STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. BUILDING 00 B. WING	02/21/2025

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction to the Investigation of Complaint IN00454047. Complaint IN00454047- No deficiencies related to allegations was cited. Survey dates: February 17, 18, 20, and 21, 2025 Facility number: 000411 Provider number: 155384 AIM number: 100275100 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 2 Medicaid: 49 Other: 9 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 5, 2025.	F 0000	Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits the Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible. We would like to respectfully request a desk review. Thank you.	
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property Based on observation, interview, and record review, the facility failed to ensure respect and dignity was provided to a totally dependent resident. The resident's call light was not within reach for 1 of 16 residents reviewed for call lights.	F 0557	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident # 46's call light was placed within	04/04/2025

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

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	A resident's call light was not within his reach, staff did not respond promptly when he yelled for help and he was not able to use his call light to alert staff when he needed help. (Resident 47) Finding includes: On 2/17/25 at 11:59 A.M., Certified Nurse Aide (CNA) 9 brought Resident 47 his lunch, set it up, and left the room with call light pad on left side of pillow at head of bed. Resident 47 could not find it and was not able to reach it. At that time, he indicated the call light pad was not always where he could reach it, especially on the night shift. On 2/18/25 at 1:27 P.M., Resident 47 was observed hollering, "Nurse's aide, I need your help finding something please" multiple times. The nurse was at medication cart by the nurse's station. Two CNAs were observed to walk down the hall past his room without stopping to check on him. The nurse went into the room and the resident indicated his entire left side was hurting and he couldn't find his call light. The nurse told the resident she would attach it to his shirt so he could find it. On 2/20/25 at 8:20 A.M., Resident 47 was up in a Broda chair. His call light was laying on his bed out of his reach. He was asking his roommate to hit his call light because he needed the nurse. On 2/20/25 at 8:29 A.M., a staff member came into his room to check the refrigerator temperature and the resident asked him to hit his call light for him so he did. Staff went in and came out of the room without moving the call light within his reach. On 2/18/25 at 11:37 A.M., Resident 47's clinical record was reviewed. Diagnoses included, but		his reach. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Staff will be re-educated on proper call light placement. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be conducted 5x per week for one month, 4x per week for one month, 3x per week for one month, 2x per week for one month, and 1x per week for two months. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The audits will be reviewed in the monthly Quality Assurance Performance Improvement meeting for six months or until no further corrective action is needed.	

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	were not limited to, stoke with hemiplegia and hemiparalysis of left non dominant side, and depression. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 2/6/25, indicated Resident 47's cognition was moderately impaired, impairment of upper and lower left extremities, he could eat with set up help, and totally dependent on staff for bed mobility, toileting, transfers, and bathing. A current falls care plan, last reviewed 11/20/23, included, but was not limited to, the following intervention: call light within reach, initiated 11/20/23 During an interview on 2/21/25 at 10:07 A.M., Registered Nurse (RN) 7 indicated Resident 47 used his call light and it should be within his reach when staff left the room. On 2/21/25 at 1:50 P.M., a current Call Light Policy, revised August 2024, was provided by the Director of Nursing (DON) and indicated, " ... Staff will ensure the call light is within reach of resident ... the call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room ... all staff members who see or hear an activated call light are responsible for responding ... " 3.1-3(t)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record review, the facility failed to ensure physician orders and care plan interventions were followed	F 0656	What corrective action will be accomplished for those residents found to have been affected by the	04/04/2025

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	for 2 of 5 residents reviewed for unnecessary medications. A resident's oxygen concentration was set incorrectly, the bedside table was not locked, and medications were given for blood pressure without checking the blood pressure prior to administration of the medication to ensure resident was within the perimeters to give the medication. (Resident 38, Resident 56) Findings include: 1. During an observation on 2/17/25 10:09 A.M., Resident 38 was sitting on the side of her bed coloring and wearing oxygen per nasal cannula. The oxygen concentrator was set at 2 liters per minute (LPM). During an observation on 2/18/25 8:55 A.M., Resident 38 was sitting on the side of her bed and the bedside table was not locked. She was wearing oxygen per nasal cannula at 2 liters per minute (LPM). During an observation on 2/20/25 8:25 A.M., Resident 38 was laying in a lowered bed and the bedside table was not locked. During an observation on 2/21/25 at 10:00 A.M., RN 7 observed Resident 38's oxygen concentrator with the rate indicator of the machine at the 4 LPM mark but indicated it was set at 3 LPM because it was the bottom of the rate indicator that mattered and it was just above the 3 LPM mark. At that time, another staff nurse observed the same and adjusted the setting at the 3 LPM mark and indicated that was were it should be set. On 2/19/25 at 9:10 A.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure, Chronic		deficient practice? Resident #38's oxygen concentrator rate indicator was placed at the correct 3 LPM mark. Resident #38's bedside table was placed in the locked position. Resident #38's blood pressure will be taken per physician's orders. Resident #38's care plans will be updated to reflect the current plan of care. Resident #56's care plan will be updated to reflect a care plan related to hypertension. Resident #56's physician orders and care plans will be followed. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Staff will be re-educated on placing the oxygen concentrator rate indicator at the correct LPM mark, residents' blood pressures are taken per physicians' orders, physicians are be followed and care plans are updated to reflect current plan of care. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur? Audits will be conducted 5x per week for one month, 4x per week for one month, 3x per week for one	

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	Obstructive Pulmonary Disease (COPD), hypertension, pneumonia, unsteadiness on feet, and other fractures of cervical (neck)vertebra and left hand. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/24/25, indicated Resident 38's cognition was moderately impaired, was a substantial/maximum assist (staff performed over half the effort) for bed mobility, transfers, toileting, and wore oxygen. Current Physician's Orders included, but were not limited to, the following: Bedside table to be locked at all times-check placement every day and night shift, dated 6/10/24 Metoprolol tartrate 25 milligram (mg) tablet, give one tablet by mouth one time a day related to hypertension (high blood pressure), hold if systolic under 60 millimeters of mercury (mmHg), dated 6/12/24 check oxygen saturation to maintain oxygen level above 90%, apply oxygen at 3 LPM per nasal cannula every day and night shift, initiated 1/24/23 A current Falls Care Plan, last reviewed 11/12/24, included, but was not limited to the following interventions: Locked bedside table, initiated 11/12/24 A current Altered Cardiovascular Status Care Plan, last reviewed 11/12/24, included, but was not limited to the following interventions: give medications as ordered, initiated 11/12/24 A current COPD Care Plan, last reviewed 11/12/24, included, but was not limited to, the following intervention: check oxygen saturation to maintain oxygen level		month, 2x per week for one month and 1x per week for two months to ensure that oxygen concentrator rate indicators are placed at the correct LPM mark and the bedside table is placed in the locked position, blood pressures are taken per physicians' orders and care plans are current. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e. what quality assurance program will be put into place? The audits will be reviewed in the monthly Quality Assurance Performance Improvement meeting for six months or until no further corrrective action is needed.	

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	above 90%, apply oxygen at 3 LPM per nasal cannula, initiated 11/12/24 The January and February 2025 Medication Administration Record (MAR) was reviewed and indicated Resident 38 received the Metoprolol 25 mg at 8:00 A.M. every day from 1/1/25 through 2/19/25. The clinical record lacked the resident's blood pressure on the following dates from 1/1/25 through 2/19/25: January 1, 3-8, 10-22, 24-31, February 2-21, 2025 During an interview on 2/21/25 at 9:40 A.M., Registered Nurse (RN) 7 indicated Resident 38's bedside table should be locked and the resident did not unlock the bedside table to move it or adjust her oxygen to her knowledge. Her blood pressure was not being checked daily, just protocol once a month and as needed. RN 7 indicated Resident 38 did not have any perimeters set that they needed to check her blood pressure before administering medications. Resident 38 was on oxygen per nasal cannula continuously, the oxygen concentrator should be set on 3 LPM, and staff checked the oxygen saturations once on day and night shifts along with checking the LPM setting on the oxygen concentrator. It should be documented in the Treatment Administration Record (TAR). RN 7 indicated it was expected that staff follow physician orders and interventions of the care plan.2. On 2/18/25 at 10:12 A.M., Resident 56's clinical record was reviewed. Diagnoses included, but was not limited to, Hirschprung's disease, Tourette's syndrome, hypertension, and autistic disorder. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/28/25 indicated			

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	Resident 56's cognitive status could not be assessed due to Resident 56 not being understood, and he had no impairment to his upper and lower extremity's. Current physician orders included, but were not limited to, "Metoprolol Tartate Tablet Give 12.5 milligrams [mg] by mouth two times a day for blood pressure hold if SBP [systolic blood pressure] less than 100 (manually), and/or HR [heart rate] less than 55, Order Date 8/21/2024." Resident 56's clinical record lacked a care plan related to hypertension. During an observation on 2/20/25 at 8:25 A.M., Registered Nurse (RN) 5 administered medications to Resident 56. Medications administered included, but was not limited to, metoprolol 12.5 mg and RN 5 failed to obtain Resident 56's heart rate. During an interview on 2/20/25 9:29 A.M., RN 5 indicated she only had to check Resident 56's blood pressure for his metoprolol. At that time, RN 5 and RN 7 indicated the record lacked Resident 56's heart rate prior to the medication being administered. During an interview on 2/21/25 at 11:01 A.M., the Director of Nursing (DON) indicated there was not a policy but it would be their policy to follow physician orders and interventions of the care plans. 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

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	Based on observation, interview, and record review, the facility failed to ensure a resident's care plan was revised for 1 of 5 residents reviewed for unnecessary medications. A resident's care plan was not reviewed or revised to remove areas of concern that were no longer relevant to the resident's care, i.e. antibiotic use, fluid restriction, and daily weights. (Resident 38) Finding includes: On 2/19/25 at 9:10 A.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), hypertension, pneumonia, unsteadiness on feet, and other fractures of cervical (neck)vertebra and left hand. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/24/25, indicated Resident 38's cognition was moderately impaired, was a substantial/maximum assist (staff performed over half the effort) for bed mobility, transfers, toileting, took a diuretic, and was not monitored for fluid intake. Current Physician's Orders included, but were not limited to, the following: monthly weight in the morning starting on the first and ending on the 5th every month, ordered 7/31/24 weekly weights due to CHF, notify primary care physician if weight gain was more than five pounds in 1 week, ordered 12/21/24 The discontinued Physician's Orders included, but were not limited to, the following: 1800 cubic milliliter (ml) fluid restriction: dietary to provide 1080 ml total-360 ml at breakfast, 240 ml at	F 0657	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #38's care plan was updated to reflect her current plan of care. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Staff responsible for care plan revisions and updates will be re-educated on care plan procedures. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be conducted 5x per week for one month, 4x per week for one month, 3x per week for one month, 2x per week for one month and 1x per week for two months. How will the corrective action be monitored to ensure the deficient practice does not recur; i.e., what quality assurance program will be put into place? The audits will be reviewed in the monthly Quality Assurance Performance Improvement meeting for six months or until no further corrective action is needed.	04/04/2025

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	lunch, and 480 ml at supper. Nursing to provide 720 ml total-300 ml day shift, 300 ml evening shift, and 120 ml night shift related to CHF, discontinued 6/26/24 Daily weights due to CHF in the morning, discontinued 8/7/23 Keflex 500 milligram (mg), give 1 capsule by mouth three times a day for ten days for upper respiratory infection, discontinued 1/18/25 A current Nutritional Care Plan, last reviewed 11/12/24, included, but was not limited to, the following interventions initiated 11/12/24: 1800 cubic milliliter (ml) fluid restriction: dietary to provide 1080 ml total-360 ml at breakfast, 240 ml at lunch, and 480 ml at supper. Nursing to provide 720 ml total-300 ml day shift, 300 ml evening shift, and 120 ml night shift daily weights due to CHF, notify primary care physician if weight gain was more then two pounds in 24 hours or 5 pounds in one week. A current Respiratory Infection Care Plan and intervention, initiated 1/9/25, indicated the resident was on antibiotic therapy as ordered by the physician. During an interview on 2/21/25 at 11:00 A.M., the Director of Nursing (DON) indicated care plans should be revised with changes to the resident's plan of care. order: On 2/21/25 at 1:50 P.M., a current non dated Care Plan Revision Policy, was provided by the DON and indicated, " ... the care plan will be updated with the new or modified interventions ... care plans will be modified as needed by the MDS Coordinator or other designated staff member ... "			

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F 0727 SS=E Bldg. 00	3.1-35(d)(2)(B) 483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON Based on interview and record review, the facility failed to provide an Registered Nurse (RN) for 8 consecutive hours, seven days a week, for 4 of 26 days reviewed. Finding includes: On 2/20/25 at 2:30 P.M., review of weekend staffing from 7/1/24 thru 9/30/24 due to Payroll Based Journal (PBJ) triggering for low weekend staffing indicated there was no RN coverage for 8 consecutive hours on Sunday, 7/21/24, Sunday, 8/4/24, Saturday, 8/31/24, and Saturday, 9/28/24. On Sunday, 7/21/24, there was RN coverage for 4.03 hours. On Saturday, 9/28/24, there was RN coverage for 4 hours. On Sunday, 8/4/24 and Saturday, 8/31/24 there was no RN coverage. During an interview on 2/21/25 at 12:12 P.M., Director of Nursing (DON) indicated they tried their best to have RN coverage every day. They had the wound nurse and Unit Manager help cover on the weekends. On 1/21/25 at 1:50 P.M., the DON provided an undated nursing Services and Sufficient Staff policy which indicated "...8. Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week..." 3.1-17(b)(3)	F 0727	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? RN coverage will be provided for eight consecutive hours a day, seven days a week. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. The facility will provide RN coverage eight consecutive hours a day, seven days a week. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be conducted 5x per week for one month, 4x per week for one month, 3x per week for one month, 2x per week for one month, and 1x per week for two months to ensure RN coverage is provided. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what	03/18/2025

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			quality assurance program will be put into place? The audits will be reviewed in the monthly Quality Assurance Performance Improvement meeting for six months or until no further corrective action is needed. T	
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role Based on interview and record review, the facility failed to ensure a qualified Infection Preventionist (IP) was working at least part-time at that facility. Documentation was not available to show how many hours were dedicated to the infection control program by the Director of Nursing (DON) who was certified and Registered Nurse (RN) 7 who had not completed training. Finding includes: During an interview on 2/21/25 at 11:34 A.M., the DON indicated she was the Infection Preventionist (IP) covering the DON position and the IP position for the last two months. She indicated RN 7 was assisting and would be the IP after completing training but was not certified at that time. The DON indicated she was the full time DON and did not have documentation of the hours she and RN 7 spent on IP duties. On 2/21/25 at 1:50 P.M., the DON provided an undated Infection Preventionist policy that indicated "1. The facility will designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program to include the antibiotic	F 0882	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility has an Infection Preventionist that has completed training and obtained certification. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. The facility will provide and Infection Preventionist part time per the regulation. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be conducted 1x weekly for six months to ensure the facility has a part time Infection Preventionist per regulations.	03/18/2025

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BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	stewardship program...11. The Infection Preventionist reports to the Director of Nursing..."		How will the corrective action be monitored to ensure the deficient practice does not recur; i.e., what quality assurance program will be put into place? The audits will be reviewed in the monthly Quality Assurance Performance Improvement meeting for six months or until no further corrective action is needed. We have information to support that we were in substantial compliance with F 882.	