| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155062 | A. Building<br>B. Wing | 05/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Brickyard Healthcare - Laporte Care Center | 1700 I Street<br>LA Porte, IN 46350 |

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|---|---|
| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure there was an appropriate diagnosis for the use of an antipsychotic medication (Seroquel) for 1 of 6 residents reviewed for unnecessary medications. (Resident B)Finding includes:The closed record for Resident B was reviewed on 5/12/26 at 1:17 p.m. The resident was admitted to the facility on [DATE] and discharged home on 3/18/26. Diagnoses included, but were not limited to heart disease, respiratory failure, type 2 diabetes, asthma, hypertensive kidney disease, chronic kidney disease, high blood pressure, heart failure, anxiety disorder, pulmonary embolism, opioid dependence, and dependence on renal dialysis.The 3/2/26 Modification of the admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and received an antipsychotic medication on a routine basis.A Care Plan, dated 2/28/26, indicated the resident was on antipsychotic therapy related to anxiety disorder. A History and Physical from the hospital admission, dated 12/27/25 to 2/24/26, indicated the resident was initially started on the Seroquel medication while in the hospital. A medication list, dated 1/20/26, indicated Quetiapine 100 mg twice a day for agitation.A Physician's Order, dated 2/25/26, indicated Quetiapine Fumarate (Seroquel) 100 milligrams (mg) give one tablet by mouth two times a day related to anxiety disorder. A Physician's Order, dated 2/27/26, indicated psychiatry to evaluate.The 2/2026 and 3/2026 Medication Administration Records indicated the resident received the Seroquel as ordered from 2/25-3/18/26.A Pharmacy recommendation, dated 3/6/26, indicated please indicate FDA (Food and Drug Administration) approved diagnosis for Quetiapine 100 mg twice a day for anxiety disorder. The recommendation was signed by the Nurse Practitioner (NP) on 3/13/26 with the diagnoses of restlessness and agitation.During an interview on 5/14/26 at 11:04 a.m., the Regional Nurse Consultant indicated the resident refused psychiatry services.During an interview on 5/14/26 at 1:25 p.m., the Director of Nursing (DON) indicated the resident never saw the psychiatric NP and there was no approved diagnosis for the use of Seroquel.This citation relates to Intake 2982545.410 IAC (Indiana Administrative Code)16.2-3.1-48(b)(1) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, record review, and interview, the facility failed to ensure a dependent resident received incontinence care and was checked and/or changed at least every two hours for 1 of 3 residents reviewed for ADLs (Activities of Daily Living). (Resident 30)Finding includes:During an interview on 5/12/26 at 9:30 a.m., Resident 30 indicated she had not been changed since 12:30 a.m. At that time, she consented for staff to check and/or change her. During an observation on 5/12/26 at 9:44 a.m., CNA 2 and CNA 3 entered the resident's room to provide incontinence care. CNA 2 indicated she had not checked or changed the resident since her shift started at 6:30 a.m. The CNA removed the bed linens and the resident was observed lying on a bed sheet and an incontinence pad and was wearing an incontinence brief. There was a large dried dark brown urine ring all the way around the incontinence pad. The bed sheets were wet all the way up the resident's back and the incontinence brief was saturated with urine. During an interview at that time, CNA 2 indicated they have a problem on the midnight shift with a CNA who did not want to change the resident. The record for Resident 30 was reviewed on 5/13/26 at 4:02 p.m. Diagnoses included but were not limited to, left leg below the knee amputation, COPD, obesity, opioid dependence, bipolar disorder, anxiety disorder, high blood pressure, and chronic pain. The 4/23/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was dependent on staff for toileting. The resident was frequently incontinent of bladder. The urinary incontinence documentation in the CNA task section of the EMR (electronic medical record) indicated incontinence care was only only documented twice a day on 4/19, 4/26, 5/4, 5/8, 5/9, and 5/11/26. During an interview 5/12/26 at 11:15 a.m., the Director of Nursing (DON) indicated there was a grievance filed for the resident's complaint regarding a CNA on the midnight shift for not changing her, however, the incident on 5/12/26 involved a different CNA . During an interview on 5/14/26 at 9:30 a.m., the DON indicated the resident was to be checked and/or changed at least every two hours. 410 IAC (Indiana Administrative Code)16.2-3.1-38(a)(2)(C) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident with constipation was treated for 1 of 1 resident reviewed for constipation and bruises and skin lesions were assessed and monitored for 3 of 4 residents reviewed for non-pressure skin conditions. (Residents 30, 68 and 65)Findings include:1. During an interview on 5/12/26 at 9:30 a.m., Resident 30 indicated she was constipated all the time.<br><br>During an observation on 5/12/26 at 9:44 a.m., CNA 2 and CNA 3 entered the resident's room to provide incontinence care. They removed the bed linens and rolled the resident onto her right side. The incontinent pad and bed sheets were wet with urine all the way up the resident's back. The incontinence brief was removed and saturated with urine. At that time, there was white bandage located on her upper left hip area. CNA 2 indicated the bandage was not covering the open area as it had moved and was wet with urine. The open area, which was located below the sacrum in the buttock crease, was exposed and not covered. The area was red with a small amount of drainage.<br><br>The record for Resident 30 was reviewed on 5/13/26 at 4:02 p.m. Diagnoses included but were not limited to, left leg below the knee amputation, COPD, obesity, opioid dependence, bipolar disorder, anxiety disorder, high blood pressure, and chronic pain.<br><br>The 4/23/26 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and was dependent on staff for toileting. The resident was frequently incontinent of bowel and bladder and received received an opioid medication.<br><br>A Care Plan, revised on 2/3/26, indicated the resident had the potential for constipation related to pain. The goal was for the resident to have a normal bowel movement at least every three days. The approaches were to follow the facility bowel protocol for bowel management.<br><br>The Bowel Movement documentation in the CNA task section indicated the resident had no bowel movement from 4/1-4/7/26, 4/10-4/13/26, 4/15-4/20/26, 4/22-4/29/26, and 5/5-5/9/26.<br><br>Skilled Evaluation Notes, dated 4/22-4/29, 5/1-5/3, and 5/5-5/9, indicated the the resident's abdomen was nondistended and had no complaints of constipation.<br><br>There was no documentation in nursing progress notes that nursing staff were aware the resident had not had a bowel movement at least one time every three days. There was no documentation indicating the resident's normal bowel pattern was longer than three days.<br><br>A Physician's Order, dated 1/15/26, indicated Docusate Sodium (a stool softener) 100 milligrams (mg) one capsule two times a day.<br><br>A Physician's Order, dated 1/17/26, indicated Magnesium Hydroxide (a laxative), 15 milliliters (ml) by mouth one time every other day.<br><br>A Physician's Order, dated 4/2/26, indicated Glycolax Powder (a laxative) give 17 grams by mouth one time a day for constipation.<br><br>A Physician's Order, dated 4/14/26, indicated Buprenorphine HCl Sublingual (a narcotic and opioid<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medication use to treat opioid use disorder (OUD) and manage severe, persistent pain) tablet 8 mg, give 1 tablet sublingually every 8 hours as needed for pain rated 6-10.<br><br>There were no as needed orders for constipation.<br><br>The Medication Administration Record for 4/2026 and 5/2026 indicated all three of the above laxatives were signed out every day as being administered to the resident.<br><br>A Physician's Order, dated 4/7/26, indicated cleanse gluteal cleft with wound cleanser, pat dry, apply betadine and cover with a bordered gauze daily and prn (as needed)<br><br>The Nurse Practitioner (NP) Wound Assessment, dated 5/12/26, indicated a full thickness abscess to the gluteal cleft that measured 1 centimeter (cm) in length by 0.20 cm in width. The wound had 100% of epithelial (the regeneration top layer of skin) tissue with moderate drainage.<br><br>During an interview on 5/14/26 at 9:30 a.m., the Director of Nursing (DON) indicated the bandage should have been covering the open area.<br><br>During an interview on 5/14/26 at 1:25 p.m., the DON indicated it looked like the resident's pattern for a bowel movement was 1 time every five to six days. She had no additional information to provide.<br><br>During an interview on 5/14/26 at 2:50 p.m., the Regional Nurse Consultant indicated the computer program did not prepopulate oe flag when the resident had gone longer than three days without a bowel movement. There was no policy for constipation, they would follow whatever bowel management the resident's physician ordered.<br><br>2. During random observations on 5/12/26 at 9:19 a.m., and at 3:00 p.m., Resident 68 was observed with dark red and purple areas to the left forearm. During an interview at that time, the resident indicated she would get bruises on her arms because she was constantly bumping her arms on the wheelchair and she needed a bigger wheelchair.<br><br>The record for Resident 68 was reviewed on 5/12/26 at 3:05 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, chronic kidney disease, rectal cancer, atrial fibrillation, high blood pressure, end state renal disease, and dependence on renal dialysis.<br><br>The admission Minimum Data Set (MDS) assessment, dated 5/8/26, indicated the resident was cognitively intact for daily decision making.<br><br>There was no care plan for bruising.<br><br>A Weekly Skin Check, dated 5/2/26 and 5/5/26, indicated the resident had swelling to the left inner forearm due to fistula placement.<br><br>There was no documentation the resident had any bruises to her arms.<br><br>The Clinical admission Assessment, dated 5/2/26, indicated there was no documentation regarding any bruising to her arms<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/14/26 at 1:25 p.m., the Director of Nursing was unaware the resident had any bruising. She indicated an incident report would be completed and the bruises would be monitored and assessed. Staff had also changed her out her wheelchair to a bigger one in hopes of preventing the resident from bumping her arms.<br><br>3. During a random observation on 5/11/26 at 11:22 a.m., Resident 65 had two round skin lesions on his left knee. At that time, the resident indicated the lesions resulted from scraping his knee on underside of the overbed table. The larger, nickel-sized lesion occurred about one week earlier, and the smaller, dime-sized lesion, about two weeks earlier.<br><br>The record for Resident 65 was reviewed on 5/13/26 at 1:59 p.m. Diagnoses included, but were not limited to, diabetes, respiratory failure, and hemiplegia (paralysis of one side of the body) following a stroke, affecting the left side.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 3/25/26, indicated the resident was cognitively intact for daily decision making.<br><br>The record lacked any documentation or prior assessment of the skin lesions.<br><br>During an interview at the resident's bedside on 5/13/26 at 3:47 p.m., RN 1 indicated she knew about one of the lesions from a while ago, but had not seen the other one before. At that time, the resident again indicated the larger lesion occurred from hitting his knee under the tray table about a week ago.<br><br>During an interview on 5/14/26 at 9:19 a.m., the Regional Nurse Consultant indicated they were aware the resident had lesions to his knee in the past, and they would have the wound nurse look at it again.<br><br>410 IAC (Indiana Administrative Code)16.2- 3.1-37(a) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, record review and interview, the facility failed to ensure a resident was using a smoking apron while smoking as care planned for 1 of 1 resident reviewed for smoking. (Resident 50)Finding includes: On 5/11/26 at 1:06 p.m., Resident 50 was observed outside in the smoking area. There were several other residents, the Activity Director and two other staff members present. The resident was not wearing a smoking apron. The Activity Director indicated the resident did not need a smoking apron. On 5/11/26 at 2:49 p.m., the resident was observed in his room seated in his chair. His wheelchair was in front of him and there were two burn holes in the cushion. The resident's record was reviewed on 5/13/26 at 10:15 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The Quarterly Minimum Data Set assessment, dated 3/16/26, indicated the resident was cognitively intact.A Smoking and Safety assessment, dated 5/6/26, indicated the resident was lethargic and falls asleep easily during tasks or activities. He also had burned clothing, skin, furniture or other. The recommendation was to use a smoking apron and staff to light and extinguish smoking material. The Tobacco Use Care Plan, dated 5/7/26, indicated to utilize a smoking apron. During an interview on 5/11/26 at 1:25 p.m., the Regional Nurse Consultant indicated she had been made aware the resident was not using a smoking apron. They were in the process of updating the list of residents who required a smoking apron and educating the staff. 410 IAC (Indiana Administrative Code)16.2-3.1-45(a) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, record review, and interview, the facility failed to ensure oxygen was on at the correct flow rate for 3 of 3 residents reviewed for oxygen. (Residents 5, 30, and 17)Findings include:1. During random observations on 5/11/26 at 12:06 p.m. and 2:25 p.m., on 5/12/26 at 9:43 a.m. and 2:59 p.m., and on 5/13/26 at 9:25 a.m., Resident 5 was observed in bed with a tracheostomy and was receiving oxygen by the way of a mask over the trach. He was connected to the oxygen concentrator in the room and the rate was set at four liters per minute. During an interview on 5/13/26 at 9:35 a.m., LPN 1 indicated the Respiratory Therapist (RT) told her it did not matter what the oxygen rate was set at as long as the humidity was at least at 28%. The record for Resident 5 was reviewed on 5/13/26 at 11:18 a.m. Diagnoses included, but were not limited to, traumatic subdural hemorrhage, traumatic brain injury, compression of the brain, tracheostomy, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 4/8/26, indicated the resident was rarely understood/rarely understands, had a tracheostomy, and received oxygen while a resident. A Physician's Order, dated 4/1/26, indicated oxygen at two liters per minute with 28% humidification via trach mask while laying in bed. A Care Plan, revised on 4/28/26, indicated the resident had a tracheostomy and was dependent on oxygen. The approaches were to provide oxygen per physician orders. A Care Plan, revised on 4/28/26, indicated the resident had an altered respiratory status/difficulty breathing. The approaches were to provide oxygen at two liters per minute and 28% humidification via trach mask. During an interview on 5/13/26 at 11:00 a.m., the Regional Nurse Consultant indicated they were going to have the Nurse Practitioner look at the oxygen settings. She had no further information to provide. 2. During random observations on 5/11/26 at 10:01 a.m., on 5/12/26 at 9:30 a.m. and at 1:00 p.m., and on 5/13/26 at 3:00 p.m., Resident 30 was observed in bed and wearing oxygen via nasal cannula at 2.5 liters per minute. The record for Resident 30 was reviewed on 5/13/26 at 4:02 p.m. Diagnoses included but were not limited to, COPD, obesity, bipolar disorder, anxiety disorder, high blood pressure, and chronic pain. The 4/23/26 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and received oxygen while a resident.A Physician's Order, dated 2/3/26, indicated continuous oxygen at two liters per minute at bedtime and prn (as needed) shortness of breath. During an interview on 5/13/26 at 11:00 a.m., the Regional Nurse Consultant indicated the oxygen was to be set as ordered by the physician. During an interview on 5/14/26 at 9:30 a.m., the Director of Nursing had no additional information to provide. 3. During random observations on 5/11/26 at 12:06 p.m. and 2:25 p.m., and on 5/12/26 at 9:43 a.m., Resident 17 was observed in bed and wearing oxygen per nasal cannula at 4.5 liters per minute. The record for Resident 17 was reviewed on 5/13/26 at 2:45 p.m. Diagnoses included but were not limited to, COPD, heart failure, heart disease, anxiety, and vascular dementia. A Care Plan, revised on 10/24/25, indicated the resident had an altered respiratory status/difficulty breathing. The approaches were to provide oxygen at four liters per physician orders. A Physician's Order, dated 2/2/26, indicated continuous oxygen at four liters per minute. The 2/20/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making, and received hospice and oxygen while a resident. During an interview on 5/13/26 at 9:35 a.m., LPN 1 indicated the resident's oxygen was to be set at four liters per minute. During an interview on 5/13/26 at 11:00 a.m., the Regional Nurse Consultant indicated she changed the oxygen from 4.5 to four liters on Tuesday 5/12/26. 410 IAC (Indiana Administrative Code)16.2-3.1-47(a)(6) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's fluid restriction was accurately documented for 1 of 1 resident reviewed for dialysis. (Resident 68)Finding includes:During an interview on 5/12/26 at 9:21 a.m., Resident 68 indicated she was not on a fluid restriction and could drink whatever she wanted. She liked apple juice and received it for all three meals. She usually drank about 1.5 of the large white styrofoam cups of water every day. The record for Resident 68 was reviewed on 5/12/26 at 3:05 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, chronic kidney disease, end state renal disease, and dependence on renal dialysis. The admission Minimum Data Set (MDS) assessment, dated 5/8/26, indicated the resident was cognitively intact for daily decision making and received dialysis while a resident.Nurse's Notes, dated 5/6/26 at 4:31 p.m., indicated the residenr received new orders from the dialysis physician to start LiquaCel 1 ounce twice a day or an equivalent protein supplement and implement a 1200 milliliters (ml) fluid restriction. Physician's Orders, dated 5/6/26, indicated 1200 ml fluid restriction every shift and Nepro with Carb Steady three times a day for nutritional support, 237 ml. Dialysis treatment on Monday, Wednesday, and Friday at the dialysis center. ProT Gold supplement two times a day. A Care Plan, dated 5/7/26, indicated the resident had the potential for fluid volume overload related to kidney failure. The goal was for the resident to comply with diet and/or fluid restrictions daily. The approaches were to restrict and give fluids per physician's order.The Medication Administration Record (MAR) for 5/2026 indicated there was no amount consumed documented for the ProT Gold protein supplement, nor was there a specific amount ordered for the resident. The 5/2026 MAR indicated the fluid restriction was documented every shift, however on most shifts the amount of 240 cubic centimeters (cc) was documented. The amount was not reflective of the intake of the Nepro, ProT Gold supplement, what the resident drank during meals and/or the water intake from the styrofoam cup at the bedside. During an interview on 5/14/26 at 1:25 p.m., the Director of Nursing indicated she was unaware the resident was receiving the Nepro supplement three times a day, she thought it was only one time. She indicated with the amounts documented, nursing staff were not taking in consideration of what dietary served her and the Nepro supplement. There was no documentation of the amount of the ProT Gold supplement to be administered or the amount consumed. 410 IAC (Indiana Administrative Code)16.2-3.1-37(a) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on record review and interview, the facility failed to ensure an opioid medication was administered and had an indication for use for 1 of 1 resident reviewed for hospice. The facility also failed to ensure a heart rate was monitored prior to the administration of blood pressure medication for 1 of 4 residents reviewed for non-pressure skin conditions. (Residents 17 and 65)Findings include:<br><br>1. The record for Resident 17 was reviewed on 5/13/26 at 2:45 p.m. Diagnoses included but were not limited to, COPD, heart failure, heart disease, anxiety, and vascular dementia.<br><br>The 2/20/26 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making and received hospice while a resident.<br><br>A Physician's Order, dated 1/28/26, indicated Morphine Sulfate Oral Solution 20 milligrams (mg)/5 milliliters (ml), give 0.25 ml by mouth every 1 hour as needed for pain rated 5-10 or shortness of breath.<br><br>The 1/2026, 3/3026, and 4/2026 Medication Administration Records (MAR) indicated the Morphine was administered to the resident when his pain rating was a 0 on the following days and times:<br><br>1/15 at 3:19 p.m., 1/25 at 4:01 p.m., 3/17 at 3:54 p.m., 3/21 at 9:40 p.m., 4/19 at 8:00 p.m.,and 4/21/26 at 3:20 a.m.<br><br>During an interview on 5/14/26 at 1:25 p.m., the Director of Nursing indicated there was a different pain scale for residents who could not communicate their level of pain. She had no additional information to provide.<br><br>2. The record for Resident 65 was reviewed on 5/13/26 at 1:59 p.m. Diagnoses included, but were not limited to, diabetes and hypertension.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 3/25/26, indicated the resident was cognitively intact for daily decision making.<br><br>A Physician's Order, dated 5/1/25, indicated Metoprolol Tartrate (a blood pressure medication) two times a day, hold for pulse rate less than 60.<br><br>The resident received the medication without a documented pulse rate on each day from 4/1/26 through 5/12/26.<br><br>During an interview on 5/14/26 at 9:46 AM, the Regional Nurse Consultant indicated the pulse should be documented with each dose of the medication administered, and should have been added to the MAR (medication administration record).<br><br>410 IAC (Indiana Administrative Code)16.2-3.1-48(a)(3)<br><br>410 IAC (Indiana Administrative Code)16.2-3.1-48(a)(4) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155062 | A. Building<br>B. Wing | 05/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brickyard Healthcare - Laporte Care Center | 1700 I Street<br>LA Porte, IN 46350 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to staff failing to perform hand hygiene after glove removal during a pressure ulcer treatment for 1 of 2 pressure ulcer treatments observed. (Resident 1)Finding includes: During a pressure ulcer treatment observation on 5/15/26 at 8:00 a.m., the Unit Manger gathered supplies for Resident 1's pressure ulcer treatment. She performed hand hygiene, donned the appropriate personal protective equipment and placed the supplies on a clean towel on the over bed table. She had clean gloves to both hands and removed the resident's sock and old bandage. With the same gloves, she cleaned the pressure ulcer with wound cleaner and patted it dry. She removed her gloves and donned a clean pair of gloves to both hands. She did not perform hand hygiene after glove removal. She opened the package of collagen particles and with her gloved hands placed the particles on the open area. She then opened a tube of zinc oxide and squeezed an amount onto her gloved finger and placed the ointment all over the wound including the surrounding skin. She removed her gloves and donned a clean pair of gloves to both hands without performing hand hygiene. She opened a bordered gauze bandage, placed it on top of the ulcer, removed her gloves and washed her hands with soap and water. During an interview on 5/15/26 at 8:13 a.m., the Unit Manager indicated she was aware she should have performed hand hygiene after glove removal. During an interview on 5/15/26 at 8:30 a.m., the Regional Nurse Consultant indicated the nurse should have performed hand hygiene after glove removal. The current 2025 Clean Dressing Change policy, provided by the Director of Nursing on 5/15/26 at 8:52 a.m., indicated loosen the tape and remove the existing dressing. If needed to minimize skin stripping or pain, moisten with prescribed cleansing solution or use adhesive remover to remove tape. Remove gloves, pulling inside out over the dressing and discard into appropriate receptacle. Wash hands and put on clean gloves. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound, pat dry with gauze, and wash hands and put on clean gloves.410 IAC (Indiana Administrative Code) 16.2-3.1-18(b) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155062 | A. Building<br>B. Wing | 05/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brickyard Healthcare - Laporte Care Center | 1700 I Street<br>LA Porte, IN 46350 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure all essential equipment was in safe operating condition for 1 of 1 kitchen. (Main Kitchen)Finding includes:During a tour of the Main Kitchen on 5/11/26 at 9:22 a.m., a large buildup of ice was observed in the walk-in freezer. There was ice on the fans, shelves, floor, and door frame. The food on the shelves had a thick layer of frost on it. At that time, the Kitchen Manager indicated the freezer had been building up with ice for a long time, and once a week, she would go in and try to scrape out all of the ice. She believed they were waiting to get a new freezer next year. During an interview on 5/12/26 at 1:58 p.m., the Maintenance Director indicated the freezer had been building up with ice for a long time. It had been looked at, but could not be repaired. It would probably be replaced next year. During an interview on 5/12/26 at 3:30 p.m., the Regional Nurse Consultant indicated she was aware of issues with freezer for months. They had been trying to figure it into the budget to replace it. On 5/13/26 at 3:10 p.m., the Regional Head of Maintenance provided a service call report, dated 5/13/26, from a repair company. The report indicated, . Inspected the walk in freezer condenser located near the northeast [NAME] of the facility . noted the customer manually defrosted the box due to ice buildup on the ceiling . Identified the box is in poor condition with saturated and taped insulation. Observed moisture dropping from the suction elbow. Recommended reinsulating the refrigeration piping and exposed line outside. Determined a new closer is needed for the walk in freezer condenser . Will order the closer and insulation and schedule a follow up when parts arrive.A policy titled, Food Safety Requirements, received from the Director of Nursing (DON) as current on 5/14/26 at 1:55 p.m., indicated, . Food safely practices should be followed throughout the facility's entire food handling process . Elements of the process include the following: . Equipment used in the handling of food .A policy titled, Maintenance Inspection, received from the DON as current on 5/15/26 at 10:37 a.m. indicated, . It is the policy of this facility . to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public . The Administrator, or designee, will perform random inspections of the physical plant using the checklist . All opportunities will be corrected immediately by maintenance personnel .410 IAC (Indiana Administrative Code)16.2-3.1-19(bb) |