduler provided the posted nurse staffing sheets and indicated it has the shifts of days (first column), evenings (second column), and night shifts (third column) but they are too dark to be readable. She was unaware the facility name needed to be filled out, and the way the times were listed, they were not able to be deciphered as the actual hours worked of nursing staff. She indicated she erased the census on the 4/18/24 sheet but forgot to rewrite it correctly. A current posted nurse staffing policy, dated 11/28/17, was provided on 4/22/24 at 1:07 P.M., by clinical support and indicated " ... 1. The facility must post the following information on a daily basis: i) Facility name ... iii) The total number and the actual hours worked by ... licensed and unlicensed nursing staff directly responsible for resident care per shift iv) Resident census ... "		week for two months. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure palatable food was served for 1 of 1 meal tray reviewed. Finding includes:	F 0804	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Dietary Manager/Designee will monitor to	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During the course of the survey, the following anonymous resident interviews were obtained: The food is horrid and temperatures are not what they should be. Half of the food is not worth eating. On 4/16/24 at 11:03 A.M., during the resident council meeting, the following anonymous resident interviews were obtained: We (the residents) have complained about the food but were told it was because corporate did the menus and restricted what the facility could have a choice of. Everything is overcooked and dry. On 4/22/24 at 8:10 A.M., a meal tray was obtained that contained oatmeal, a sausage patty, and a piece of french toast. All food items were bland and tasteless. The french toast had hard edges. On 4/22/24 at 9:54 A.M., the Dietary Manager indicated there had been no complaints about the taste of the food to her knowledge. She indicated sometimes french fries and french toast were troublesome due to not being steam table friendly, and often dry out. She indicated if any residents complained about the taste of the food, they would be offered seasonings such as salt and pepper. On 4/22/24 at 11:03 A.M., a current non-dated Food Preparation policy was provided and indicated "Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature ... Using spices or herbs to season food in accordance with recipes"		ensure palatable food is served How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. The Dietary staff will be re-educated on food palatability. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? The Dietary Manager will educate the dietary staff on the ensuring the food is palatable before it is served. The Dietary Manager will conduct random audits with residents 5x per week for one month, 4x a week for one month, 3x a week for one month, 2x a week for one month and 1x a week for two months to ensure the meals they are receiving is palatable. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	3.1-21(a)(1) 3.1-21(a)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on observation, interview, and record review, the facility failed to accurately document care planned interventions for a resident. Restorative walking nursing tasks were not completed as documented for 1 of 2 residents reviewed for Activities of Daily Living (ADLs). (Resident 18)	F 0842	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? CNA #50 re-educated on documentation requirements after tasks are performed.	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	Findings include: On 4/15/24 at 10:39 A.M., Resident 18 indicated the therapy department had told her she needed to use her walker and walk as much as possible, but would need a staff member to walk with her. She indicated she had asked staff to assist her in the past and was told they were too busy. She indicated she had not asked since, as she did not want to bother anyone. On 4/19/24 at 10:30 A.M., Resident 18's clinical record was reviewed. Diagnosis included, but were not limited to, renal failure, heart failure, and depression. The most recent Annual and State Optional MDS (Minimum Data Set) Assessment, dated 2/22/24, indicated no cognitive impairment, active range of motion (AROM) was completed 7 of 7 days during the look back period for at least 15 minutes a day, and walking was completed 6 of 7 days. Resident 18 required limited assistance of 1 staff with transfers. A current restorative program in AROM to maintain current strength and range of motion (ROM) care plan included, but was not limited to, the following intervention: Performing AROM exercises while sitting to bilateral upper and lower extremities, 10 reps each plane with assistance of 1 for guidance and cues, dated 3/15/22. A current restorative program in walking to maintain current ability in walking on and off the unit care plan included, but was not limited to, the following intervention: Monitor and report changes in ROM ability, dated 3/15/22.		How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Nursing staff will be re-educated on documentation requirements after tasks are performed. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Documentation audits will be conducted by the DNS/Designee for 5x a week for 1 month, 4x a week for 1 month, 3x a week for one month, 2x a week for one month, and 1x a week for two months to ensure documentation is performed after the task is complete. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	Walking, assistance of 1 staff, dated 3/15/22. Walking on and off unit using walker or push wheelchair with assistance of 1 for supervision and safety cues for 50 to 100 feet twice a day, dated 3/24/22. Resident 18's clinical record indicated on 4/18/24 she had spent 15 minutes walking a total of 150 feet, and had spent 15 minutes performing AROM to bilateral upper and lower extremities, signed by Certified Nurse Aide (CNA) 17 on 4/18/24 at 6:08 A.M. Resident 18's clinical record indicated on 4/19/24 she had spent 15 minutes walking a total of 25 feet, and had spent 15 minutes performing AROM to bilateral upper and lower extremities, signed by CNA 50 on 4/19/24 at 7:17 A.M. On 4/18/24 at 8:45 A.M., CNA 17 indicated she hadn't walked with Resident 18 yet that morning, but planned to later that day. On 4/19/24 at 12:30 P.M., Resident 18 indicated a member of the therapy staff had been in her room that morning and watched her go to the bathroom and back with her walker. She indicated she did not walk in the hall alone or with staff, and did not do any exercises. On 4/19//24 at 12:40 P.M., CNA 50 indicated she sometimes walked with Resident 18 before dialysis on Monday, Wednesday and Friday, and sometimes after. She indicated most of the time Resident 18 was gone for dialysis by the time she got there in the mornings. At that time, CNA 50 indicated she had not seen Resident 18 yet that day as she had already left for dialysis by the time she got there that morning.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/22/24 at 6:37 A.M., Qualified Nurse Aide (QMA) 9 indicated staff should document tasks after they are performed just in case it's not correct or changes before it was documented. On 4/22/24 at 10:25 A.M., a current non-dated Documentation in Medical Record policy was provided and indicated "Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care" 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure for 1 of 2 residents reviewed for pressure ulcers and 1 of 1 residents observed for incontinence care. Staff did not use Enhanced Barrier Precautions (EBP) for a resident with an open wound. Staff did not use hand hygiene between dirty and clean tasks, did not lather before placing hands under water when washing their hands. (Resident 23, Resident 32) 1. On 4/16/24 at 11:02 A.M., Resident 23's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most recent Quarterly MDS Assessment, dated 3/24/24, indicated a severe cognitive impairment, and a stage 3 pressure ulcer. A current risk for pressure ulcer care plan included, but was not limited to, the following intervention: Enhanced Barrier Precautions (EBP): gown and glove use during high-contact resident care activities related to open wound, dated 3/26/24. On 4/22/24 at 10:25 A.M., a copy of Resident 23's current orders was provided and lacked an order for EBP. On 4/19/24 at 8:14 A.M., Certified Nurse Aide (CNA) 8 was observed to enter Resident 23's room without a gown or gloves. A sign for EBP indicated staff should use gown and gloves with high contact care was posted outside the	F 0880	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? CNA # 8 was re-educated on Enhanced Barrier Precautions. CNA # 24 was re-educated on hand hygiene. How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Nursing staff will be re-educated on Enhanced Barrier Precautions and Hand Hygiene. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? DNS/Designee will conduct audits 5x a week for one month, 4x a week for one month, 3x a week for one month, 2x a week for one month and 1x a week for two months to ensure staff is following Enhanced Barrier Precautions and Hand Hyrgiene Prevention protocol is followed.	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	resident's door, as well as a cart just outside the room with personal protective equipment (PPE). CNA 8 touched the resident's cheeks and forehead with bare hands, pulled up the floor mat from the side of the bed and put it up, and left the room. CNA 8 came back to the room again without a gown or gloves and touched the resident again on her neck, making contact with the resident and her uniform top. On 4/19/24 at 9:35 A.M., the Infection Preventionist indicated staff should put on a gown and gloves for all residents on EBP anytime there was resident contact. 2. During an observation on 4/19/24 at 9:27 A.M., CNA (Certified Nurse Aide) 24 provided incontinence care on Resident 32. CNA 24 used her gloved hands to clean Resident 32's bottom after he had had a bowel movement. At that time, she removed her gloves, and failed to perform hand hygiene before she donned new gloves. Then, she applied cream to the resident and failed to perform hand hygiene before she donned new gloves. She fastened the resident's brief, then removed gloves, put the bed rail down, placed the wipes in the drawer, and washed her hands. CNA 24 failed to lather her hands with soap. During an interview on 4/19/24 at 9:47 A.M., the IP (Infection Preventionist) indicated staff should sanitize or wash hands between dirty and clean tasks and hands should be scrubbed and lathered for 40 seconds. On 4/10/24 at 11:00 A.M., the Regional consultant provided an undated Personal Protective Equipment policy that indicated, "...Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene..."		How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/19/24 at 11:00 A.M., the Regional consultant provided an undated Hand Hygiene policy that indicated, "...5. Hand Hygiene technique when using soap and water:..Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers..." On 4/22/24 at 10:25 A.M., a current non-dated Enhanced Barrier Precautions policy was provided and indicated "An order for enhanced barrier precautions will be obtained for residents with any of the following ... Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) ..." 3.1-18(b) 3.1-18(l)			
F 0919 SS=D Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview and record review, the facility failed to ensure the call system was accessible to residents while in their bed. Resident call lights were not within reach while they were in their beds for 1 of 1 residents reviewed for a urinary tract infection, 1 of 2 residents reviewed for pressure ulcers, and 1 random observation. (Resident 64, Resident 51, Resident 17)	F 0919	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The resident's call light was placed within reach. How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	Findings include: 1. On 4/19/24 at 7:45 A.M., Resident 64 was observed sitting up in bed eating and her call light was laying on the floor between her bed and her roommate's bed. At that time, Theresa miller, was helping Resident 64 with meal set up and then left the room without moving the call light from the floor. On 4/16/24 at 10:52 A.M., Resident 64's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure, weakness, and atrial fibrillation. Resident 64 was admitted on 2/8/24. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/25/24, indicated Resident 64 was cognitively intact and an extensive assist of 2 staff for bed mobility, transfers, and toileting. A current Falls Care Plan, dated 2/9/24, included, but was not limited to, the following intervention: call light within reach, initiated 2/9/24 2. During a random observation on 4/16/24 at 8:39 A.M., Resident 51 was laying in her bed and the call light was wrapped around the bed rail on left side and the button was on the outside of the bed rail. When asked if she could push her call light button, the resident tugged on the cord and indicated, "I don't know where it is. Usually it's laying on the blanket by me." When the resident continued to pull on it, she pulled the end out of the wall trying to get to it and indicated again, "I don't know where it is." On 4/16/24 at 8:41 A.M., Certified Nurse Aide (CNA) 52 was observed responding to the call		taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Staff will be re-educated on the proper placement of the residents' call lights. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Random audits will be conducted 5x weekly for one month, 4x weekly for one month, 3x weekly for one month, 2x weekly for one month and 1x weekly for two months to ensure residents' call lights are within reach. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	light, plugged the end back into the wall, was told Resident 51 pulled it out trying to find it, but she didn't move the call light from the bed rail. During an interview on 4/22/24 at 8:40 A.M., CNA 80 indicated Resident 51 and Resident 64 could use their call lights and it should be within reach and easily accessible for resident's to push the button. 3. On 4/15/24 at 9:34 A.M., Resident 17 was observed sitting up in a wheelchair, eyes closed, bedside table in front of her, and no call light within reach. On 4/16/24 at 11:35 A.M., Resident 17 was observed lying in bed, head of the bed elevated with call light lying on cabinet next to bed out of reach of resident. On 4/17/24 at 8:31 A.M., Resident 17 was observed sitting up in wheelchair eating breakfast with call light behind resident out of reach. On 4/17/24 at 10:49 A.M., Resident 17 was observed lying in bed with head of bed elevated watching television. Call light was observed lying on cabinet next to bed out of reach of resident. When the resident was asked if she had a call light close to her to use, she looked at the bed control and asked "Is this it?" On 4/16/24 at 10:30 A.M., Resident 17's clinical records were reviewed. Diagnosis included but were not limited to, displaced fracture of olecranon process of right ulna, dementia, and urinary tract infection. The current Quarterly, State Optional MDS (Minimum Data Set) Assessment, dated 2/23/24, indicated Resident 17 was severely cognitively			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	impaired and required extensive assistance of two for bed mobility, transfers and toilet use and limited assistance of one for eating. The current care plan for "I have an ADL [Activities of Daily Living] self care deficit related to (specify) impaired mobility, limited ROM, pain; fracture right ulna, dementia", dated 12/11/2023, included, but was not limited to the following intervention, call light within reach, dated 12/11/23. The current care plan for "I am at risk for falls r/t [related to] history of repeated falls with fracture", dated 12/11/23, included, but was not limited to the following intervention, call light within reach, dated 12/11/23. During on interview on 4/18/24 at 8:21 A.M., CNA 50 indicated all the residents on Station 1 could use the call light. During an interview on 4/19/24 at 1:47 P.M., LPN 25 indicated call lights should be clipped to clothing or bed sheets within reach of the resident. On 4/19/24 at 11:00 A.M., a current Call Light: Accessibility and Timely Response Policy, dated February 2023, was provided by the Regional Consultant which indicated "...5. Staff will ensure the call light is within reach of resident and secured, as needed..." 3.1-19(u)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and visitors for 4 of 4 rooms on A and B Halls and 2 of 2 shower rooms on A and B Halls tested for hot water. The water temperatures were above 120 degrees and a raised toilet seat was stored on the floor. (Room 60, Room 64, Room 66, Room 70, A Hall shower room, and men's shower room) Findings include: 1. On 4/16/24 at 9:15 A.M., the water temperature in Room 70's bathroom felt hot. The temperature was 121.4 degrees with the thermometer. On 4/19/24 at 8:25 A.M., the water temperature in Room 70's bathroom felt hot. The temperature was 125.5 degrees with the thermometer then immediately dropped back down stopping at 105 degrees. On 4/19/24 at 10:53 A.M., the water temperature in Room 70's bathroom was 132.5 degrees with the thermometer. Administrator was notified and indicated she would notify the maintenance man immediately. On 4/19/24 12:28 P.M., the water temperature in Room 70's bathroom was 101.1 degrees with the thermometer. During an interview on 4/19/24 at 12:31 P.M., Qualified Medication Aide (QMA) 37 indicated she had no problems with the water getting too hot or fluctuating today while giving showers on Cottonwood Lane Station B Hall. She indicated there was only one shower left to do.	F 0921	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Messmer Mechanical was notified that the water temperature in Rooms 60, 64, 66, 70 and A Hall Shower Room and the men's shower room was not at an acceptable temperature. The contractor arrived at the facility and repairs were completed to ensure the water temperatures were at an acceptable range. How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. If the water temperature is not at an acceptable temperature when tested, a contractor will be called to repair the water heater or equipment as needed. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? The Maintenance Director/designee will audit the water temperatures 5x weekly for one month, 4x weekly for one month, 3x weekly for one month,	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 4/19/24 at 10:58 A.M., the resident in the adjoining room to Room 70, who shared a bathroom, indicated he had never been burned by the hot water. He indicated he could take himself to the bathroom and if the water felt too hot he would turn the cold water on. 2. During an observation on 4/15/24 at 9:45 A.M., an uncovered, raised toilet seat sat on the bathroom floor under the sink. The same was observed on 4/19/24 at 11:00 A.M. During an interview on 4/22/24 at 9:14 A.M., CNA (Certified Nurse Aide) 52 indicated she was unsure of how a raised toilet seat should be stored in the bathroom, but it should not be placed directly on the ground. 3. On 4/15/24 between 12:07 P.M. and 12:14 P.M., the following water temperatures were obtained on the A Hall and B Hall: Room 60 (shared with room 61)-- 124.1 degrees Fahrenheit Room 64 (shared with room 65)--124.5 degrees Fahrenheit Men's shower room-- 123.9 degrees Fahrenheit A hall shower room-- 122.2 degrees Fahrenheit During an interview on 4/15/24 at 12:26 P.M., CNA 48 indicated she noticed the water temperatures felt overly hot, but she had not reported it. On 4/15/24 between 12:53 P.M. and 12:58 P.M., the following water temperatures were obtained by the Maintenance Director on the A Hall and B Hall with the facility's thermometer: Room 60--124.8 degrees Fahrenheit Room 64--124.3 degrees Fahrenheit Men's shower room--118 degrees Fahrenheit		2x weekly for one month and 1x weekly for 2 months. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Hall shower room--123.4 degrees Fahrenheit On 4/19/24 between 11:00 A.M. and 11:05 A.M., the following temperatures were obtained on the A Hall and B Hall: Room 60--126 degrees Fahrenheit Room 64-- 110.5 degrees Fahrenheit Men's shower room-- 129.7 degrees Fahrenheit A Hall shower room-- 129.1 degrees Fahrenheit During an interview on 4/15/24 at 12:49 P.M., the Maintenance director indicated he randomly checks water temperatures in a few rooms a day. At that time he indicated he was unsure what the water temperature should be, and the thermometer was a brand new one. The thermometer's are used until the battery dies and then the facility replaced them. During an interview on 4/22/24 at 11:18 A.M., the Maintenance Director indicated a mixing valve had to be replaced last Thursday due to issues with the water temperatures. He indicated the water temperature should not be less than 100 degrees or more than 120 degrees. On 4/15/24 at 2:28 P.M., the Administrator provided the Safe Water Temperatures, revised February 2023 policy, that indicated, "...5. Water temperatures will be set to a temperature of no more than 120 degrees F [Fahrenheit]..." On 4/22/24 at 10:25 A.M., the DON (Director of Nursing) provided an undated Safe and Homelike Environment policy that indicated, "..."Sanitary" includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	of the activities of daily living..." 3.1-19(e)			
F 9999 Bldg. 00	1. 3.1-7 STAFF TRAINING AND DEVELOPMENT PROGRAMS Sec. 3. (a) Each facility shall provide in service training and shall require all staff working with developmentally disabled residents to attend staff development programs concerning developmental disabilities. Written records of such training shall be kept in the facility. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide in service training for staff specific to the 5 residents listed as having intellectual and or developmental disabilities. Findings include: During an interview on 4/22/24 at 9:55 A.M., the Administrator indicated the facility did not provide in services to staff specifically related to the intellectual and or developmental disabilities. During an interview on 4/22/24 at 10:30 A.M., the Regional Consultant indicated they use a contracted consultant company and they take care of the Qualified Intellectual Disability Professional (QIDP) Program requirements. At that time, documentation of in services provided were requested but not made available during the survey period.	F 9999	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The staff will be re-educated on specific intellectual and or developmental disabilities for identified residents. Employees will have required criminal background checks completed prior to hire. All Staff will complete required education on residents' rights, abuse and dementia. A Social Services Director began employment on 5/14/24. How will other residents having the potential to be affected by the deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? The DCE/Designee will conduct audits monthly to ensure staff is	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 4/22/24 at 2:34 P.M., the Administrator indicated there was not a policy about the QIDP Program and requirements, but it was their policy to follow regulations. 2. 3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure criminal background checks were completed through an approved source for 1 of 5 new employee files reviewed. (CNA 38) Findings include: On 4/19/24 at 3:30 P.M., CNA 38's employee file was reviewed. Hire date was 1/23/24. The file lacked documentation of a criminal background check completed through the Indiana State Repository. On 4/22/24 at 11:15 A.M., the Administrator indicated the facility used a company who utilized the Indiana State Repository for their background checks, but the company ran this employee through Kentucky because that was where the employee lived and she was unable to provide verification the criminal history background check had also come from the Indiana State Police		completing their required education and staff is educated on specific intellectual and or developmental disabilities for identified residents. The DCE/Designee will audit new employee files prior to hire to ensure all required background checks are complete. ED/Designee will ensure Social Services coverage is provided if the position is not filled. How will the corrective action be monitored to ensure the deficient practice will not recur? Audits will be reviewed in the monthly QAPI meeting for six months or until no further corrective action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	repository. A current Background Investigation Policy, reviewed 1/6/23, was provided by the Administrator on 4/22/24 at 3:17 P.M. The policy lacked information about the requirement of having to be ran through the Indiana State Repository, but indicated " All prospective new hires and rehires will have background investigations conducted at the time of employment ... all candidates will automatically receive an email and text invitation from (background check company name) to log into "myportal" allowing them to provide personnel (sic) information ... all positions with (facility company name) are contingent upon successful completion of a background check ... " 3. 3.1-14 Personnel (k) There shall be an organized ongoing in service education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (u) In addition to the required in service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure resident rights and dementia training was completed for 3 of 5 employees hired greater than 1 year ago and abuse training for 2 of 5 employees hired greater than 1 year ago. (Certified Nurse Aide (CNA) 32, LPN 4, CNA 36) Findings include: 1. On 4/19/24 at 3:13 P.M., CNA 32's employee file was reviewed. Hire date was 10/31/07. The file lacked documentation of dementia, resident rights, and abuse in service training. 2. On 4/19/24 at 3:15 P.M., Licensed Practical Nurse (LPN) 4's employee file was reviewed. Hire date was 11/5/03. The file lacked documentation of dementia, resident rights, and abuse in service training. 3. On 4/19/24 at 3:20 P.M., CNA 36's employee file was reviewed. Hire date was 4/22/20. The file lacked documentation of abuse in service training. A current Long-Term Care Training Requirement Policy was provided on 4/22/24 at 3:17 P.M., by the Administrator and indicated " ... The intent of this is to improve resident safety ... These required trainings include: ... Resident's Rights, Abuse, Neglect, and Exploitation ... behavioral health ... " 4. 3.1-34 SOCIAL SERVICES			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	(b) At least fifteen (15) minutes of time shall be provided per resident per week by the qualified social worker or social service designee for social service duties. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide a qualified social worker or social service designee for 6 of 13 days reviewed from 4/10/24 through 4/22/24. Findings include: On 4/15/24 at 12:39 P.M., the Administrator indicated their Social Services Director (SSD) quit without notice 1/25/24. The assistant SSD was promoted and covering from 1/26/24 until she quit on 4/9/24. Since then, they have been looking for a SSD. The contracted consulting company comes every other week, we get help from our other buildings, and their current staff has picked up some of the responsibilities. On 4/22/24 at 10:00 A.M., the Administrator provided dates of SSD coverage and the following dates were not listed: 4/10/24 through 4/15/24 4/22/24 On 4/22/24 at 1:30 P.M., the Administrator indicated there was not a plan of coverage for the SSD going forward. A current Social Services Policy, revised February 2023, was provided on 4/22/24 at 1:07 P.M., by the Regional Consultant and indicated " The facility, regardless of size, will provide medically-related social services to each resident, to attain or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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
	maintain the resident's highest practicable physical, mental, and psychosocial well-being ... The facility should provide social services or obtain needed services from outside entities ... "			