STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MERRILLVILLE CARE CENTER	8800 VIRGINIA PLACE MERRILLVILLE, IN 46410

(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 IN00433824, IN00434233 and IN00436579. Complaint IN00433824 - No deficiencies related to the allegations are cited. Complaint IN00434233 - No deficiencies related to the allegations are cited. Complaint IN00436579 - No deficiencies related to the allegations are cited. Survey dates: June 10, 11, 12, 13 and 14, 2024 Facility number: 000253 Provider number: 155362 AIM number: 100266660 Census Bed Type: SNF/NF: 146 Total: 146 Census Payor Type: Medicare: 5 Medicaid: 97 Other: 44 Total: 146 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/18/24.	F 0000	Date of Compliance 7/12/2024 for deficiencies Asking for desk review/paper compliance	
F 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents			

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

Jacqueline Carpenter-Heard | Executive Director | 07/02/2024

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

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Bldg. 00	§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure dependent residents received help with Activities of Daily Living (ADLs) related to build up on teeth for 1 of 7 residents reviewed for ADLs. (Resident 54) Finding includes: On 6/10/24 at 10:38 a.m., Resident 54 was observed sitting in bed. The resident's mouth was dry and crusty. His teeth were noted to be discolored and had build up on them. On 6/11/24 at 2:39 p.m., Resident 54 was observed sitting in bed. His mouth was dry and crusty when he opened it. His teeth were discolored and had build up on them. On 6/13/24 at 3:59 p.m., Resident 54 was observed in bed. His mouth was dry and crusty. His teeth were discolored and had build up on them. Resident 54's record was reviewed on 6/11/24 at 3:50 p.m. Diagnoses included, but were not limited to, cerebral infarction and chronic respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 3/19/24, indicated the resident was severely cognitively impaired. He was dependent on staff for oral hygiene, toileting hygiene, and personal hygiene. A Care Plan, dated 7/27/23, indicated the resident had an ADL self-care deficit related to weakness,	F 0677	F 677 ADL Care Provided for dependent residents Res-54 Facility Failed to Ensure dependent residents received help with Activities of Daily Living (ADLs)- oral care related to build up on teeth. Res Identified Oral care was provided immediately for Resident F The CNA was immediately re-educated regarding the ADL- Oral Care policy including the need to have the appropriate oral care provided for the resident. Others All current dependent residents can be affected by this alleged deficient practice. All current dependent residents were reviewed, and no other dependent residents were noted to be affected by the deficient practice. Monitor The DNS/designee will audit all dependent residents requiring oral care 3 times a week x one month, then 2 times a week x 1 month, then weekly x 4 months to ensure all dependent residents requiring ADL and oral care are receiving oral care. Audits will include all shifts, units and weekends. The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six	07/12/2024

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	history of a cerebral infarction, chronic respiratory failure, status post tracheostomy removal. Interventions included, but were not limited to, oral care assistance as needed. A Care Plan, dated 5/10/24, indicated the resident was at risk for dental problems related to discolored teeth and the resident was dependent on staff for oral care. Interventions included, but were not limited to, assist with oral care as ordered and as needed. A Physician's Order, dated 5/13/24, indicated oral care every shift. The June 2024 Medication Administration Record (MAR) indicated oral care was signed off as completed every shift. During an interview on 6/13/24 at 3:48 p.m., CNA 1 indicated the resident received oral care by wiping his mouth with a foam swab dipped in mouth wash. She had never brushed his teeth with a toothbrush. During an interview on 6/14/24 at 10:18 a.m., the Nurse Consultant indicated the resident was unable to follow commands to swish water or spit. She had no further information to provide. 3.1-38(a)(3)(C)		months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue. Date of compliance 7/12/2024 div="" div="" div="" div="" div="" div="" div=""	
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-			

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	§483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on record review and interview, the facility failed to ensure residents with impaired vision received the necessary services for 1 of 1 resident reviewed for vision. (Resident 70) Finding includes: During an interview on 6/10/24 at 2:49 p.m., Resident 70 indicated he needed to get his cataracts checked. He had an appointment set up over a year ago, but it was canceled. Resident 70's record was reviewed on 6/12/24 at 8:56 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and hyperlipidemia. The Quarterly Minimum Data Set assessment, dated 3/13/24, indicated the resident was cognitively intact. His vision was listed as adequate with no corrective lenses. A Progress Note, dated 1/27/23, indicated the resident had received a referral for a cataract evaluation from the optometrist. The appointment was scheduled for 2/7/23. A Progress Note, dated 2/3/23, indicated the resident wanted to cancel his scheduled eye appointment due to the cold weather and would like to reschedule when the weather was warmer.	F 0685	table class="Table Ltr TableWordWrap SCXW218060915 BCX8" border="1" data-table data-tablelook="0" aria-rowcount="11" >div class="TableCellContent SCXW218060915 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 13px 0px 6px; user-select: text; overflow: visible;" F 685 Treatment/Devices to maintain Hearing/Vision div class="TableCellContent SCXW218060915 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 13px 0px 6px; user-select: text; overflow: visible;" Res- 70 Facility Failed to Ensure residents with impaired vision received the necessary services div class="TableCellContent SCXW218060915 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding:	07/12/2024

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	A Progress Note, dated 2/6/23, indicated the resident's family had been informed of his choice to cancel his eye appointment and it would be rescheduled for a later date. An optometry note, dated 1/4/24, indicated the resident was referred for removal of right eye cataract but was unable to make the appointment last year. His right eye distance vision was still blurry. The recommendation was to get a consult for a cataract evaluation of the right eye and possible treatment. A written order was given to the charge nurse, who indicated the resident had been scheduled in the past and refused to go. Care plan meeting reviews, dated 2/22/24 and 4/30/24, indicated the resident had last been seen by optometry on 1/4/24. No further information was documented. There was a lack of documentation the facility had attempted to reschedule the appointment or make any further arrangements for the resident to receive the recommended specialty eye care services. During an interview on 6/13/24 at 2:12 p.m., Social Services 1 indicated she was still looking for a traveling eye doctor/specialist who could come see the resident and possibly perform any procedures in the facility because the resident required a stretcher for transportation. If she were to make an outside appointment for him, they would refuse to see him since he could not transfer himself off the stretcher, and the ambulance staff would not assist the resident with transferring once at the appointment. She was unable to provide any documentation she had followed up with the 1/4/24 optometry recommendation and indicated she needed to be		0px 13px 0px 6px; user-select: text; overflow: visible;" Res Identified Resident's cataract surgery has been scheduled for July 8th div class="TableCellContent SCXW218060915 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 13px 0px 6px; user-select: text; overflow: visible;" Others All current residents requiring hearing services/vision can be affected by this alleged deficient practice. Any resident who was seen by the optometrist in the past 6 months has been reviewed to ensure any recommendations/referrals made have been followed up on. div class="TableCellContent SCXW218060915 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 6px 0px; user-select: text; overflow: visible;" Education The ED/designee re-educated the Social Services staff on Ancillary Services/Hearing and Vision Services Policy div class="TableCellContent SCXW218060915 BCX8" style="-webkit-user-drag: none;	

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	better about her documentation. 3.1-39(a)(1)		-webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 6px 0px; user-select: text; overflow: visible;" Monitor The ED/designee will audit residents who are seen by optometrist to ensure any referrals/recommendations are followed up on. The ED/designee will audit all residents requiring Ancillary services 3 times a week x one month, then 2 times a week x 1 month, then weekly x 4 months to ensure all residents are seen for Ancillary services quarterly or as required. Audits will include all shifts, units and weekends. div class="TableCellContent SCXW218060915 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 6px 0px; user-select: text; overflow: visible;" Q.API The Executive Director/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue div class="TableCellContent SCXW218060915 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding:	

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			2px 6px 0px; user-select: text; overflow: visible;" Date of compliance 7/12/2024	
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, record review, and interview, the facility failed to ensure a dependent resident was transferred with a Hoyer lift (a full body mechanical lift) as indicated on the Resident Care Sheet for 1 of 1 resident reviewed for accidents. (Resident 113) Finding includes: On 6/11/24 at 8:55 a.m., CNA 2 was observed attempting to transfer Resident 113 from her bed into her wheelchair. The resident was on her bed in a semi-seated position, her left arm was contracted and she had a splint on her right hand. Resident 113 was unable to sit upright on the side of bed by herself and was falling backward. The CNA was leaning forward in front of her, instructing Resident 113 to hold on to her neck as CNA 2 was attempting to hold the resident around her waist. The resident was unable to hold onto the CNA with her right arm only. Her legs were stretched forward and her feet were not securely	F 0689	table class="Table Ltr TableWordWrap SCXW98929047 BCX8" border="1" data-table data-tablelook="0" aria-rowcount="9" >div class="TableCellContent SCXW98929047 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 6px 0px; user-select: text; overflow: visible;" F 689 Free of Accident Hazards/Supervision/Devices div class="TableCellContent SCXW98929047 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 6px 0px; user-select: text;	07/12/2024

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	on the floor. After several minutes, CNA 3 entered the room and indicated to CNA 2 that the resident could not be transferred like that, she needed a sit to stand lift (a device that assists residents from a seated to standing position for transferring). The resident's record was reviewed on 6/11/24 at 1:33 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) of the non dominant side, cerebral ischemia and degenerative disease of the nervous system. The Quarterly Minimum Data Set assessment, dated 4/8/24, indicated the resident was cognitively intact and was dependent for transfers, bed mobility and toileting. The Resident Care Sheet indicated the resident was a two person assist with a Hoyer mechanical lift for transfers. During an interview with CNA 2 on 6/11/24 at 9:10 a.m., she indicated she was not familiar with the resident and should have checked the Care Sheet prior to attempting to transfer her. During an interview with the D Unit Manager on 6/11/24 at 11:10 a.m., she indicated the resident needed a Hoyer mechanical lift for transfers and she would begin education with the staff. On 6/12/24 at 11:29 a.m., the resident was observed seated in her wheelchair in the hallway. Her left arm was contracted, she had a splint on her left hand and her left leg was in a foot rest. During an interview on 6/12/24 at 1:26 p.m., CNA 4 indicated he had transferred the resident by himself from the bed that morning by standing		overflow: visible;" Res 113 The facility failed to ensure a dependent resident was transferred with a Hoyer lift as indicated on the resident care sheet div class="TableCellContent SCXW98929047 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 6px 0px; user-select: text; overflow: visible;" Res Identified Resident 113's care sheet and care plan reflect Hoyer lift for transfer and CNAs involved were immediately re-educated on Safe Resident Handling/transfer policy and care sheets div class="TableCellContent SCXW98929047 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 6px 0px; user-select: text; overflow: visible;" Others An audit to be completed on all residents that are total assist with transfers. Care plans will be reviewed for each dependent resident requiring a Lift for transfers and deemed appropriate as needed per resident preferences and abilities. div class="TableCellContent SCXW98929047 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color:	

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	and pivoting her to the wheelchair. He was not aware she was supposed to be transferred with a mechanical lift. The policy, "Safe Resident Handling/Transfers", indicated, "...All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lift are a safer alternative and should be used..." and, "...Staff members are expected to maintain compliance with safe handling/ transfer practices...." 3.1-45(a)		transparent; margin: 0px; padding: 2px 6px 0px; user-select: text; overflow: visible;" Education All nursing staff were re-educated on Safe Resident Handling/transfer policy, ADL care provided for dependent residents and use of Resident care sheets div class="TableCellContent SCXW98929047 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Monitor The DCE/designee will conduct random observations of staff completing transfers for dependent residents requiring a Hoyer lift to ensure that residents are being transferred as per their plan of care and resident care sheet. These observations will include all shifts, units and weekends, div class="TableCellContent SCXW98929047 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" QAPI The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance	

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			Committee that further monitoring is needed, audits will continue. div class="TableCellContent SCXW98929047 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Date of compliance 7/12/2024	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and	F 0693	div class="TableCellContent	07/12/2024

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	interview, the facility failed to ensure gastrostomy tube (peg tube) care was completed as ordered related to incorrect enteral feeding administration for 1 of 3 residents reviewed for peg tubes. (Resident 54) Finding includes: On 6/10/24 at 10:38 a.m., Resident 54 was observed in bed. He had a tube feeding pump connected to Jevity 1.5 cal (type of feeding) infusing at 70 milliliters per hour (ml/hour) On 6/11/24 at 2:39 p.m., Resident 54 was observed in bed. He had a tube feeding pump connected to Jevity 1.5 cal infusing at 70 ml/hour. Resident 54's record was reviewed on 6/11/24 at 3:50 p.m. Diagnoses included, but were not limited to, cerebral infarction and chronic respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 3/19/24, indicated the resident was severely cognitively impaired. He was dependent on staff for oral hygiene, toileting hygiene, and personal hygiene. A Care Plan, dated 7/27/23, indicated the resident was dependent on tube feedings. Interventions included, but were not limited to, elevate head of bed at least 30-45 degrees during and for 30 to 60 minutes after feeding and enteral formula and feedings as ordered. The June 2024 Physician's Order Summary indicated enteral tube feeding of Jevity 1.5 cal at 75 ml/hour for 22 hours a day. During an interview on 6/13/24 at 9:27 a.m., the		SCXW41480997 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" F 693 Tube Feeding /Restore eating Skills div class="TableCellContent SCXW41480997 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Res 54 The facility failed to ensure gastrostomy tube (peg tube) care was completed as ordered related to incorrect enteral feeding administration div class="TableCellContent SCXW41480997 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Res Identified The feeding for Res 54 was noted at the correct rate when nursing was informed — 1.5 /hour X 22 hours div class="TableCellContent SCXW41480997 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;"	

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	Director of Nursing had no further information to provide. 3.1-44(a)(2)		Others All residents who receive enteral feedings were reviewed to ensure their feeding was set at correct rate on feeding pump. No other residents identified to have been affected. div class="TableCellContent SCXW41480997 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Education All licensed nursing staff were immediately re-educated on Enteral feeding policy. div class="TableCellContent SCXW41480997 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Monitor The DCE (Director of Clinical Education)/designee educated all nursing staff on the Enteral feeding and physician orders policy before the compliance date. The DNS/designee will audit all residents requiring Enteral feedings 3 times a week x one month, then 2 times a week x 1 month, then weekly x 4 months to ensure all dependent residents requiring Enteral are receiving feedings as ordered. Audits will include all shifts, units and	

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			weekends. div class="TableCellContent SCXW41480997 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" QAPI The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue div class="TableCellContent SCXW41480997 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Date of compliance 7/12/2024	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and			

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	483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure a resident received proper care and treatment related to oxygen administration flow rate for 1 of 1 resident reviewed for oxygen. (Resident 13) Finding includes: On 6/11/24 at 2:33 p.m., Resident 13 was observed in bed. He had a nasal cannula in his nares and the oxygen concentrator was set to a flow rate 4.5 liters per minute (lpm). On 6/13/24 at 8:57 a.m., Resident 13 was observed in bed. He had a nasal cannula in his nares and the oxygen concentrator was set to a flow rate 4.5 lpm. Resident 13's record was reviewed on 6/11/24 at 2:21 p.m. Diagnoses included, but were not limited to, acute respiratory failure, chronic bronchitis, and adult failure to thrive. The Significant Change Minimum Data Set (MDS) assessment, dated 4/8/24, indicated the resident was cognitively intact for daily decision making and was dependent on staff for all activities of daily living including, eating, hygiene, and bathing. The June 2024 Physician's Order Summary indicated oxygen at 3 liters per minute per nasal cannula if oxygen saturations were 90% or below, as needed for shortness of breath. A Care Plan, dated 6/13/24, indicated the resident required oxygen therapy. Interventions included, but were not limited to, administer oxygen as needed per Physician's Orders.	F 0695	div class="TableCellContent SCXW58046678 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" F 695 Respirator/tracheostomy Care and Suctioning div class="TableCellContent SCXW58046678 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Res 13 The facility failed to ensure a resident received proper care and treatment related to oxygen administration flow rate div class="TableCellContent SCXW58046678 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Res Identified Resident #13's oxygen concentrator was immediately changed; the concentrator was corrected to a flow rate of 3 LPM per MD order, Resident with no ill effects from alleged deficient practice. div class="TableCellContent SCXW58046678 BCX8"	07/12/2024

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	During an interview on 6/13/24 at 10:33 a.m., the Nurse Consultant indicated she had no further information to provide. A policy titled, "Oxygen Administration," indicated "...1. Oxygen is administered under orders of a physician, except in the case of an emergency..." 3.1-47(a)(6)		style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Others All current residents receiving oxygen could be affected by this alleged deficient practice. An audit of all current residents receiving oxygen was completed to ensure that all current residents receiving oxygen had their concentrators on and the correct flow rate set on the oxygen concentrator, div class="TableCellContent SCXW58046678 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Education All licensed nursing staff were immediately re-educated the Oxygen Administration policy. div class="TableCellContent SCXW58046678 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Monitor The DCE (Director of Clinical Education) educated all licensed nursing staff on the Oxygen Administration policy. Unit Managers/designees will audit 3 residents 3 times a week x one	

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			month, then 2 residents 3 times a week x 1 month, then 3 residents weekly x 4 months to ensure oxygen concentrators are turned on and the flow rate is correct. Audits will include all shifts, units and weekends. div class="TableCellContent SCXW58046678 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" QAPI The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audits will continue. div class="TableCellContent SCXW58046678 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Date of compliance 7/12/2024	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the			

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	comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a follow up for a pain specialist's medication order was completed for 1 of 1 resident reviewed for pain. (Resident 128) Finding includes: During an interview on 6/10/24 at 11:43 a.m., Resident 128's daughter indicated she had taken the resident to see a pain specialist in April. The resident had a history of spinal fusion surgery and would sometimes have pain when doing activities of daily living (ADLs) and therapy. She was aware the resident would not get back to her prior level of function and was worried about her being in pain. The specialist had ordered Tramadol (an opioid pain medication) as needed (PRN). The daughter had taken the prescription to a pharmacy, had the medication filled, brought the medication to the facility, and had given it to the resident's nurse. She had recently found out the resident had never received the Tramadol medication and she was not told why. She had asked the D Wing Unit Manager about it and was told there was no order for the medication and the pain assessment showed the resident was not having any pain. She had spoken with the Director of Nursing (DON) about her concerns a couple days ago. The resident's record was reviewed on 6/11/24 at 2:51 p.m. Diagnoses included, but were not limited to, wedge compression fracture of T (thoracic vertebrae) 11-12, dementia with psychotic disturbance, and arthrodesis (joint fusion). The Quarterly Minimum Data Set assessment, dated 5/21/24, indicated the resident was	F 0697	div class="TableCellContent SCXW169151137 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 13px 0px 6px; user-select: text; overflow: visible;" F 697 Pain Management div class="TableCellContent SCXW169151137 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 13px 0px 6px; user-select: text; overflow: visible;" Res 128 The facility failed to ensure a follow up for a pain specialists medication order was completed div class="TableCellContent SCXW169151137 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 13px 0px 6px; user-select: text; overflow: visible;" Res Identified Resident #128 has been assessed for pain. Pain medications are being administered per pain assessment and documented in the MAR. Orders were received by the physician. div class="TableCellContent SCXW169151137 BCX8"	07/12/2024

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	cognitively impaired and received a scheduled pain medication. A current care plan indicated the resident was at risk for pain related to a wedge compression fracture. The interventions included, to administer pain medication as ordered. The Physician's Order Summary, dated 6/2024, indicated the resident received Tylenol (acetaminophen) 500 mg (milligrams) every eight hours. There were no orders for Tramadol. The Medication Administration Records (MAR), dated 6/2024, 5/2024, and 4/2024, indicated the resident had not received any Tramadol medication. A Pain Evaluation in Advanced Dementia assessment, dated 4/8/24, had a score of zero which indicated no signs and symptoms of pain. A Progress Note, dated 4/22/24 at 10:04 a.m., indicated the resident had returned from her appointment and there were no new orders. A Progress Note Late Entry, dated 6/5/24 at 2:35 p.m., written for 4/22/24, indicated the resident's daughter was requesting the resident start Tramadol 50 mg daily and that the pain specialist had ordered it. There were no orders received from the specialist and no script had been received. The resident had no pain upon assessment. The facility's Nurse Practitioner (NP) was notified of the daughter's request and denied it. The NP felt the resident's pain was managed with Tylenol. There was lack of any documentation that the pain specialist's office had been contacted for clarification or follow up or that the resident's daughter had been updated.		style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 13px 0px 6px; user-select: text; overflow: visible;" Others DNS/designee reviewed residents who received pain medication to ensure pain assessments were completed, MAR was complete, and effectiveness of medication was documented. div class="TableCellContent SCXW169151137 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 13px 0px 6px; user-select: text; overflow: visible;" Education All licensed nursing staff were immediately re-educated on the Consulting physician/practitioner orders and Pain Assessment policy div class="TableCellContent SCXW169151137 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 13px 0px 6px; user-select: text; overflow: visible;" Monitor All residents prescribed pain medications can be affected by the alleged deficient practice. The DCE (Director of Clinical Education) educated all licensed nursing staff on the Consulting physician/practitioner orders and Pain Assessment policy. The	

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	A Progress Note Late Entry, dated 6/9/24 at 9:33 a.m., written for 4/22/24, indicated the Tramadol order per the family's request was on hold due to waiting for the pain specialist to clarify. There was lack of any documentation of any further follow-up with the pain specialist's office or that the resident's daughter had been updated. A Progress Note, dated 6/7/24 at 10:28 a.m., indicated the pain specialist's office had been contacted to obtain clarification orders from the resident's appointment in April. A Nurse Practitioner Note, dated 4/3/24, indicated, "...Plan...wedge compression fracture of T 11-T 12 vertebra...PRN Tramadol. Continue lidocaine, PRN Tylenol..." A Nurse Practitioner Note, dated 5/17/24, indicated, "...Her daughter tells staff that her mother is in a lot of pain. She wants her mother to have pain medication. She did not appear to be in pain during her visit today... No diaphoresis, screaming, wincing, grimacing, or guarding present...Plan...wedge compression fracture of T 11-T 12 vertebra...PRN Tramadol. Continue lidocaine, PRN Tylenol..." During an interview on 6/13/24 at 9:33 a.m., the DON indicated she had spoken with the resident's daughter last week and the daughter indicated she had taken the resident to the pain specialist on 4/15/24 and received an order for Tramadol. The daughter had the order filled at a pharmacy, brought it in, and gave it to staff. The DON indicated staff had not given the medication since they had no script or orders from the Doctor's office. The DON had called the Doctor's office last week to clarify and had not received a call		DNS/designee to review residents who are seen by pain specialists to ensure any new orders are followed up on. These audits to be completed 3 times weekly x 1 month, then 2 times weekly x 1 month, then weekly x 4 months. div class="TableCellContent SCXW169151137 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 13px 0px 6px; user-select: text; overflow: visible;" QAPI The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audits will continue, div class="TableCellContent SCXW169151137 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 1px 13px 0px 6px; user-select: text; overflow: visible;" Date of compliance 7/12/2024	

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	back. She had then contacted the facility Physician and obtained the order for the Tramadol per the resident's daughter's request. She was unsure why no one had followed up with the pain specialist sooner. During an interview on 6/13/24 at 11:42 a.m., the D Wing Unit Manager indicated the resident's daughter had brought in a bottle of PRN Tramadol and given it to the nurse. She had not brought in any order or script. The Unit Manager had contacted the pain specialist office and had not heard back. She then contacted the facility NP, who had completed a pain assessment and had not agreed with the daughter and indicated Tylenol would cover any pain. There was a pain assessment documented every shift on the MAR and the resident had no documented pain. She had not completed any further follow-up with the pain specialist's office, as she felt the situation had been handled by the facility NP. A facility policy, received as current, titled, Consulting Physician/Practitioner Orders, indicated, "...A consulting physician/practitioner may include, but is not limited to, a resident's: ...d. Specialist...Regarding orders for controlled substance the nurse will: a. verify that the order and original, valid prescription, match. b. Forward the original, valid prescription, with the verification order to the pharmacy per protocol. c. If the orders do not match, or in the absence of an original, valid prescription, obtain an original, valid prescription, and forward it along with the written order to pharmacy per protocol..." 3.1-37(a)			
F 0756 SS=D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act			

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Bldg. 00	On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the			

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	pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on record review and interview, the facility failed to update physician's orders after a medication regimen review was conducted for 1 of 5 residents reviewed for unnecessary medications. (Resident 68) Finding includes: Resident 68's record was reviewed on 6/12/24 at 11:38 a.m. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. The Quarterly Minimum Data Set assessment, dated 4/22/24, indicated the resident was cognitively intact for daily decision making and received dialysis treatments. A Pharmacy Medication Regimen Review, dated 4/23/24, indicated a recommendation was made to reduce polypharmacy. Current orders included pantoprazole (decreases stomach acid) 40 milligrams (mg) every morning, melatonin (a sleep aid) 8 mg every night, hydroxyzine (antihistamine used to reduce itching) 25 mg every night and Zyrtec (treats allergy symptoms) 10 mg daily. The Physician/Prescriber response indicated to change hydroxyzine 25 milligrams by mouth to nightly as needed. The June 2024 Physician's Order Summary indicated hydroxyzine 25 milligram tablet by mouth at bedtime. During an interview on 6/13/24 at 2:45 p.m., the Nurse Consultant indicated the orders should have been updated.	F 0756	table="" border="1" data-table data-tablelook="0" aria-rowcount="12">F 756 Drug Regimen Review/ Report Irregular Res 68 The facility failed to update physicians' orders after a medication regimen review was conducted Res Identified Res #68's order for Hydroxyzine was changed to nightly as needed per recommendation immediately Others All current residents receiving medications have the potential to be affected by this alleged deficient practice, an audit of all current resident's pharmacy recommendations was completed to ensure that all current residents' recommendations have been addressed. A look back of all current resident's pharmacy recs has been completed s Educa-tion Nursing management was re-educated on the Medication Regimen review protocol/policy Monitor The DCE (Director of Clinical Education) educated all licensed nursing staff on Medication Regimen Review DNS/designees will audit monthly medication regime reviews to ensure all pharmacy recommendations have been addressed and any physician order changes have been updated. QAPI The Director of	07/12/2024

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	3.1-(i)		Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audits will continue. Date of compliance 7/12/2024	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable	F 0757	table class="Table Ltr TableWordWrap SCXW116815539 BCX8" border="1" data-table data-tablelook="0"	07/12/2024

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	mental, physical, and psychosocial well-being, related to a medication scheduled during the resident's routine dialysis time and blood sugars levels and insulin administration not documented, for 2 of 5 residents reviewed for unnecessary medications. (Residents 28 and 74) Findings include: 1. During an interview with Resident 28 on 6/11/24 at 8:54 a.m., he indicated he attended dialysis three times a week on Tuesdays, Thursdays and Saturdays. Tuesdays and Thursdays he was picked up around 9:30 a.m. and returned around 3:00 p.m. On Saturdays, he was picked up earlier, around 6 a.m. Resident 28's record was reviewed on 6/12/24 at 2:23 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus, dependence on renal dialysis and cerebral infarction. The Quarterly Minimum Data Set (MDS) assessment, dated 4/24/24, indicated the resident was cognitively intact and was dependent for bed mobility, transfers and toileting. A Physician's Order, dated 1/25/24, indicated to give Pepcid (a medication used to treat stomach acid) 20 milligrams, in the afternoon on Tuesdays, Thursdays and Saturdays for GERD (gastroesophageal reflux disease). The May and June 2024 Medication Administration Record (MAR) indicated the Pepcid was scheduled to be given on Tuesdays, Thursdays and Saturdays at 2:00 p.m. The medication was not given on the following days due to the resident not being in the facility: 5/2/24		aria-rowcount="10" >div class="TableCellContent SCXW116815539 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" F 757 Drug regimen is Free from Unnecessary Drugs div class="TableCellContent SCXW116815539 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Res 28, 74 The facility failed to ensure each resident’s medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, related to a medication being scheduled during the resident's routine dialysis time and blood sugar levels and insulin administration not documented div class="TableCellContent SCXW116815539 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Res	

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	5/4/24 5/7/24 5/14/24 5/21/24 5/23/24 6/4/24 6/6/24 6/11/24 During an interview with the Administrator on 6/13/24 at 2:05 p.m., she indicated the medical director indicated if a resident was at dialysis when a medication was due, it was just not given. When asked why the medication was scheduled only during dialysis times, she indicated that should be looked into. She later indicated the medication had been discontinued. The policy, "Medication Administration" was reviewed and did not pertain to medication scheduling. 2. The record for Resident 74 was reviewed on 6/12/24 at 2:34 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and congestive heart failure. The Significant Change Minimum Data Set assessment, dated 5/16/24, indicated the resident was cognitively impaired and received insulin injections. A care plan, updated 3/25/24, indicated the resident had diabetes. The interventions included, "...diabetes medications as ordered by physician...glucose monitoring as per order..." The Physician's Order Summary, dated 6/2024, indicated an order for Humalog (insulin) per sliding scale (insulin given based on blood sugar results) with meals:		Identi-fied The MD was notified, and the medications and insulin times were changed for Residents 28 and 74. Residents with no ill effect from alleged deficient practice. div class="TableCellContent SCXW116815539 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Others An audit of medications for all current residents who receive dialysis was completed to ensure that medications were not scheduled during dialysis times. Residents who receive blood sugar checks and insulin administration were reviewed x past to ensure the blood sugar results and insulin administrations were documented in the . MD was notified for any resident found to have been affected by the deficient practice. div class="TableCellContent SCXW116815539 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Educa-tion The DCE (Director of Clinical Education) educated all licensed nursing staff on the Unnecessary Drugs policy and medication	

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	151-200=2u (units) 201-250=10u 251-300=15u 301-350=20u 351-400=25u The Medication Administration Record (MAR), dated 6/2024, indicated the blood sugar result and the amount of insulin administered were left blank on the following dates and times: - 8:00 a.m. on 6/8/24, and 6/9/24 - 12:00 p.m. on 6/6/24, 6/8/24, and 6/9/24 - 5:00 p.m. on 6/1/24, 6/2/24, 6/3/24, 6/7/24, 6/8/24, and 6/9/24. There were no eMAR (electronic medication administration record) notes documented for the above dates and times. A Daily Blood Sugar Log, dated 6/2024, was provided by the Director of Nursing (DON). There were documented blood sugars for the above dates and times but no documented insulin administration. The resident's blood sugar at 8:00 a.m. on 6/8/24 was 176, he should have received 2 units of insulin. The resident's blood sugar at 8:00 a.m. on 6/9/24 was 203, he should have received 10 units of insulin. The resident's blood sugar at 12:00 p.m. on 6/6/24 was 329, he should have received 20 units of insulin. The resident's blood sugar at 12:00 p.m. on 6/9/24 was 244, he should have received 10 units of insulin. The resident's blood sugar at 5:00 p.m. on 6/1/24 was 183, he should have received 2 units of insulin. The resident's blood sugar at 5:00 p.m. on 6/2/24		administration policy. div class="TableCellContent SCXW116815539 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 2px 8px 0px 6px; user-select: text; overflow: visible;" Monitor The DCE (Director of Clinical Education) educated all licensed nursing staff on the Unnecessary Drugs policy and medication administration policy. Unit Managers/designees will review new orders for dialysis residents to ensure medications have not been scheduled during dialysis times. These audits to be completed 5 times weekly x , then 3 times weekly x 30 days, then weekly x 4 months. UM/designee to review medication administration audit report for residents who receive insulin and/or blood sugar checks to ensure documentation present on . These audits to be conducted 5 times weekly x 30 days, then 3 times weekly x 30 days, then weekly x 4 months. div class="TableCellContent SCXW116815539 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;"	

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	was 161, he should have received 2 units of insulin. The resident's blood sugar at 5:00 p.m. on 6/9/24 was 344, he should have received 20 units of insulin. During an interview on 6/13/24 at 3:22 p.m.. the DON indicated when there was a QMA working the unit, the blood sugars were documented on a paper log since they could not administer insulin. The nurses would administer the insulin but would not document it in the MAR. They would then cosign the blood sugar log. When staff completed their monthly audits, if any blanks were noted, they would have the nurse who worked document a late entry. 3.1-48(a)(1)		QAPI The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audits will continue.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to dirty and greasy food equipment, an accumulation of dust on fan blades, food spillage, lack of hair restraints, touching food with gloved hands after touching other items, and the dishwasher gauge not functioning for 1 of 1 kitchen observed. (The Main Kitchen). This had the potential to affect 137 residents who received food from the kitchen. Findings include: 1. During the Kitchen Sanitation Tour on 6/10/24 at 9:10 a.m. with the Dietary Food Manager (DFM), the following was observed: a. A bag of noodles, located in the dry storage room, was not fastened. Loose noodles were observed on the shelves and on top of food boxes. b. The upper shelf located on the oven had an accumulation of crumbs and dust. c. There was an accumulation of dust and dried food spillage on the front of the convection oven. d. A large orange fan, located on a shelf in the dish room, had an accumulation of dust on the fan blades and fan cover. The fan was in use at that time and blowing directly towards clean dishes. e. The dishwasher was identified as being high temperature by the DFM. The final rinse temperature gauge did not move during the rinse	F 0812	div class="TableCellContent SCXW94375439 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" F812 Food Procurement, Store/Prepare/Serve-Sanitary div class="TableCellContent SCXW94375439 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" All residents eating an oral diet The facility failed to ensure sanitary conditions with respect to foods not stored properly in dry storage, upper shelf of oven with dust and dried food, accumulation of dust and dried food spillage on front of convection oven, large fan in dish room w/ dust on it blowing on clean dishes, gauge on dish machine not working correctly, gloves not being used correctly, and beard guards not being worn appropriately. div class="TableCellContent SCXW94375439 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding:	07/12/2024

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	cycle and registered at 140 degrees Fahrenheit. There was also no plastic cover over the gauge. The June 2024 Dish Machine Temperature Log indicated the final rinse cycle registered 140 degrees Fahrenheit for the noon and evening meal on 6/9 and the breakfast meal on 6/10/24. During an interview at that time, the DFM indicated he would call someone out to look at the dishwasher. 2. On 6/10/24 at 11:06 a.m., Dietary Employee 1 was observed to donn a pair of clean gloves and proceeded to the walk in refrigerator. He exited the refrigerator with a bag of lettuce. He opened the bag of lettuce and put some on a plate, he then obtained a knife and a boiled egg. He held the boiled egg with his gloved hand while slicing it. He did not change gloves prior to doing this. The Dietary Employee was not wearing a beard guard while preparing the salad. During an interview at that time, the DFM indicated the above was in need of cleaning and the Dietary Employee should have been wearing a beard guard and changed his gloves prior to touching the boiled egg. 3.1-21(i)(3)		0px 12px 0px 7px; user-select: text; overflow: visible;" Res Identified No residents were harmed by the alleged deficient practice. div class="TableCellContent SCXW94375439 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" Others All current residents eating an oral diet can be affected by this alleged deficient practice. div class="TableCellContent SCXW94375439 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" Education DSM/designee have re-educated the Dining Service staff on the deficient practices including proper storage of all food items, cleaning of oven (inside and out), cleaning of convection oven (inside and out), cleaning of fans in all areas of the kitchen, proper dish machine temps and operation of the machine, proper glove usage, wearing hairnets/beard guards appropriately. Cleaning schedules have been updated to include behind the kitchen equipment. div class="TableCellContent	

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			SCXW94375439 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" Monitor All items identified were immediately corrected. The DSM/designee will audit kitchen sanitation 3 times per week x 1 month, then 2 times a week x 1 month, then weekly x 4 months. div class="TableCellContent SCXW94375439 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" QAPI The Executive Director/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue. div class="TableCellContent SCXW94375439 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" Date of compliance 7/12/2024	

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F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure a sanitary environment was maintained related to an accumulation of dust and debris on floors, piping, and fan blades, as well as loose and detached base boards for 1 of 1 kitchen areas. (The Main Kitchen) Findings include: During the Kitchen Sanitation Tour on 6/10/24 at 9:10 a.m. with the Dietary Food Manager (DFM), the following was observed: a. The wall located behind the convection oven and the oven had an accumulation of dust and debris along the base of the wall. The white pipes located behind the convection oven and oven had an accumulation of dried food spillage. b. The ceiling vent located in between the steam table and the exit door to the kitchen had an accumulation of dust. c. A fan, anchored to the wall in the dish room, had an accumulation of dust on the fan blades and fan cover. The fan was not in use at the time. d. The base board located underneath the eye wash sink in the dish room was loose in some sections and pulled away from the wall. During an interview at that time, the DFM indicated all of the above was in need of cleaning	F 0921	div class="TableCellContent SCXW30179040 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" F921 Safe/Functional/Sanitary/Comfortable Environment div class="TableCellContent SCXW30179040 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" All residents eating an oral diet have the potential to be affected The facility failed to provide a safe/functional/sanitary/comfortable environment with respect to the wall located behind the convection oven and the oven/range had an accumulation of a dust and debris along the base of the wall, the white pipes located behind the convection oven and oven/range had an accumulation of dried food spillage, the ceiling vent located in between the steam table and the exit door to the kitchen had an accumulation of dust, a fan anchored to the wall in the dish	07/12/2024

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	and/or repair. 3.1-19(f)		room had an accumulation of dust on the fan blades and fan cover, the base board located underneath the eye wash sink in the dish room was loose in some sections and pulled away from the wall. div class="TableCellContent SCXW30179040 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" Res Identified No residents were harmed by the alleged deficient practice. div class="TableCellContent SCXW30179040 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" Others All residents eating an oral diet have the potential to be affected div class="TableCellContent SCXW30179040 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" Education Maintenance concerns (baseboard by eye wash station in dish room and ceiling vent) have been corrected. DSM/designee have re-educated the Dining Service	

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	155362	A. BUILDING 00 B. WING	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MERRILLVILLE CARE CENTER	8800 VIRGINIA PLACE MERRILLVILLE, IN 46410

(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
			staff on the deficient practices including cleaning behind all equipment, and cleaning of all fans throughout the kitchen and dish room. div class="TableCellContent SCXW30179040 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" Monitor All items identified were immediately corrected. The DSM/designee will audit kitchen sanitation 3 times per week x 1 month, then 2 times a week x 1 month, then weekly x 4 months. div class="TableCellContent SCXW30179040 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" QAPI The Executive Director/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue. div class="TableCellContent SCXW30179040 BCX8" style="-webkit-user-drag: none; -webkit-tap-highlight-color:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			transparent; margin: 0px; padding: 0px 12px 0px 7px; user-select: text; overflow: visible;" Date of compliance 7/12/24	