STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TERRACE CARE CENTER	1900 ANDREW AVE LA PORTE, IN 46350

(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 Complaints IN00423424 and IN00424049. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00423424 - Federal/state deficiencies related to the allegations are cited at F692 and F757. Complaint IN00424049 - Federal/state deficiencies related to the allegations are cited at F692 and F757. Survey dates: January 8 and 9, 2024 Facility number: 000061 Provider number: 155136 AIM number: 100288620 Census Bed Type: SNF/NF: 125 Total: 125 Census Payor Type: Medicare: 9 Medicaid: 92 Other: 24 Total: 125 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/17/24.	F 0000	**Brickyard Terrace 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.** **Brickyard Terrace Care Center respectfully requests consideration for a desk review.** Date of compliance 1/31/24	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Shepperd	Executive Director	02/01/2024

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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	(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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed for residents with weight loss for 1 of 3 residents reviewed for nutrition. (Resident B) Finding includes: Resident B's record was reviewed on 1/8/23 at 9:06 a.m. The resident was admitted to the facility on 11/18/23 and discharged to the hospital on 12/11/23. Diagnoses included, but were not limited to, multiple sclerosis, respiratory failure, diabetes mellitus, and chronic kidney disease. The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 12/11/23, indicated the resident was severely impaired for daily	F 0692	**Brickyard Terrace 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.** **F692 Nutrition** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident B discharged from the facility. Resident with no ill effect from alleged deficient practice. **How will you identify other**	01/31/2024

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	decision making. He required assistance with eating and received a mechanically altered diet. A shower sheet, dated 11/20/23, indicated the resident weighed 149.6 pounds. On 12/8/23, Resident B's weight was 143.3 pounds. A Care Plan, dated 12/2/23, indicated the resident was at nutritional risk related to varying meal intakes, requiring a mechanically altered diet due to dysphagia, and a decreased ability to feed himself. Interventions included, but were not limited to, monitor weight per orders, observe meal intakes, and provide Mighty Shake three times daily per order. A Dietary/ Nutrition Note, dated 11/25/23 at 8:39 a.m., indicated the resident had meal intakes varying from 0-100%. The resident would continue to be monitored via Nutrition at Risk (NAR). A Follow-up Note, dated 12/3/23 at 3:08 p.m., indicated the Nurse Practitioner ordered shakes/supplements three times a day and weekly weights due to poor appetite for the resident. The Meal Consumption logs for 11/18/23 - 12/11/23 were blank for the following meals: - Lunch meal on 11/18/23, 11/22/23, 11/26/23, and 12/10/23 - Dinner meal on 11/18/23, 11/22/23, 11/26/23, 12/1/23, 12/7/23, and 12/10/23 During an interview on 1/9/24 at 1:10 p.m., the Director of Nursing indicated the meal consumption logs should have been filled out to completion. He was being followed by the		**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 this alleged deficient practice. Full house audit completed of all residents in house to ensure meal consumption logs are filled out. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All clinical staff were educated on filling out meal consumption logs. ·Director of nursing/designee will audit 5 residents per week x 6 months to ensure meal consumption logs are being filled out. **·All audits will include all meals 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 complete audit tool to reflect proper meal consumption logs are completed. ·The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee	

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	Registered Dietician for weight loss. This citation relates to Complaints IN00423424 and IN00424049. 3.1-46(a)		monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of Compliance: 1/31/2024**	
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 medications were managed appropriately related to medications not signed out as ordered for 2 of 3 residents reviewed for unnecessary medications (Residents B and C). Findings include:	F 0757	**Brickyard Terrace 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**	01/31/2024

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	1. Resident B's record was reviewed on 1/8/23 at 9:06 a.m. Diagnoses included, but were not limited to, multiple sclerosis, respiratory failure, diabetes mellitus, and chronic kidney disease. The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 12/11/23, indicated the resident was severely impaired for daily decision making. He received an antidepressant, anti-anxiety, and opioid medication. The November 2023 Physician Order Summary (POS), indicated the resident received the following medications: - Actos (diabetic medication) tablet 30 milligrams (mg) by mouth once daily - Diazepam (antidepressant medication) tablet 2 mg by mouth three times daily - Glimepiride (diabetic medication) tablet 1 mg by mouth once daily - Protonix (reduces amount of acid in the stomach) tablet delayed release 20 mg by mouth once daily The November and December 2023 Medication Administration Record (MAR), indicated the medications were not administered as ordered on the following dates and times: - Actos tablet on 12/7/23 at 8:00 a.m. - Diazepam tablet on 11/19/23 at 5:00 a.m. and 8:00 p.m., 11/27/23 at 8:00 p.m., 12/8/23 at 5:00 a.m., 1:00 p.m., and 8:00 p.m., 12/9/23 at 5:00 a.m. and 8:00 p.m., 12/10/23 at 5:00 a.m., 1:00 p.m., and 8:00 p.m., and 12/11/23 at 5:00 a.m. and 1:00 p.m. - Glimepiride tablet on 12/7/23 at 8:00 a.m. - Protonix tablet on 11/28/23 at 5:00 a.m. During an interview on 1/9/24 at 1:10 p.m. , the Director of Nursing indicated she was unable to locate documentation of the medications being		**only in response to the regulatory requirement.** **F757 Free from unnecessary drugs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B discharged from facility. No ill effect due to alleged deficient practice. ·Resident C's medications administered as he will allow, care plan updated. No ill effect due to alleged deficient practice. **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 this alleged deficient practice. Full house audit completed of all residents in house that receive medications to ensure medications are given as ordered. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All clinical staff were educated on proper medication administration/documentation. ·Director of nursing/designee will audit 5 residents each week x 6	

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	administered. The nursing staff should have put in a progress note with the reason the medications were not administered. 2. Resident C's record was reviewed on 1/8/23 at 11:50 p.m. Diagnoses included, but were not limited to, dementia, major depressive disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/23, indicated the resident was severely cognitively impaired. He received an anti-anxiety, antidepressant, and opioid medication. A Physician Order, dated 9/1/23, indicated lorazepam (an anti-anxiety medication) 2 milligram/milliliter (mg/ml), 0.5 milliliter (ml) by mouth four times a day. The December 2023 Medication Administration Record (MAR) indicated the lorazepam medication was not marked off as administered on the following dates and times: - 12/1/23 at 12:00 p.m., 12/4/23 at 10:00 p.m., 12/16/23 at 10:00 p.m., 12/20/23 at 4:00 p.m., 12/22/23 at 10:00 p.m., 12/25/23 at 10:00 p.m., 12/30/23 at 10:00 p.m., and 12/31/23 at 10:00 p.m. During an interview on 1/9/24 at 1:10 p.m., the Director of Nursing indicated she was unable to locate documentation of the administration of the medication. This citation relates to Complaints IN00423424 and IN00424049. 3.1-48(a)(6)		months to ensure proper medication administration/documentation is in place. **·All audits will include all shifts and 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 complete audit tool to reflect medications are being administered as ordered and documented. 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, audit will continue. **Date of compliance: 1/31/24**	