STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155390	A. BUILDING 00 B. WING	10/12/2023

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BRICKYARD HEALTHCARE - WOODBRIDGE CARE CENTER	816 N FIRST AVE EVANSVILLE, IN 47710

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00419369, IN00419071, IN00417333, and IN00418540. Complaint IN00417333 - Federal/state deficiencies related to the allegations are cited at F690. Complaint IN00418540 - Federal/state deficiencies related to the allegations are cited at F690. Complaint IN00419369 - No deficiencies related to the allegations are cited. Complaint IN00419071 - No deficincies related to the allegations are cited. Survey dates: October 10, 11, 12, 2023 Facility number: 000438 Provider number: 155390 AIM number: 100274170 Census Bed Type: SNF/NF:52 Total: 52 Census Payor Type: Medicare: 3 Medicaid: 40 Other: 9 Total: 52 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 19, 2023.	F 0000	PLAN OF CORRECTION FOR WOODBRIDGE CARE CENTER F000 INITIAL COMMENTS . The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after November 7, 2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lana Ballard	Area Vice President/HFA	11/01/2023

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

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F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to treat a urinary tract	F 0690	F690 Bowel and Bladder Incontinence, Catheter, UTI	11/07/2023

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	infection (UTI) for 2 of 3 residents reviewed for infections. Resident F resident's lab results weren't reviewed, follow up appointments with specialists weren't scheduled, and treatment related to the UTI found were not done in a timely manner which resulted in a hospitalization from 9/22/23 to 9/30/23. Resident C had a Urinary Tract Infection (UTI) that was not diagnosed, the resident was then hospitalized that resulted in a necessary surgery being postponed. (Resident F and Resident C) Findings include: 1. During an observation on 10/11/23 at 11:24 A.M., Resident F was observed sleeping in bed. On 10/10/23 at 12:39 P.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, renal insufficiency and neurogenic bladder. Resident F's most recent Quarterly Minimal Data Set (MDS) Assessment, dated 9/19/23 indicated the resident was cognitively intact and required an extensive assist of 1 person for toileting. Resident F's care plans included, but were not limited to, "I have a history of chronic/ recurring urinary tract infections r/t [related to] esbl [Extended Spectrum Beta-Lactamase. Beta-lactamases are enzymes produced by bacteria that could make them resistant to some antibiotics] infection, dated 9/20/23. Resident F's Physician Orders included, but were not limited to: - "UA [urine analysis] WITH C&S [culture and sensitivity] IF INDICATED one time only for DYSURIA related to PERSONAL HISTORY OF		What correction action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident F was started on antibiotic per physician order. Resident C was started on antibiotic per physician order. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. IDT will review all UA's to ensure UA is obtained and culture is reviewed and treated per physician orders. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All licensed nursing staff and IDT will be re-educated and in-serviced on bowel and bladder program along with collecting UA's and reporting. Audits will be completed by the DNS/designee to ensure UA's are being collected and reported to physician/designee with appropriate follow up. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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	URINARY (TRACT) INFECTIONS," dated 9/11/23. - "Contact Deaconess Clinic Urology in AM to inquire which atb [antibiotic] resident is to be placed on for atb resistant UTI et [and] clarify if Urologist wants staff to resume straight cath [catheter] BID [two times a day] order," dated 9/19/23. A urinalysis report, dated 9/12/23, indicated the urine sample was collected at the facility on 9/12/23 at 12:00 A.M., received by the lab at 9/12/23 at 3:52 P.M., results were reported from the lab to the facility on 9/12/23 at 6:28 P.M., and results were reviewed by the facility on 9/18/23 at 12:47 P.M. The results included the following: Protein: reference range- less than 30, result- 70 Blood: reference range- negative, result- small Leukocyte Esterase: reference range- negative, result- large Appearance: reference range- clear, result- turbid urine red blood cells: reference range- less than 3, result- 27 urine white blood cells: reference range- less than 5, result- greater than 100 bacteria: reference range- none, result- few squamous epithelial: reference range- less than 5, result- 8 A urine culture report, dated 9/12/23, indicated the urine speciman for culture was collected on 9/12/23 at 12:00 A.M., received by the lab at 9/12/23 at 3:52 P.M., the result was reported from the lab to the facility on 9/14/23 at 7:04 A.M., and was reviewed by the facility on 9/18/23 at 1:01 P.M. The results included the following: Greater than 100,000 Escherichia Coli, ESBL producing organism detected.		To ensure compliance, the DNS or designee will be responsible for the lab log audit tool to include M-F times 4 weeks, then weekly times 4 weeks, monthly times 6 months and then quarterly until continued compliance is maintained. If a threshold of 100% is not achieved an Action Plan will be developed to ensure compliance. Date of Compliance: November 7, 2023	

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	Resident F's progress notes from September 2023 included, but were not limited to: 9/11/23 at 7:45 P.M. - "daughter here this afternoon asking about in and out cath [catheter] resident [sic]. will pass on to following shift to see if we are able to get order for this. daughter states we were doing this prior to residents [sic] latest hospital admission." 9/12/23 at 1:08 A.M. - "Urine specimen obtained via in and out cath. Prior to cath, resident states she toileted herself. Once laying in bed her abdomen was distended but not tender to touch. Once cath inserted, urine specimen obtained and bladder emptied. 1,000cc [mililiters] of malodorous,cloudy yellow urine obtained. At the end of the stream urine became thick and white. Res [resident] tolerated procedure well. Denies burning with urination. Fluids encouraged." 9/13/23 at 1:42 P.M. - "Received call from residents [sic] daughter [name of person] stating that she had gotten notification on my chart that residents [sic] US [sic] had came back positive for a UTI. Call placed to DR [name of doctor] office, md [doctor of medicine] aware and stated that they were waiting for the culture to culture out due to her allergies and that they would then start her on something. Notified res daughter and she stated okay" 9/19/23 at 6:18 P.M. - " ... Staff to follow up with urologist in AM to determine which atb [antibiotic] is appropriate to treat atb resistant UTI et [and] to clarify if staff to resume [sic] straight catheterization BID [twice daily]. Fluids ecouraged [sic] et within easy reach. Meticulous peri-care provided, contact precautions being observed.			

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	Will continue to monitor." 9/19/23 at 9:07 P.M. - "ESBL producing organism detected in urine, resident to be placed on contact isolation. Bedside commode obtained et placed in room for resident's use only. Staff observing all necessary measures." 9/20/23 at 12:40 A.M. - "Referral sent to [name of hospital] Infectious disease at this time." 9/22/23 at 12:00 A.M. - "Admin [administrator] states that patient has been having increased behaviors. She recently returned from a stay at an inpatient psych [psychology] hospital. Last week she was able to have a conversation; however, this week she is chanting, crying and yelling. Staff states she has not slept for 3 days. Staff states she has a UTI. Results were sent to infectious disease and facility has been waiting numerous days for orders as to which antibiotic she is to take. DON [Director of Nursing] was notified that no orders had been received for antibiotics for treatment of UTI." 9/22/23 at 7:34 P.M. - "daughter called unit at 1715 [5:15 P.M.] and stated she wanted her mother sent to ER [emergency room] to be checked since she has a UTI and has not been placed on antibiotic yet." Resident F was hospitalized from 9/22/23 through 9/30/23. Hospital notes included, but were not limited to: - "... Patient is hysterically crying during exam and is focused on that she has been sitting in feces and urine. Patient was sent from nursing home for altered mental status but unable to obtain further clarification from their facility as they are not			

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	picking up their phone ... patient was admitted to Internal Medicine service for further management of acute kidney injury, metabolic encephalopathy ... recent urine culture, with ESBL. Started on ertapenem [name of antibiotic] ... " A confidential correspondence indicated that Resident F had a positive urine culture and the results were known for 8 days and nothing was done about it. During an interview on 10/11/23 at 1:01 P.M., Registered Nurse (RN) 5 indicated the facility failed to receive an order from the doctor and infectious disease to treat Resident F and the resident's daughter requested to send her to the ER. During an interview on 10/12/23 at 8:31 A.M., Licensed Practical Nurse (LPN) 7 indicated she thought Resident F received antibiotics prior to being admitted to the hospital and that she was colonized. During an interview on 10/12/23 at 9:32 A.M., the DON indicated they try to do what they can to keep the resident in the facility. During an interview on 10/12/23 at 9:39 A.M., Licensed Practical Nurse 9 indicated Resident F did not have a UTI care plan at the time of her UTI, but he would have expected her to have one prior to her hospital stay. 2. On 10/10/23 at 9:26 A.M., Licensed Practical Nurse (LPN) 3 indicated Resident C had a catheter and a current UTI. On 10/10/23 at 10:44 A.M., Resident C's clinical record was reviewed. Diagnosis included, but were not limited to, sepsis, neuromuscular dysfunction of bladder, disorder of kidney and			

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	ureter, and infrarenal abdominal aortic aneurysm. The most recent quarterly Minimum Data Set (MDS), dated 8/14/23, indicated no cognitive impairment. Resident C required extensive assistance with bed mobility, transfers, and toileting, and had an indwelling urinary catheter. Current physician orders included, but were not limited to, the following: Ertapenem Sodium (an antibiotic) Solution Reconstituted 1 GM (gram) intravenously every 24 hours for infection for 30 Days from 9/22/23 through 10/22/23. A current risk for infection related to catheter use care plan was dated 11/22/22. A current history of chronic/recurring urinary tract infections related to suprapubic catheter care plan, dated 8/14/23, included, but were not limited to, the following interventions: Observe and report signs and symptoms of UTI: changes in color, odor or consistency of urine, dysuria, frequency, fever, pain (dated 8/14/23). Progress notes included, but were not limited to, the following: 9/3/23 at 7:43 P.M. Resident C was reaching for an item and fell. 9/5/23 at 11:00 P.M. "[MD] reviewed and addressed labs prior to 9/4/23 visit" Diagnostic result review of the following labs: antibody screen, CBC (complete blood count) auto differential, basic metabolic profile, urine culture, urine 24 hour creatinine, lipid profile, liver profile, hemoglobin a1c, urinalysis with microscopic, culture if indicated, EKG with interpretation, ALT, AST, creatinine/GFR, free T4, TSH. The progress			

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	notes lacked information as to when the labs had been done. 9/6/23 at 10:59 A.M. "This writer phoned [family member], listed contact, to insure he was aware that [Resident C] slid out of her wheelchair and was not injured" 9/7/23 at 11:01 P.M. eMAR - Medication Administration Note "Change foley catheter drainage bag weekly and PRN [as needed] changed due to bag leaking" 9/11/23 at 4:30 P.M. "covid tested and negative results" 9/11/23 at 7:59 P.M. "resident came in approx [4PM] from smoke break and had large emesis [vomit] in room ..." 9/11/23 at 11:00 P.M. written by the Nurse Practitioner (NP) "Notified by nursing vomiting x2 nights unable to keep down prn phenergan [an antiemetic medication] or any meds i.e. bp [blood pressure], cool and clammy covid neg, 176/107, 90-99, 80% RA [room air] 88% on 2L [liters] 97.8, states not feeling well has not been eating well isdiabetic [sic] 483 did eat dinner, lethargic but easy to wake lungs diminished orders for IM [intramuscular] phenergan 25mg [milligrams]/ml [milliliter] ... IM ... PRN QID [four times a day] ... supplemental O2, CXR [chest xray] and labs ... IM phenergan effective 88-90% on 2L 98/52, 105 hx [history] COPD" 9/12/23 at 2:06 P.M. "COVID 19 Test Result: Negative" 9/12/23 at 7:55 P.M. "CNA notified this nurse of resident having emesis in her bedroom while			

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	sitting up in w/c watching tv. Upon entering, resident noted to be diaphoretic and lethargic. Does wake up when name called. Mumbling words. Blood glucose 483 VS: 176/107 p94 T97.8 forehead infrared, resp 18 SaO2 80% on room air. Per nursing measure, supplemental oxygen started via concentrator however was not effective. Once liquid oxygen per portable tank administered SaO2 increased to 90% on 2L/NC [liters per nasal canula]. Staff instructed to lay resident down in bed after cleaning her up and elevate HOB [head of bed] to prevent aspiration ... No cough or SOB [shortness of breath] noted at rest. Res [resident] weak. On call NP phoned and notified of assessment findings. New orders rec'd [received]. Will call back to update on status once IM Phenergan administered. If effective will administer routine PO [by mouth] Clonidine [blood pressure medication] for HTN [hypertension]" 9/12/23 at 11:39 P.M. "Res tested again for covid and test results were negative. No further emesis. Tolerated IM injection well. Sleeping. NP phoned and updated on resident's current vitals and assessment findings. No new orders at this time" 9/13/23 at 5:25 A.M. "Res currently laying in bed with HOB elevated. SaO2 91% on 2L/NC from portable liquid oxygen tank. Resp 18. Skin warm and dry. BP 163/91 pulse 107 T98.2. Did have a cough during assessment. No sputum produced. Denies feeling SOB. Will continue to monitor" 9/13/23 at 1:41 P.M. "Staff called this nurse to residents room stating that res was not acting like her self. When I entered the room res was noted to be leaning over in her chair to the left and hard to arouse. When asked what was wrong res stated that she just didn't [sic] feel well and that she			

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	thought that she needed to go to the hospital. Res BP was noted to be low, 60s/30s with her pulse low and thready. Res foley cath is patent and draining yellow urine, small amount of sediment noted in the bag. MD updated of res change in condition and stating that she needed to go to the hospital, new order was obtained to send her to [hospital] er [emergency room] for eval and treatment. [Transportation service] called for transport and report called to [hospital] er ..." 9/13/23 at 7:50 P.M. Resident admitted to the hospital with acute kidney injury, sepsis, hypotension, and complicated urinary tract infection. 9/14/23 at 12:17 P.M. Resident returned from the hospital. "Transferred to personal W/C [wheelchair]with extensive assistance x2 staff members. VSS [vital signs stable] ... BP 124/67; HR [heart rate] 81; T [temperature] 97.5; RR [respiratory rate] 18; O2 SAT [oxygen saturation] 93% RA. midline intact to LUE [left upper extremity] and flushes well with no resistance. Resident will continue IV ATB [antibiotic] r/t [related to] urinary sepsis w/e-coli bacteria. 9/22/23 at 7:30 P.M. "spoke with [representative] at [surgery center] today and she states surgery for September 28 is cancelled [sic] until she is finished with antibiotic for UTI. when antibiotic is finished on October 22 we are to get medical clearance from [medical director] and then surgery will be [sic] rescheduled ..." 9/26/23 at 11:00 P.M. "Patient is on IV antibiotics for complicated UTI. She was recently hospitalized for hypotension, AKI [acute kidney injury], and sepsis. She was seen by infectious disease and has IV Invanz [an antibiotic] daily			

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	until 9/26/23 ... through a PICC [peripherally inserted central catheter] line. She is to follow up with infectious disease NP 1-2 weeks from now. Shealso [sic] has appointment with urology, [urologist name] on 10/26/23. She has a 5.6cm [centimeter] infrarenal AAA [abdominal aortic aneurysm], but will not receive intervention for that until her urinary infection is cleared. Patient reports being tired all the time for about the last 3 months ..." 10/6/23 at 9:43 A.M. eMAR - Medication Administration Note "Resident refused, stating "I don't feel well."" 10/6/23 at 8:31 P.M. "resident has felt better today. yesterday was in bed all day due to feeling sick to stomach and having some diarrhea" 10/9/23 at 12:00 A.M. "During session resident presented as neutral with flat affect. Resident described she was not feeling well and nursing stated that her blood pressure was up. Resident described feeling weak her speech was slightly slurred and she had trouble staying awake ... We will follow-up" 10/10/23 at 12:00 P.M. "resident has had increasing lethargy today. does not want to lay down for nap" 10/10/23 at 4:01 P.M. "has continued to be lethargic and is now slurring her words. desires to go out to hospital to be checked out. vitals stable. o2 97% on room air bp 102/83 hr 61" 10/10/23 at 7:33 P.M. "res sent to ER" Blood pressure readings for Resident C included, but were not limited to, the following:			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - WOODBRIDGE CARE CENTER	816 N FIRST AVE EVANSVILLE, IN 47710

(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
	9/12/23 7:53 P.M. 176 / 107 9/12/23 9:15 P.M. 118 / 66 9/12/23 10:48 P.M. 99 / 53 9/12/23 11:38 P.M. 98 / 52 9/13/23 5:29 A.M. 163 / 91 9/13/23 9:26 A.M. 114 / 65 The Medication Administration Record (MAR) for 9/2023 indicated Resident C did not receive her blood pressure medication on the evening of 9/12/23 due to vomiting. Behavior monitoring from 7/31/23 through 10/12/23 indicated no behaviors were observed any day on any shift. Resident C's clinical record lacked a urinalysis or urine culture since 3/2023. Current hospital records as follows: New diagnosis of Hepatitis C, possible liver cirrhosis, kidney stone. The resident received emergency kidney dialysis, was identified as having a decompressed bladder around Foley catheter on admission and one kidney was atrophied. Labs obtained in the hospital on 9/13/23 included, but were not limited to, the following: A urine culture, dated 9/13/23, indicated escherichia coli (a bacteria) ESBL (extended spectrum beta-lactamase) producing organism detected. A blood culture, dated 9/13/23, indicated enterobacterales (a bacteria), escherichia coli, and ESBL were detected. A progress note from an infectious disease physician, dated 9/16/23 (during Resident C's			

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	hospitalization), indicated a recommendation for Ertapenem for a total of 14 days, to end on 9/26/23.fd On 10/10/23 at 12:19 P.M., the Director of Nursing (DON) indicated Resident C had not had a urine culture done prior to the hospitalization on 9/13/23 possibly because she was colonized. At that time, the DON indicated she was unaware what bacteria Resident C was colonized with, and to find out could take "a lot of digging". On 10/11/23 at 10:29 A.M., DON indicated Resident C's March 2023 labs were reviewed on 9/6/23 because something was "not right" with the resident, but could not find an exact reason for the review in the resident's chart. She indicated Resident C began to have some odd behaviors on 8/24/23. She indicated on that date, she had come back from LOA (leave of absence) with behaviors that were different for her that had continued until the hospitalization on 9/13/23. The DON also indicated she was still unsure what the resident was colonized with, as she may have gotten her mixed up with another resident, and Resident C may not have been the one that was colonized. She indicated when a resident was colonized, the doctor would have the staff go off of symptoms to check for a UTI, then do a urinalysis and culture if indicated. She further indicated Resident C was supposed to have AAA surgery on 8/28/23, but it was postponed due to a yeast infection she had at that time, then postponed again due to being on IV antibiotics for 30 days. She indicated Resident C's AAA was originally scanned on 3/10/23, then again on 3/17/23 and 7/22/23 that showed an increase in size. She then indicated when a resident came back from the hospital, all labs and orders were reviewed by either herself or LPN 3. She indicated she was unaware of the discrepancy			

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	between the infectious disease physician order and the admitting order for the IV antibiotic, and if she had been aware, she would have questioned it to verify what the order should have been. On 10/11/23 at 1:18 P.M., the DON indicated she had called the Medical Director and he told her he had changed the original order for the 14 day antibiotic to a 30 day because he "knows her better than infectious disease" and wanted her to be on it for a longer period of time. On 10/12/23 at 9:01 A.M., LPN 7 indicated when Resident C had been sent to the hospital on 9/13/23, she was working that day. She indicated the night shift nurse for the previous night had notified her that morning that Resident C's blood pressure had been high and her cognition was "off". She indicated she had been aware that Resident C had a history of frequent UTIs and that a symptom she had displayed in the past was weakness. She indicated she had noticed a recent shift with Resident C that she had previously been energetic and happy, and recently she had been weak and not as happy. On 10/12/23 at 8:45 A.M., Certified Nurse Aide (CNA) 21 indicated Resident C would have symptoms of deliriousness and weakness with UTIs, and had been sick for about a month prior to her hospitalization on 9/13/23. CNA 21 indicated she was unaware of any precautions for Resident C's aneurysm, other than to be mindful of the area when assisting to transfer and positioning in the bed. On 10/12/23 at 10:40 A.M., a current Behavioral Health Services policy, dated 1/1/23, was provided and indicated "Assess and develop a person-centered care plan for concerns identified			

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	in the resident's assessment ... Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record ..." On 10/12/23 at 10:40 P.M., a current Comprehensive Care Plans policy, dated 1/1/23, was provided and indicated "The comprehensive care plan will describe, at a minimum, the following ... The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." On 10/12/23 at 10:40 A.M., the Regional Consultant provided a current Notification of Changes policy, revised 1/1/23, that indicated "...The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification...significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-Threatening conditions, or b. clinical complications...circumstances that require a need to alter treatment. This may include: ...ii. acute condition. iii. exacerbation of a chronic condition..." A nursing assessment policy was requested and not provided. This Federal tag relates to Complaint IN00417333 and Complaint IN00418540. 3.1-41(a)(2)			