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	01/24/2023

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00375007, IN00386371, IN00390234, and IN00390590. Complaint IN00375007 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00386371 - Substantiated. Federal/State deficiencies related to the allegations are cited at F757 and F921. Complaint IN00390234 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00390590 - Substantiated. Federal/State deficiencies related to the allegations are cited at F760. Survey dates: January 18, 19, 20, 23, and 24, 2023 Facility number: 000061 Provider number: 155136 AIM number: 100288620 Census Bed Type: SNF/NF: 117 Total: 117 Census Payor Type: Medicare: 11 Medicaid: 85 Other: 21 Total: 117 These deficiencies reflect State Findings cited in	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. Kindly, Tiffany A. Shepperd**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany A. Shepperd	Executive Director	02/07/2023

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	accordance with 410 IAC 16.2-3.1. Quality review completed on 1/26/23.			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §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, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependent residents related to incontinence care, nail care, changing urinary catheters, and dining assistance for 4 of 7 residents reviewed for ADL care. (Residents 66, 74, 218, and E) Findings include: 1. On 1/18/23 at 2:09 p.m., Resident 66 was seated in a chair in the activity lounge. A urine odor was noted. When the resident stood from the chair, the back of her pants were wet and the area extended to mid thigh. The resident proceeded to the other activity room located across the hall. At 2:18 p.m., 2:45 p.m., and 3:10 p.m., the resident continued to go back and forth between the activity rooms. The resident remained in the wet pants. Multiple staff were in the activity rooms and the resident was not provided assistance to change her pants. The record for Resident 66 was reviewed on 1/20/23 at 9:53 a.m. Diagnoses included, but were not limited to, Alzheimer's disease with early onset, psychosis, and delirium. The 10/29/22 Quarterly Minimum Data Set (MDS)	F 0677	**F677** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #66 incontinence care provided. Resident with no ill effect from alleged deficient practice ·Resident #74 fingernails cleaned and trimmed. Resident with no ill effect from alleged deficient practice. plan related to refusals of nail care initiated. ·Resident #218 no longer resides in the facility. ·Resident #E orders input for condom catheter to be changed every 24 hours. Resident with no ill effect from 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	02/07/2023

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	assessment indicated the resident was cognitively impaired for daily decision making and required extensive assistance with dressing and toilet use. The resident was also frequently incontinent of urine. A Care Plan, reviewed 11/14/22, indicated the resident had a physical functioning deficit related to having a self care impairment. Interventions included, but were not limited to, may require up to extensive assistance of 1 or 2 with toilet use. Interview with the Director of Nursing on 1/24/23 at 2:34 p.m., indicated the resident should have been assisted in a more timely manner with changing her pants. 2. On 1/18/23 at 11:00 a.m., Resident 74 was observed in bed. At that time, her fingernails were long and dirty. On 1/19/23 at 3:23 p.m., the resident was observed sitting up in a high back wheelchair. At that time, her fingernails were long and dirty. On 1/20/23 at 9:37 a.m., and on 1/23/23 at 11:00 a.m., the resident was observed in bed. At those times, her fingernails were long and dirty. The record for Resident 74 was reviewed on 1/20/23 at 1:20 p.m. Diagnoses included, but were not limited to, fractured femur, stroke, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 12/26/22, indicated the resident was severely impaired for decision making and had no behaviors of refusing care. She was an extensive assist with a 2 person physical assist for personal hygiene and totally dependent on staff for bathing.		alleged deficient practice. All residents that require incontinence care were audited to ensure that care is being provided. A full house audit completed to ensure that all current residents had clean/trimmed nails. A full house audit completed to ensure that all residents that require assistance with meals, receive assistance with eating. A full house audit to ensure anyone receiving condom catheter has orders to change the catheter per MD orders. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·Clinical staff were educated on providing incontinence care for all incontinent residents in house. ·Clinical staff were educated on providing nail care to all residents. ·Clinical staff were educated on aiding residents that require feeding assist. ·Clinical staff were educated on obtaining orders to change condom catheters. ·Director of nursing/designee will audit 5 residents per week x 6 months to ensure proper incontinence care is provided to residents who require incontinence care. ·Director of nursing/designee will audit 5 residents per week x 6 months to ensure proper nail care	

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	The Care Plan, revised on 1/3/23, indicated the resident had a self care impairment related to the fracture and arthritis. There was no Care Plan indicating the resident refused care. There was no documentation in the clinical record the resident refused nail care. Interview with the Memory Unit Manager on 1/24/23 at 2:45 p.m., indicated there was no documentation the resident refused nail care or a Care Plan for refusal of care. 3. During an interview with Resident 218 on 1/18/23 at 10:35 a.m., indicated he needed to be fed due to his fractured cervical spine. The staff would drop off the meal tray and come back in 30 minutes to feed him and then the food would be really cold. On 1/20/23 from 8:07 a.m., to 8:34 a.m., the resident was observed in bed and his breakfast tray was on the over bed table. During that time frame, no staff member had came into the room to feed him. At 8:34 a.m., CNA 1 was standing at the bed side providing care. The breakfast tray remained on the over bed table untouched and covered. Interview with CNA 1 at that time, indicated the tray had been there for a little bit, but she did not bring it in and did not know when the tray was placed there. She was preparing to feed the resident. Interview with the Unit Manager on 1/20/23 at 8:42 a.m., indicated the first cart of breakfast trays arrived to the unit around 7:30 a.m., and the second cart came down to the unit minutes after.		is provided. ·Director of nursing/designee will audit 5 residents per week x 6 months to ensure proper meal assistance is provided to residents who require feeding assist. ·Director of nursing/designee will audit all residents with a condom catheter weekly x 6 months to ensure orders are in place to change condom catheter. ·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 proper incontinence care, fingernail care, and feeding assist is provided using attached audit sheet. ·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** **2/7//2023**	

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	On 1/20/23 at 1:03 p.m., the resident was laying in bed and awake. His lunch tray was observed on the over bed table not touched. CNA 2 was observed entering the room to feed him. The resident's roommate's family member indicated the resident was waiting for someone to come and feed him. Interview with CNA 2 at that time, indicated she did not deliver the tray to his room for lunch. Interview with a dietary aide on 1/20/23 at 1:09 p.m., indicated the Memory Unit trays were delivered at 12:30 p.m. The record for Resident 218 was reviewed on 1/23/23 at 12:34 p.m. Diagnoses included, but were not limited to, type 2 diabetes, anxiety disorder, muscle weakness, and cervical fracture. The 1/16/23 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. The resident needed extensive assist with 1 person physical assist for eating. A Care Plan, dated 1/10/23, indicated the resident had a physical functioning deficit related to a cervical fracture. The approaches were to provide up to extensive assistance times 1 with eating. Interview with the Memory Unit Manager on 1/24/23 at 10:15 a.m., indicated the resident required assistance from the staff to be fed. 4. During an interview with Resident E on 1/18/23 at 11:24 a.m., he indicated he wore a condom (external urinary catheter) catheter due to his multiple sclerosis. The resident indicated the condom catheter was supposed to be changed			

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	every day and it had not been done. The record for Resident E was reviewed on 1/23/23 at 10:48 a.m. Diagnoses included, but were not limited to, multiple sclerosis and pain. The Admission Minimum Data Set (MDS) assessment, dated 1/9/23, indicated the resident was moderately impaired for decision making. The resident needed extensive assist with 2 person physical assist for toilet use, and personal hygiene. A Care Plan, revised on 1/20/23, indicated the resident had an alteration in elimination of bowel and bladder and wore a condom catheter. The approaches were to provide condom catheter care per facility policy. Physician's Orders, dated 1/3/23, indicated the resident may have a condom catheter. There were no orders on how often the catheter was to be changed. There was no documentation on the 1/2023 Medication Administration Record or the Treatment Administration Record for changing the catheter on a daily basis. The current undated "Condom Catheter Care" policy, provided by the Director of Nursing on 1/23/23 at 3:38 p.m., indicated any condom catheter would be changed every 24 hours or as per manufacturer's instructions. Interview with the Memory Unit Manager on 1/23/23 at 11:45 a.m., indicated she had thought his mother was changing the catheter every day. There was no documentation in the chart to			

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	indicate it had been done every day. 3.1-38(a)(2)(C) 3.1-38(a)(2)(D) 3.1-38(a)(3)(E)			
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, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure edema was assessed and monitored and Physician's Orders were obtained for moisture associated skin damage (MASD - which is caused by prolonged exposure to various sources of moisture, including urine or stool.) for 1 of 2 residents reviewed for edema and for 1 of 6 residents reviewed for skin conditions non-pressure related. (Residents D and E) Findings include: 1. The closed record for Resident D was reviewed on 1/23/23 at 2:37 p.m. The resident was admitted to the facility on 8/23/22 and left against medical advice on 8/24/22. Diagnoses included, but were not limited to, morbid obesity, type 2 diabetes, cancer of the cervix, anemia, edema, and sepsis. There was no Minimum Data Set (MDS) assessment available for review.	F 0684	**F684** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident E admitted to facility on 8/23/2022 and discharged from facility 8/24/2022. Resident had no tx order for non-pressure area in her orders upon discharge. Resident had no ill effect due to alleged deficient practice. ·Resident D received a full assessment related to his edema and physician was notified. Resident with no ill effect from alleged deficient practice. Care plan was initiated. **How will you identify other residents having the potential to be affected by the same**	02/07/2023

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	There was no Care Plan for the MASD. A Nurses' Note, dated 8/23/22 at 7:50 p.m., indicated the resident arrived at the facility at 7:15 p.m. There were multiple bruises noted to the lower abdomen, excoriation to the inner thighs, and several open areas to the buttocks. A Skin Only Evaluation, dated 8/23/22 at 7:50 p.m., indicated the resident had current skin issues. Excoriation was observed to the groin and inner thighs. There were multiple open areas to both buttocks with excoriation. All of the areas were painful for the resident. . A Nurses' Note, dated 8/24/22 at 5:11 a.m., indicated the resident was alert and oriented. The bilateral buttocks had excoriation. All areas were cleansed and a treatment was applied. A Wound Evaluation, dated 8/24/22 at 11:12 a.m., by the Wound Nurse Practitioner (NP), indicated the resident had MASD to the right upper thigh that measured 7.12 centimeters (cm) by 6.34 cm, the right buttock that measured 10.63 cm by 8.85 cm, and the left buttock that measured 14.52 cm by 6.75 cm. All of the above areas had 100% of epithelial tissue. The NP had indicated Nystatin powder twice a day for the upper thigh area and Nystatin cream to both buttocks twice a day and prn (as needed). There were no Physician's Orders for a treatment of the MASD (open areas) on the resident's buttocks. There was no documentation any treatment had been completed. There were no preventative creams ordered for the resident.		**deficient practice and what corrective action will be taken?** ·All residents that admit with non-pressure areas have the potential to be affected by this alleged deficient practice. Full house audit completed of all residents in house with non-pressure areas to ensure we have tx orders in place. ·All current residents that have concerns related to edema have the potential to be affected by this alleged deficient practice. Full house audit completed of all residents in house with concerns related to edema to ensure assessments are in place. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·Clinical staff were educated on obtaining tx orders for non-pressure areas. ·Clinical staff were educated on providing a full assessment for any resident with concerns of edema. ·Director of nursing/designee will audit 5 residents per week x 6 months to ensure tx orders are in place for non-pressure areas. ·Director of nursing/designee will audit 5 residents per week x 6 months to ensure proper assessments for edema are in place. **·All audits will include all**	

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	Interview with the Director of Nursing on 1/24/23 at 11:46 a.m., indicated there were no Physician's Orders for a treatment for the MASD on the resident's buttocks. She indicated the Wound NP was at the facility and assessed the open areas and ordered a treatment for all of them. 2. During an interview with Resident E on 1/18/23 at 11:19 a.m., indicated his ankles and feet were swollen. He indicated his feet and ankles were so bad, he had to get a bigger pair of shoes. At that time, Agency RN 1 entered the room and removed the resident's socks. Both feet and ankles were swollen. The record for Resident E was reviewed on 1/23/23 at 10:48 a.m. Diagnoses included, but were not limited to, multiple sclerosis, high blood pressure, and pain. The Admission Minimum Data Set (MDS) assessment, dated 1/9/23, indicated the resident was moderately impaired for decision making. The resident needed extensive assist with 2 person physical assist for bed mobility and transfers. There was no Care Plan for edema. A Coms - Skin Only Evaluation, dated 1/2, 1/9, 1/16, and 1/19/23, indicated the resident had no skin issues. A Wound Nurse Practitioner (NP) Note, dated 1/10/23 at 10:07 p.m., indicated a comprehensive skin and wound evaluation was completed. The resident had dry skin to both feet. The wound plan of care was to moisturize his feet daily. A Care Plan Meeting Note, dated 1/17/23 at 11:13 a.m., indicated the resident had an issue with		**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 ensure that all residents with non-pressure areas will receive treatment orders. ·The Director of nursing/designee will complete audit tool to reflect proper assessments are in provided for all residents with edema. ·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: 2/7/2023**	

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	lower leg edema. The Unit Manager indicated she would discuss the concern with the team and would resolve. There was no assessment or documentation of the edema to the feet and ankles in the clinical record. There were no Physician's Orders for any moisturizing lotion for his feet. Physician's Orders, dated 1/19/23 with a start date of 1/20/23, indicated furosemide (a diuretic medication) 10 milligrams (mg) daily for 7 days for edema. Interview with the Memory Unit Manager on 1/23/23 at 11:45 a.m., indicated she was made aware of the edema during the care conference, however, there was no documentation she notified the Physician. There was no documentation of an assessment in the clinical record of the edema. She was unaware the Wound NP had recommended to moisturize the resident's feet every day. She had not assessed the resident's edema. This Federal tag relates to Complaint IN00390234. 3.1-37(a)			
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- §483.25(a)(1) In making appointments, and			

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	§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 follow up visits to an Ophthalmologist occurred for a resident needing cataract surgery for 1 of 1 residents reviewed for vision and hearing. (Resident 85) Finding includes: During an interview on 1/18/23 at 11:06 a.m., Resident 85 indicated he had a consult about cataract surgery but had not heard anything more about it. The record for Resident 85 was reviewed on 1/20/23 at 10:40 a.m. Diagnoses included, but were not limited to, type 2 diabetes, chronic pain, high blood pressure, and anxiety. The Significant Change Minimum Data Set (MDS) assessment, dated 12/26/22, indicated the resident was cognitively intact. Interview with Social Service (SS) Employee 1 on 1/23/23 at 4:10 p.m., indicated after 2020, they had trouble getting vision services for the residents, so they were sending residents out to local eye doctors. She did remember the resident going out to see the Optometrist and would look into it. A SS Note, dated 1/23/23 at 5:10 p.m., indicated the resident was seen by an Optometrist on 3/3/22. He was then seen again on 3/17/22 to pick up his new glasses. He was referred to an Ophthalmologist and an appointment was	F 0685	**F685** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #85 Social Services made an appointment for resident to follow-up with eye doctor for consult regarding cataract. Resident had 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. Audit completed of all residents in house requiring vision services to ensure timely follow-up/services were scheduled. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** · Clinical and Social Service staff were educated on scheduling timely follow-up appointments for	02/07/2023

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	scheduled on 5/16/22. The resident had refused to go due to health conditions at that time. The resident asked if the writer could call and reschedule the appointment with the Ophthalmologist and was in agreement to go that time. A SS note, dated 1/24/23 at 8:39 a.m., indicated an appointment was scheduled for 4/27/23 at 1:15 p.m. The resident was made aware. Interview with SS on 1/24/23 at 8:50 a.m., indicated the resident did go out of the facility for an eye appointment last March and another appointment was set up in May 2022. The resident refused to go to that appointment for health reasons. There was no follow up with the resident or the surgeon after May of 2022 to see if he wanted to still have the consult and have his cataracts removed. 3.1-39(a)(1)		eye appointments. · Social Services/Designee will audit 5 residents a week x 6 months to ensure proper scheduling of eye appointments is taking place. · All audits will include all units. **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 timely scheduling of eye appointments. · 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 2/7/2023**	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and			

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	§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure Physician's orders were in place for a wedge positioning device for 1 of 2 residents reviewed for limited range of motion (ROM). (Resident 62) Finding includes: On 1/20/23 at 9:44 a.m. and again at 11:15 a.m., Resident 62 was observed sitting in a wheelchair in her room. The resident had a wedge device between both of her legs. A Velcro strap was attached to the device and around the resident's left leg. Another Velcro strap was attached to the device and around the resident's right leg but not strapped closed. On 1/20/23 at 1:27 p.m., Resident 62 was observed sitting in a wheelchair by the nurse's station. The resident had a wedge device between both of her legs with the Velcro straps around both legs and strapped. Record review for Resident 62 was completed on 1/20/23 at 1:04 p.m. Diagnoses included, but were not limited to, stroke and dementia. The Quarterly Minimum Data Set (MDS)	F 0688	**F688** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #62 nursing received an order for wedge positioning device. Resident with no ill effect from 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 that have wedge positioning devices have the potential to be affected by this alleged deficient practice. Full house audit completed of all residents in house with wedge positioning device to ensure proper orders are in place was completed. **What measures will be put into place or what systemic changes will you make to**	02/07/2023

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	assessment, dated 11/2/22, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assistance for bed mobility, transfers, and dressing. The resident had a functional limitation in ROM to both sides of her lower extremities. A Care Plan, dated 2/25/22 and revised 10/17/22, indicated the resident had a physical functioning deficit related to: Contractures to the right hand and elbow and bilateral legs/feet. An intervention included to apply and remove splints per the Physician's order. There was no documentation to indicate a Physician's order was received for the wedge positioning device to include directions for use. Interview with QMA 1 on 1/20/23 at 1:27 p.m., indicated she had applied the resident's wedge positioning device to her legs that morning. She believed the resident was supposed to wear it while she was sitting up in the wheelchair to keep her legs together for positioning. Interview with the Rainbow Unit Manager on 1/20/23 at 1:34 p.m., indicated she believed therapy was doing a trial run on the wedge positioning device. The resident was to wear it while up in the wheelchair so her legs did not fall to one side. The nursing staff was to put the device on and take it off. There was not a Physician's order for the positioning device. She indicated she must have overlooked getting an order but there should have been one. 3.1-42(a)(2)		**ensure that the deficient practice does not recur?** ·Clinical staff were educated on obtaining orders for all wedge positioning devices. ·Director of nursing/designee will audit 5 residents per week x 6 months to ensure orders are in place for wedge cushion devices. ·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 proper orders are in place for wedge cushion devices. ·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: 2/7/2023**	
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance			

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Bldg. 00	§483.25(g) Assisted nutrition and hydration. (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 observation, record review, and interview, the facility failed to ensure acceptable parameters of nutrition were maintained related to completing food consumption documentation for residents with a history of weight loss for 2 of 3 residents reviewed for nutrition. (Residents 34 and 74) Findings include: 1. The record for Resident 34 was reviewed on 1/20/23 at 11:52 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 12/23/22, indicated the resident was moderately impaired for daily decision making	F 0692	**F692** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #34 meal consumption log filled out. Resident with no ill effect from alleged deficient practice. ·Resident #74 meal consumption log filled out. Resident with no ill effect from alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	02/07/2023

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	and she needed extensive assistance with eating. The resident also received a mechanically altered, therapeutic diet. A Care Plan, dated 12/10/22, indicated the resident was at nutritional risk related to obesity, she required a therapeutic and mechanically altered diet, her meal intakes varied, and she had decreased ability to feed herself at meals. The resident had significant weight losses documented on 8/28, 9/9, 10/16, and 12/2/22. Interventions included, but were not limited to, monitor and record meal intakes daily. A Physician's Order, dated 1/5/23, indicated the resident was to receive a mechanical soft diet with double protein at meals for wound healing. The food consumption log, dated 12/20/22 through 1/19/23, indicated the following: - No dinner was documented on 12/28/22. - No breakfast was documented on 1/6/23. - No breakfast or lunch was documented on 1/3, 1/12, and 1/14/23. Interview with the Director of Nursing on 1/24/23 at 2:34 p.m., indicated the resident's meal intake should have been documented. 2. The record for Resident 74 was reviewed on 1/20/23 at 1:20 p.m. Diagnoses included, but were not limited to, fractured femur, stroke, dementia, depression, and high blood pressure. The resident was admitted on 9/18/22. The Quarterly Minimum Data Set (MDS) assessment, dated 12/26/22, indicated the resident was severely impaired for decision making. The resident had no oral problems, weight loss or weight gain. She weighed 128 pounds.		**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 monthly for six months. Thereafter, if determined by the Quality Assurance committee that	

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	The Care Plan, revised on 1/3/23, indicated the resident had a self care impairment related to the fracture and arthritis. The approaches were to provide up to extensive assistance with 1 staff with eating. The Care Plan, revised on 1/10/23, indicated the resident was at nutritional risk. The approaches were monitor and record meal intakes daily. A Registered Dietitian (RD) Note, dated 1/10/23 at 11:03 a.m., indicated the resident had a significant weight loss of 8.5% in the last 30 days. The weekly weights were as follows: - 1/15/23 119 pounds - 1/8/23 119 pounds - 1/1/23 120 pounds - 12/22/22 128 pounds - 12/11/22 130 pounds - 12/2/22 131 pounds The meal consumption logs in last 30 days indicated the breakfast meal was not documented on 12/28, 12/29, 12/30/22, 1/1, 1/3, 1/8, 1/15, and 1/18/23. The lunch meal was not documented on 12/28, 12/29, 12/30/22, 1/1, 1/8, and 1/15/23. The dinner meal was not documented on 12/26/22, 1/8, and 1/11/23. Interview with the Memory Unit Manager on 1/23/23 at 10:45 a.m., indicated the resident's meal consumption intakes were to be completed after every meal. 3.1-46(a)(1)		further monitoring is needed, audit will continue. **Date of Compliance: 2/7/2023**	
F 0693 SS=D	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills			

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Bldg. 00	§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 interview, the facility failed to check placement for a peg tube prior to the administration of medication for 1 of 1 peg tubes observed during medication pass. (Resident 49) Finding includes: On 1/19/23 at 4:14 p.m., LPN 1 was observed preparing and pouring medications for Resident 49. All the medications were crushed separately and to be administered through the peg tube. He entered the resident's room, washed his hands with soap and water, and donned clean gloves. He placed the enteral feeding on hold and listened to the resident's bowel sounds by using a stethoscope. He proceeded to flush the peg tube	F 0693	**F693** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #49 nursing verified placement of feeding tube prior to administering medications and feeding. Resident with no ill effect from 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?**	02/07/2023

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	and administer the medication one by one. He did not did not check for placement prior to administration. The record for Resident 49 was reviewed on 1/24/23 at 9:16 a.m. Diagnoses included, but were not limited to, stroke, peg tube, and dysphagia (difficulty swallowing). Physician's Orders, dated 8/22/22, indicated the resident was NPO (nothing by mouth). Jevity enteral feeding was to be infused at 64 cubic centimeters (cc) per hour continuously. The current and undated, "Medication Administration via Enteral Tube" policy, provided by the Regional Nurse Consultant on 1/24/23 at 3:50 p.m., indicated enteral tube placement must be verified prior to administration of fluids or medications. Interview with the Regional Nurse Consultant on 1/20/23 at 10:08 a.m., indicated the LPN should have checked for placement prior to administration of the medications. 3.1-44(a)(2)		·All current residents with feeding tubes have the potential to be affected by this alleged deficient practice. Full house audit completed of all residents in house that have feeding tubes to ensure proper verification of placement. **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 verifying placement prior to administering medications and feeding. ·Director of nursing/designee will audit all residents that receive tube feeding 5x weekly x 6 months to ensure proper verification of site is being observed prior to administration of medications and feeding. **·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 proper verification of placement of feeding tube prior to administering medications or feedings weekly. ·The Director of Nursing/designee will present the	

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			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: 2/7/2023**	
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 comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure narcotic pain medication was available for a resident who was newly admitted and experiencing severe pain for 1 of 2 residents reviewed for pain. (Resident 224) Finding includes: During an interview with Resident 224 on 1/19/23 at 8:52 a.m., she indicated her pain medications were not available for 2 days after she was admitted. She wanted a pain pill yesterday evening and was told there were none available. During an interview on 1/19/23 at 3:30 p.m., the resident indicated the nurse told her only 3 pills were available and they were still waiting for the doctor to sign the pain prescription. During an interview on 1/20/23 at 9:35 a.m., the resident indicated her pain medication was not available in the middle of the night. She asked for	F 0697	**F697** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #224 pain medications administered and available upon request. No ill effects identified related 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 with pain medication orders have the potential to be affected by alleged deficient practice. Full house audit completed for all residents in	02/07/2023

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	a pain pill around 8:00 p.m. and received it, however nothing was available after that. Her pain level was currently a 9 out of 10. The record for Resident 224 was reviewed on 1/23/23 at 10:10 a.m. The resident was admitted on 1/11/23 at 3:00 p.m. Diagnoses included, but were not limited to, partial traumatic amputation or right great toe, cellulitis of lower limb, and frostbite to toes and fingers. A Care Plan, dated 1/12/23, indicated the resident needed pain management and monitoring related to a surgical procedure. The approaches were to administer pain medications as ordered. Physician's Orders, dated 1/11/23, indicated the resident was to receive Hydrocodone-Acetaminophen tablet (a narcotic pain medication) 7.5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed (prn) for pain. Physician's Orders, dated 1/19/23 at 2:37 p.m., indicated Norco tablet 5-325 mg. Give 1 tablet by mouth every 8 hours as needed for severe pain only. Acetaminophen 650 mg every 6 hours prn for mild to moderate pain. The Medication Administration Record (MAR), dated 1/2023, indicated the resident received a Norco tablet for the first time on 1/12/23 at 11:31 a.m. The resident's pain was a 9 out of 10. The resident received another Norco tablet on 1/13/23 at 8:00 a.m. and 4:24 p.m. The Controlled Substance Accountability Sheet indicated on 1/18/23 at 2:30 p.m., a Norco tablet was administered and the quantity remaining was 0. On 1/19/23 (no time) 3 tablets were received and		house that receive pain medications to ensure medications are available. **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 pain medication orders/and administration ·Director of nursing/designee will audit 5 residents each week x 6 months to ensure pain medication is available for administration. **·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 pain medications are available and administered per order/request weekly. ·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: 2/7/2023**	

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	at 3:30 a.m. the resident received a pain pill. A Pain Assessment, dated 1/12/23, indicated the resident had frostbite at the right great toe and heels. The pain was achy, sharp at times, dull, stabbing, and throbbing. An Audit Report indicated the original Norco pain medication order was dated 1/11/23 at 5:01 p.m. The Physician had not signed the order until 1/12/23 at 11:22 a.m. Interview with the Director of Nursing on 1/23/23 at 12:20 p.m., indicated a total of 20 tablets were dispensed to the Alexa machine (automated emergency drug supply). The resident received her first Norco on 1/12/23 in the late morning. The nurse who took the order should have immediately sent the request in for the Physician or Nurse Practitioner to sign the prescription so the pharmacy would dispense the narcotic medication. 3.1-37(a)			
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;			

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	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 manage medications appropriately related to not signing out medications as ordered for 1 of 7 residents reviewed for unnecessary medications. (Resident C) Finding includes: The record for Resident C was reviewed on 1/23/23 at 9:45 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance. The 12/31/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident had short and long term memory problems and was moderately impaired for daily decision making. The resident also had trouble sleeping during the last 7-11 days. A Physician's Order, dated 2/14/22, indicated the resident was to receive Aricept (a medication for dementia) 5 milligrams (mg) every evening and Namenda (a medication for dementia) 5 mg at bedtime. A Physician's Order, dated 2/20/22, indicated the resident was to receive Melatonin 5 mg at bedtime	F 0757	**F757** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident C given medications as he will allow, careplan 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**	02/07/2023

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	related to a sleep disorder. The September 2022 Medication Administration Record (MAR), indicated the Aricept, Namenda, and Melatonin were not signed out as being given on 9/27/22. The October 2022 MAR, indicated the Melatonin had not been signed out as being given on 10/6, 10/11, and 10/12/22. The November 2022 MAR, indicated the Aricept and Namenda had not been signed out as being given on 11/29/22 and the Melatonin had not been signed out on 11/29 and 11/30/22. Interview with the Director of Nursing on 1/24/23 at 2:34 p.m., indicated the medications should have been signed out as being given. This Federal tag relates to Complaint IN00386371. 3.1-48(a)(6)		**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 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: 2/7/2023**	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility	F 0760	**F760**	02/07/2023

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	failed to ensure a resident was free of a significant medication error related to receiving the wrong medications for 1 of 7 residents reviewed for unnecessary medications. (Resident B) Finding includes: The record for Resident B was reviewed on 1/20/23 at 10:36 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, psychotic disorder, hypertension, and type 2 diabetes mellitus. The Annual Minimum Data Set (MDS) assessment, dated 11/17/22, indicated the resident was cognitively intact. During the assessment reference period, the resident had received injections, antipsychotic medications, anti-anxiety medications, antidepressant medications, and a diuretic (water pill). A Care Plan, reviewed on 10/17/22, indicated the resident was at risk for impaired cognition related to Schizophrenia, Mood Disorder, and Dementia. Interventions included, but were not limited to, Zyprexa (an antipsychotic medication) and Depakote (mood stabilizer) as ordered. A Change of Condition note, dated 8/26/22 at 9:18 a.m., indicated the resident was given the wrong medication. The Physician was notified and orders were received to send the resident to the emergency room for evaluation. The resident's blood pressure was 174/93 (normal blood pressure 120/80). Nurses' Notes, dated 8/26/22 at 9:47 a.m., indicated the resident was given a few medications in error. The Physician was notified and orders were received to send the resident to the emergency		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #26 admitted to hospital on 8/26/2022 for full medical evaluation and readmitted into facility on 8/29/2022. Resident #26 reviewed with no ill effects due to 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 facility residents with medication orders have the potential to be affected by this deficient practice. Full house medication audit of all current residents with medication orders. **What measure will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?** • Facility Nursing staff educated on Medication Administration Policy, including the five rights. • Director of Nursing Services/designee will audit 5 resident chart's each week x 6 months to reflect proper medication administration. Audit will include all shifts, units, and weekends. **How will the corrective action(s) to be monitored to ensure the deficient practice**	

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	room for evaluation. The resident's blood pressure was 172/112 and when rechecked, it was 150/82. Nurses' Notes, dated 8/26/22 at 2:44 p.m., indicated the resident was being admitted for observation for hypotension (low blood pressure). The facility investigation indicated on the morning of 8/26/22, LPN 2 reported a medication error to the Director of Nursing (DON). The LPN indicated she had mistakenly given Resident B the 8:00 a.m. medications meant for his roommate. The resident received Anoro Ellipta Aerosol (an inhaler) 1 puff, Aspirin 81 milligrams (mg), Thiamine (a vitamin) 100 mg, Namenda (a dementia medication) 10 mg, and Rifaximin (an antibiotic) 550 mg. The LPN was a new nurse to the facility and she had been checked off on the Medication Administration Policy on 8/23/22. The LPN finished her shift on 8/26/22 and proceeded to submit her resignation. Interview with the DON on 1/20/23 at 1:37 p.m., indicated Resident B did receive the medications in error and he was sent to the emergency room for evaluation. She also indicated there were no changes in the resident's baseline. This Federal tag relates to Complaint IN00390590. 3.1-48(c)(2)		**will not recur, I.e., what quality assurance program will be put into place?** • The Director of Nursing Services/designee will complete audit tool to reflect proper application and measurement weekly. • The Director of Nursing Services/Designee will present the summaries of the audits the QAPI Committee monthly for six months. Thereafter, if determined by the QAPI Committee that further monitoring is needed, the audit will continue. **Date of compliance: 2/7/2023**	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink			

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	Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on interview, observation, and record review, the facility failed to ensure food served to resident rooms was palatable for 1 of 1 units observed. This had the potential to affect the 19 residents who resided on that unit and received food from the kitchen. (Residents 44, 54 and Rainbow Unit) Findings include: 1. Interview with Resident 44, who resided on the Rainbow Unit, on 1/18/23 at 2:29 p.m., indicated she received her meals in her room. The food was not warm for a lot of the meals she had been served. A follow up interview with Resident 44 on 1/24/23 at 10:30 a.m., indicated the lunch that she had received the day before was cold. 2. Interview with Resident 54, who resided on the Rainbow Unit, on 1/19/23 at 10:12 a.m., indicated she sometimes would eat her meals in her room. The vegetables were often raw and the food overall was not served hot. On 1/23/23 at 12:23 p.m., the lunch trays were delivered to the Rainbow Unit in a food cart. The last tray was removed at 12:31 p.m. The tray had a plastic dome lid covering the plate. At that time,	F 0804	**F804** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·#44 food heated to palatable temperature prior to serving. No ill effect due to the alleged deficient practice. ·#54 Food heated to palatable temperature prior to serving. No ill effect due to the 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 for each unit. The last tray on each cart temped prior to serving to ensure temperature is holding at appropriate degree. **What measures will be put into place or what systemic**	02/07/2023

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	the Dietary Manager (DM) removed the plastic dome lid and used a food thermometer to obtain the following food temperatures: - Pork: 122 degrees - Stuffing: 135 degrees - Cut carrots: 131 degrees The food was then tasted. The pork and cut carrots were not warm to taste. The stuffing was warm to taste. Interview at that time with the DM, indicated she believed the food should be served at 120 degrees but she would have to look at the policy. The food should always be served hot to the residents. A facility policy titled, "Food Preparation Guidelines", and received as current from the facility on 1/23/23, indicated, "...3. Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include:..." "...c. Serving hot foods/drinks hot and cold foods/drinks cold...." 3.1-21(a)(2)		**changes will you make to ensure that the deficient practice does not recur?** ·All staff were educated on palatable temperatures. ·Dietary manager/designee will audit 5 trays each week x 6 months to ensure palatable temperatures are maintained. **·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 Dietary manager/designee will complete audit tool to reflect resident satisfaction and meal temperatures. ·The Dietary manager/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: 2/7/2023**	
F 0812 SS=E 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.			

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	(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure a sanitary kitchen related to built up grease on the flat top, stove top, and sides of the oven in 1 of 1 kitchens observed (Main Kitchen). This had the potential to affect 116 residents who received food from the kitchen. Findings include: 1. During the initial kitchen tour on 1/18/23 at 9:18 a.m., with Cook 1, the following was observed: - The flat top, stove top, and sides of the oven had a build up of grease. 2. During the follow-up tour in the kitchen on 1/23/23 at 11:46 a.m., with the Dietary Manager the following was still observed: - The flat top, stove top, and sides of the oven had a build up of grease. Interview with the Dietary Manager at that time indicated the dietary staff was responsible for cleaning. There should not have been a build up of grease on the cooking appliances.	F 0812	**F812** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Grease buildup on oven and flattop cleaned. No ill effect due to the 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. ·Cleaning audits of oven and flattop weekly to ensure proper sanitation practices are followed. **What measures will be put into place or what systemic changes will you make to**	02/07/2023

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	3.1-21(i)(3)		**ensure that the deficient practice does not recur?** ·Facility staff were educated on kitchen sanitation. ·Dietary manager/designee will audit oven and flattop 5 times each week x 6 months to ensure kitchen sanitation is maintained. **·Audits will include 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 Dietary manager/designee will complete audit tool to reflect kitchen sanitation. ·The Dietary manager/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: 2/7/2023**	
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 and interview, the facility failed to ensure the residents' environment, as well as the kitchen area, was clean and in good repair related to dirty floors, marred walls, marred doors, loose baseboards, lime build up on faucets,	F 0921	**F921** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	02/07/2023

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	leaking faucets, slow draining sinks, burnt out light bulbs, dirty sinks, and dirty soap dispensers in 1 of 1 kitchen areas and on 3 of 3 units. (The Main Kitchen, Rainbow, Reflections, and Memory Lane Units) Findings include: 1. During the Environmental tour with the Director of Maintenance on 1/24/23 at 3:34 p.m., the following was observed: Rainbow Unit a. The over bed light fixture in Room 12 for bed 1 had a burnt out light bulb. The bathroom faucet was leaking water around the knobs after being turned on. The wall behind the toilet was gouged and marred. The walls in the bathroom were marred. The corner wall by the closet was marred and a section of baseboard was missing. Two residents resided in the room and shared the bathroom. b. The faucet leaked in the bathroom of Room 13. One resident used this bathroom. c. The faucet leaked in the bathroom of Room 15. The wall by the bathroom closet was gouged and marred. The wall behind the toilet was gouged and the baseboard was peeling away from the wall. The baseboard was missing next to the closet door. Two residents resided in the room and share the bathroom. d. The baseboard next to the closet in the bathroom of Room 16 was loose and the bathroom sink was slow to drain. Two residents shared the bathroom.		**practice?** · Over bed light fixture in room #12 replaced, the leaking faucet was repaired. The wall behind the toilet in room #12 repaired. Walls in the bathroom repaired. Corner wall by the closet repaired and baseboard replaced. No ill effects related to alleged deficient practice · Faucet in room #13 repaired. No ill effects related to alleged deficient practice · Faucet in room #15 repaired. The wall by the bathroom closet repaired and baseboard repaired and replaced in the room. No ill effects related to alleged deficient practice · Baseboard replaced in room #16 and bathroom faucet repaired. No ill effects related to alleged deficient practice · Room #17 faucet repaired, and baseboard replaced. No ill effects related to alleged deficient practice · Room #19-bathroom door and bathroom/room walls repaired. Baseboard was also replaced, and bathroom tile replaced. Facet in the bathroom was repaired. No ill effects related to alleged deficient practice · Walls in room #214 repaired No ill effects related to alleged deficient practice · Bathroom walls and door in #220 repaired. No ill effects related to alleged deficient practice	

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	e. The sink in the bathroom of Room 17 was slow to drain. There were also sections of loose baseboard. Two residents shared the bathroom. f. The bathroom door as well as the bathroom walls in Room 19 were marred. One resident resided in the room. g. The walls and door in Room 22 were scratched and marred and the floors were dirty. Two residents resided in the room. Reflections Unit a. The bathroom door frame in Room 104 had areas of chipped paint and was marred. The bathroom door was also scuffed at the base on the inside of the door. The paint was warped underneath the bathroom sink. Two residents shared the bathroom. b. The wall next to bed 2 in Room 109 was scratched and marred. The wall behind the head of the bed was also marred. There was no pull cord for the call light in the bathroom. The baseboard in the left hand corner behind the toilet was pulling away from the wall. The wall behind the toilet was marred. The caulk around the bathroom sink was cracked in sections. Two residents resided in this room and shared the bathroom. c. The floor tile in Room 110 was discolored with a pinkish tint in some sections. The door to the room was scratched and marred. The bathroom faucet had an accumulation of lime build up and leaked when turned on. Areas of paint had been peeled off next to the bathroom call light. Two residents resided in this room and shared the bathroom.		· Floor mat next to bed 2 in room #223 cleaned and walls in room/bathroom repaired. No ill effects related to alleged deficient practice · Floor in the kitchen cleaned and sanitized. No ill effects related to alleged deficient practice · Handwashing sink in the kitchen cleaned and repaired No ill effects related to alleged deficient practice. · Soap dispenser in kitchen above handwashing sink cleaned. No ill effects related to alleged deficient practice · Bottom part of the wall by the hand washing sink repaired. No ill effects related 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. Facility audit completed to identify any other areas with environmental concerns. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All facility staff were educated on identifying environmental	

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	d. The door to Room 112 as well as the walls were scratched and marred. One resident resided in this room. e. A section of baseboard was missing from behind the door in Room 119. The wall was marred behind the resident's recliner and where an arm chair was located. The floor tile beneath the bathroom sink was dark and discolored. Standing water was observed in the bathroom sink on 1/19/23 at 11:20 a.m. One resident resided in this room. Memory Lane a. The wall behind the head of bed 2 as well as the side of the wall in Room 214 was marred. Two residents resided in the room. b. The bathroom walls and door frame in Room 220 were marred. There was lime build up on the bathroom sink faucet. One resident used the bathroom. c. The floor mat next to bed 2 in Room 223 was dirty. The walls in the room as well as in the bathroom were scuffed and marred. One resident resided in the room. Interview with the Director of Maintenance at the time, indicated all of the above were in need of cleaning and/or repair. 2. During the initial kitchen tour on 1/18/23 at 9:18 a.m. with Cook 1, the following was observed: a. The floor had a build up of dirt and debris. b. The hand washing sink was dirty and slow to drain.		concerns related to marred walls/doors, missing base boards, lime buildup, leaking faucets, discolored floor tile, slow draining sinks, sanitation and reporting it to the maintenance director through Building Engines for timely repairs as well as environmental services for timely housekeeping. ·Maintenance Director/designee will audit 5 resident rooms and the kitchen 5x weekly x 6 months to ensure that there's no repairs needed, or sanitation concerns identified. **Audits will include 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?** ·Maintenance Director/designee will complete audit tool to reflect proper repairs and sanitation occur weekly. ·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: 2/7/2023**	

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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
	c. The soap dispenser above the hand washing sink was dirty. d. The corner bottom part of the wall by the hand washing sink was cracked and gouged. 3. During the follow-up tour in the kitchen on 1/23/23 at 11:46 a.m. with the Dietary Manager, the following was still observed: a. The floor had a build up of dirt and debris. b. The hand washing sink was dirty and slow to drain. c. The soap dispenser above the hand washing sink was dirty. d. The corner bottom part of the wall by the hand washing sink was cracked and gouged. Interview with the Dietary Manager at that time, indicated the dietary staff was responsible for deep cleaning the kitchen and the above areas should have been cleaned or repaired. She had told maintenance that morning about the sink. She was unaware the sink was slow to drain until that morning. This Federal tag relates to Complaint IN00386371. 3.1-19(f)			