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	08/02/2024

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 the Investigation of Complaint IN00437603 and IN00439994. Complaint IN00437603 - No deficiencies related to the allegations are cited. Complaint IN00439994 - Federal/state deficiencies related to the allegations are cited at F660 and F684. Survey dates: August 1 and 2, 2024 Facility number: 000253 Provider number: 155362 AIM number: 100266660 Census Bed Type: SNF/NF: 142 Total: 142 Census Payor Type: Medicare: 5 Medicaid: 92 Other: 45 Total: 142 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/5/24.	F 0000		
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals,			

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

Jacqueline Carpenter-Heard | Executive Director | 08/20/2024

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

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	the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's			

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	comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on record review & interview, the facility failed to implement a complete discharge planning process and ensure that the discharge needs of each resident were identified and met related to lack of ongoing Physician follow up for an abnormal wound culture result, indicating an	F 0660	**Brickyard Merrillville Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability**	08/30/2024

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	infection, prior to discharge from the facility, for 1 of 3 residents reviewed for skin conditions. (Resident B) The deficient practice was corrected by 7/31/24, prior to the start of the survey, and was therefore past noncompliance. The facility investigated the delay in treatment following the receipt of abnormal wound culture results, completed audits for all wound cultures in the last 90 days, educated all nursing staff on the policy for wound culture tracking and notifications, and implemented a Laboratory Tracking Log. Finding includes: Resident B's closed record was reviewed on 8/1/24 at 10:57 a.m. Diagnoses included, but were not limited to, motor vehicle injury, fracture of upper end of left humerus, fracture of medial condyle of left femur, fracture of left side rib, and insomnia. The Admission Minimum Data Set (MDS) assessment, dated 7/9/24, indicated the resident was cognitively intact for daily decision making. There was an impairment to the upper and lower left extremities. He required substantial assistance for hygiene and transfers. A Care Plan, dated 7/8/24, indicated the resident had altered skin integrity, non-pressure skin conditions related to a traumatic wound to the left medial knee. Interventions included, but were not limited to, conduct weekly skin inspections, monitor for signs and symptoms of infection such as swelling, redness, warmth, discharge, or odor, and notify physician of significant findings. A Nurses' Note, dated 7/8/2024 at 11:48 a.m., indicated the resident had a traumatic wound to		**by the facility and is submitted only in response to the regulatory requirement.** **F 660 Discharge Planning Process** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B- The deficient practice was corrected by 7/31/24, prior to the start of the survey, and was therefore past noncompliance. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents with wound cultures have the potential to be affected by this alleged deficient practice. Completed audits for all wound cultures in the last 90 days and any affected residents were addressed and corrected. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**	

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	the left knee measuring 8 centimeters (cm) by 4.5 cm. A Physician's Order, dated 7/10/24, indicated to obtain a wound culture to the traumatic wound on the resident's left medial knee. A Nurses' Note, dated 7/10/24, indicated the resident had a change of condition. Redness, warmth, and swelling was noted to the left lower extremity surrounding the wound to the left medial knee. The wound was cleansed with wound cleanser, serous drainage was noted from wound, and then sampled with a wound culture swab in a sterile manner. A Nurses' Note, dated 7/16/2024 at 3:12 p.m., indicated the Physician was informed of the wound culture results. "No new orders at this time. Awaiting new orders at this time." The resident and the Power of Attorney (POA) were informed. The Wound Culture report, undated with the sample collected on 7/10/24, indicated the left medial knee wound had many enterobacter cloacae (gram-negative bacteria) and many staphylococcus aureus (gram-positive bacteria). There were moderate gram negative bacilli, moderate gram positive cocci, rare white blood cells, and rare epithelial cells. The "McGreer's Definitions for Healthcare Associated Infections for Surveillance for Long Term Care Facilities" indicated the following criteria: SKIN AND SOFT TISSUE INFECTION Cellulitis/soft tissue/wound infection One of the following criteria must be met: 1. Pus present at a wound, skin, or soft tissue		The DCE (Director of Clinical Education) educated all nursing staff on the policy for Wound Culture tracking and Notification. Adhoc QAPI meeting was completed. DNS/Designee to do 5 Random Audits 5x a week for 4 weeks, Then 5 Random Audits 3x a week for 4 weeks, Then 5 Random Audits 2x a week for 4 weeks then 5 Random Audits once a week x 3 months. Audits will include all shifts, units and weekends. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The 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. **Date of compliance 8/30/2024**	

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	site. (OR) 2. The resident must have four or more of the following signs or symptoms: - fever (>38ºC) or worsening mental/functional status; and/or the presence of new or increasing (at the affected site): - heat - redness - swelling - tenderness or pain - serous drainage A Nurses' Note, dated 7/23/24 at 10:45 a.m., indicated the resident was discharged home with family, medications and instructions were received, and the resident and family acknowledged understanding. No concerns were voiced at the time. There was no further follow up regarding the abnormal wound culture results or orders received prior to discharge. A Nurses' Note, dated 7/24/24 at 7:17 a.m., indicated an antibiotic was ordered for discharged Resident B by the Nurse Practitioner (NP) and sent to an outside pharmacy. During an interview on 8/2/24 at 12:30 p.m., the Interim Administrator indicated the nurse who put in the note had a language barrier, which was the reason for the note that said there were no orders and also awaiting orders. The Physician was notified of the wound culture and there were no new orders at the time. The NP sent in an order for the antibiotic to appease the family, as they called the facility the day after the resident's discharge requesting antibiotics. There was no other follow up until the facility received the communication from the family and the facility had since			

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	implemented a corrective plan of action related to this incident. An Ad Hoc QAPI, dated 7/31/24, was received on 8/2/24 at 12:45 p.m. from the Director of Nursing, and indicated the identified opportunity for improvement/deficient practice was delay in treatment following receipt of culture results. The facility completed audits for all wound cultures in the last 90 days to check for any outstanding results or follow up that was needed. All nursing staff was educated on the policy for wound culture tracking and notifications. The Laboratory Tracking Log included Resident B, who had a wound culture completed on 7/10/24. The wound culture resulted on 7/14/24 and were abnormal results. The action taken was placing an order sent to an outside pharmacy. A Policy titled, "Wound Cultures," indicated "...1. A wound will only be cultured in accordance with a physician order, when signs and symptoms of infection are present...6. Notify physician of initial and final culture results." This citation relates to Complaint IN00439994. 3.1-12(a)(19)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

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	and the residents' choices. Based on record review and interview, the facility failed to ensure medications were managed appropriately related to medications not signed out and given as ordered for 2 of 3 residents reviewed for unnecessary medications. (Residents B and G) Findings include: 1. Resident B's closed record was reviewed on 8/1/24 at 10:57 a.m. Diagnoses included, but were not limited to, motor vehicle injury, fracture of upper end of left humerus, fracture of medial condyle of left femur, fracture of left side rib, and insomnia. The Admission Minimum Data Set (MDS) assessment, dated 7/9/24, indicated the resident was cognitively intact for daily decision making. There was an impairment to the upper and lower left extremities. He required substantial assistance for hygiene and transfers. A Physician's Order, dated 7/3/24 at 9:00 p.m., indicated Xanax (an anti-anxiety medication) extended release 1 milligram oral tablet once daily. The July 2024 Medication Administration Record indicated Xanax was not marked as administered from 7/3/24 thru 7/9/24. A Nurses' Note, dated 7/4/24 at 10:48 a.m., indicated the resident's son stated the resident had not received Xanax during his hospital stay and did not want the resident to take it any longer. A Nurses' Note, dated 7/15/24 at 12:53 p.m., indicated the Nurse Practitioner reviewed the medication list and a new order was received to	F 0684	**Brickyard Merrillville Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** F 684 Quality of Care **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B and Resident G were both discharged, and no further correction could be done. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents have the potential to be affected by alleged practice. A 30-day look back was completed to ensure that any medications not given the MD was notified and all other medications were given as scheduled.	08/30/2024

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	discontinue Xanax, melatonin, Ambien (a sedative), and hydroxyzine (an antihistamine). During an interview on 8/2/24 at 12:30 p.m., the Interim Administrator indicated the medication was not available, but the family had also requested the medication be discontinued from use. There was no documentation in the resident's record to indicate the NP or Physician was contacted by facility staff regarding discontinuing the Xanax prior to 7/15/24. 2. Resident G's record was reviewed on 8/1/24 at 2:14 p.m. Diagnoses included, but were not limited to, local infection of the skin and subcutaneous tissue, high blood pressure, and type 2 diabetes mellitus. The Admission Minimum Data Set, dated 7/13/24, was still in progress. A Care Plan, dated 7/17/24, indicated the resident had a wound infection. Interventions included, but were not limited to, administer antibiotic therapy as per order until 8/13/24. The July 2024 Physician's Order Summary (POS) indicated the resident received the following antibiotic intravenous medications: - Cefazolin sodium solution reconstituted 2 grams every 8 hours until 8/13/24 - Ceftriaxone sodium solution reconstituted 2 grams once a day for 10 days - Vancomycin solution 1 gram once a day for 10 days The July 2024 Medication Administration Record		**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The DCE (Director of Clinical Education) educated all nursing staff on the policy for Medication administration and Physician Notification. DNS/Designee to do 5 Random Audits 5x a week for 4 weeks, Then 5 Random Audits 3x a week for 4 weeks, Then 5 Random Audits 2x a week for 4 weeks then 5 Random Audits once a week x 3 months. Audits will include all shifts, units and weekends. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The 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.	

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	(MAR) indicated the following medications were not administered as ordered: - Cefazolin was not marked as administered on 7/15/24 at 10:00 p.m. and 7/26/24 at 2:00 p.m. The corresponding Nurses' Note indicated the medication was "on order." - Ceftriaxone was not marked as administered on 7/30/24 at 12:00 p.m. The corresponding Nurses' Note indicated the medication was "on order." - Vancomycin was not marked as administered on 7/30/24 at 6:00 a.m. The corresponding Nurses' Note indicated the medication was "on order." During an interview on 8/2/24 at 1:11 p.m., the Interim Administrator indicated she had no further information related to the antibiotics not signed out as administered. This citation relates to Complaint IN00439994. 3.1-37(a)		**Date of compliance 8/30/2024**	