STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Terrace Care Center	1900 Andrew Ave 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48383 Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for a dependent resident related to incontinence care and providing assistance in getting out of bed in a timely manner for 1 of 3 residents reviewed for ADLs. (Resident D) Finding includes: On 5/19/25 at 8:50 a.m., Resident D was observed lying in her bed with her breakfast covered and sitting on her bedside table. The resident indicated she had not been able to eat breakfast yet because she was told wound care was supposed to come see her next and that was 40 minutes ago. She liked to get up and out of bed to eat and they told her they would get her up after her wound treatment. The resident also indicated a nurse's aide had put her diaper on wrong during the night and that's why I peed the bed all night long, so now I'm stuck sitting in this puddle. The resident lifted the blanket to the side and lifted her body up to reveal a large wet spot in the middle of her bed that covered the middle half of the bed. The resident's brief was dry and had been changed that morning. On 5/19/25 at 8:59 a.m., CNA 1 was observed asking a nurse if the resident could get up and eat. She wanted to get out of bed to eat but was waiting on wound care. The nurse indicated the resident could be up. CNA 1 did not re-enter resident D's room, she gowned up and went into another resident's room to provide care. During an interview on 5/19/25 at 9:04 a.m., CNA 1 indicated she knew the resident's bed was soiled and she had changed the resident's brief, but did not change the bed because the resident wanted to get out of bed to eat and she was going to be seen by wound care. She was going to change her bed at that time. Resident D's record was reviewed on 5/20/25 at 9:31 a.m. The diagnoses included, but were not limited to, kidney failure, ileostomy status, weakness, and history of falling. A Care Plan, dated 4/18/25, indicated the resident had an ADL self-care performance deficit related to weakness and difficulty in walking. Interventions were to provide AM preferred routine of dressing and grooming before breakfast and assist with toilet and transfer. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Minimum Data Set (MDS) assessment, dated 4/24/25, indicated the resident was cognitively intact for daily decision making. Eating and oral hygiene required set up and clean up assistance. The resident required substantial/maximum assistance for toileting and shower/bathing. The resident required dependent care with lower body dressing and the resident was frequently incontinent. During an interview on 5/19/25 at 9:14 a.m., the Administrator indicated she understood the concern and would re-educate CNA 1 immediately. This citation relates to Complaint IN00456969. 3.1-38(a)(2)(B) 3.1-38(a)(2)(C)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48383 Based on observation, record review, and interview, the facility failed to administer medications as ordered related to antibiotic therapy for 3 of 3 residents reviewed for Intravenous Therapy and failed to ensure wound treatments were completed and signed out as ordered for 1 of 3 residents reviewed for non-pressure related skin conditions. (Residents C, F and G) Findings include: 1. Resident C's record was reviewed on 5/19/25 at 9:38 a.m. The diagnoses included, but were not limited to, local infection of the skin and subcutaneous tissue unspecified, depression, hypertension (high blood pressure), kidney failure, asthma, and pain in unspecified hip. The Admission Minimum Data Set (MDS) assessment, dated 4/24/25, indicated Resident C was cognitively intact for daily decision making. Eating, oral hygiene, personal hygiene, and upper body dressing required set up or clean up assistance. Toileting required supervision or touching assistance. Shower and bathing required partial/moderate assistance, and lower body dressing and putting on footwear required substantial/maximum assistance. The resident had a surgical wound that was present on admission. A Nurse Note, dated 4/16/25 at 11:00 p.m., indicated communication was received regarding a new admission. Medication orders had been reviewed and verified and compared to discharge medication reconciliation. Antibiotic required an end date and rounding was notified. A Hospital Patient Summary Report, dated 4/1/25, indicated the resident had a recent history of a prosthetic antibiotic spacer implantation that became infected. The Hospital Discharge Report, dated 4/17/25, indicated 1 of 2 doses of Cefazolin was received. The last dose was administered on 4/17/25 at 3:15 p.m. and the next dose was due at bedtime. The Hospital Discharge Summary, dated 4/17/25, indicated the resident required 6 weeks of antibiotic therapy. A Care Plan, dated 4/17/25, indicated the resident had a surgical incision to the left hip. Interventions were to keep the incision site clean and dry, assess skin condition weekly, and to monitor for signs and symptoms of infection. A Nurses Note, dated 4/17/25 at 8 :35 p.m., indicated the resident arrived via private transportation service, the resident had pain to his left hip where there was a surgical incision on the left hip with a clean and dry dressing intact. The resident was on antibiotics and had a patent PICC line. A Physician's Order, dated 4/18/25 indicated to administer Cefazolin (antibiotic) 2 grams (GM) intravenously (IV) every 8 hours for infection of the left hip. A Medication Administration Note, dated 4/18/25 at 5:53 a.m., indicated Cefazolin intravenous solution 2 gm was not given due to waiting on delivery from pharmacy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The April 2025 Medication Administration Record (MAR) indicated Cefazolin was documented as view progress notes on 4/17/25 and was not signed out, on 4/18/25 the medication was marked as discontinued. The resident did not receive the 4/17/25 Cefazolin dose. There was no follow up documented with the surgeon or infectious disease physician to verify an antibiotic end date or course of treatment. An Advance Care Planning Note, dated 4/20/25 at 11:00 p.m., indicated the resident was at the facility for rehabilitation for a post infection of his prosthetic limb (sic) and was post antibiotics. A Physician's Order, dated 4/21/25 indicated to apply betadine swab sticks to left hip every day shift and cover with an island bordered gauze dressing. The April 2025 Treatment Administration Record (TAR) indicated the wound treatment for the left hip was not signed out on 4/25/25, 4/28/25, and 4/29/25. A Physician's Order, dated 4/29/25 indicated to discontinue PICC (Peripherally Inserted Central Catheter) line. During an interview on 5/19/25 at 10:00 a.m., the Director of Nursing (DON) indicated Resident C's discharge instructions indicated he had received 1 of 2 doses of Cefazolin. She indicated the Nurse Practitioner (NP) came in and discontinued the order and indicated the antibiotic was completed. She was not here on that day but when she returned, she questioned the order. The NP notes indicated they were completed, and they were following physician's orders. No other clarification was completed. During an interview on 5/19/25 at 11:14 a.m., the DON indicated the NP who discontinued the antibiotic was no longer with the facility. During a phone interview on 5/19/25 at 11:37 a.m., the NP indicated indicated she reviewed the record and the discharge instructions had indicated the antibiotic would be completed on 4/17/25. She indicated, as far as I knew he completed the antibiotic before I got there on the 18th. The infectious disease nurse had told her the resident was finished with antibiotics as well. She usually talked with the nursing staff to verify any medications because she did not have an active MAR available on her screen. During a phone interview on 5/19/25 at 1:51 p.m., Resident C's orthopedic surgeon indicated Resident C had been readmitted to the hospital for a small collection of fluid at the infection site (left hip) and for worsening back pain. The resident was failing treatment due to the lack of antibiotics. The resident had a known infected total hip and he had completed two surgeries on the resident. The resident had a big abscess and osteomyelitis of the spine. The resident should have been treated with at least 4-6 weeks of antibiotic treatment outpatient; one dose of the medication would not even make sense. There was no follow up with my office. He indicated this was not the resident's first hip surgery and the resident knew he needed antibiotics, and he indicated that he asked the staff frequently why he wasn't receiving any. He indicated he looked over the discharge paperwork in the system and the instructions for continued antibiotics were correct at that time. The resident had capacity, and this should have been followed up with regardless if there was a communication deficit in the paperwork. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/19/25 at 4:10 p.m., the Infection Prevention (IP) nurse indicated there were no active signs of infection and the resident had never mentioned he should have been on antibiotics, the resident was very talkative, and he had been at the facility before, he was comfortable here. The paperwork indicated the Cefazolin antibiotic stop date was 4/17/25. She did not recall a conversation with the NP regarding this resident. There was no warmth or redness at the site. During an interview on 5/20/25 at 12:01 p.m., the DON and the Administrator indicated they understood the concerns about the wound treatment and medication not being given as ordered and had no additional information to provide. 2. Resident F's record was reviewed on 5/20/25 at 10:48 a.m. The diagnoses included, but were not limited to, chronic non-pressure ulcer of the left foot, major depression, insomnia, osteomyelitis (infection of bone and muscle) and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 4/29/25, indicated the resident was cognitively intact for daily decision making and the resident received IV therapy. A Care Plan, dated 4/23/25, indicated the resident had an infection related to a wound. Interventions were to administer antibiotics and treatment as ordered. A Physician's Order dated 4/23/25 indicated to administer Cefazolin (antibiotic) 2 grams (GM) intravenously (IV) every 8 hours for wound infection until 5/5/25. The April 2025 Medication Administration Record (MAR) indicated Cefazolin was not signed out on the following dates: 4/24/25 at 10:00 p.m. 4/25/25 at 2:00 p.m. 4/28/25 at 10:00 p.m. 4/30/25 at 6:00 a.m. During an interview on 5/20/25 at 1:15 p.m., the DON indicated she could not find any documentation indicating why the Cefazolin antibiotics were not given. 3. Resident G's record was reviewed on 5/20/25 at 12:11 p.m. The diagnoses included, but were not limited to, osteomyelitis (bone and muscle infection), stroke, heart disease, and hypertension (high blood pressure). A Care Plan, dated 5/13/25, indicated the resident had an infection. Interventions were to administer antibiotics per physician orders, monitor temperature, and maintain universal precautions when providing care. A Baseline Care Plan, dated 5/15/25, indicated the resident was cognitively intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 5/14/25, indicated to administer Ampicillin-Sulbactam (antibiotic) 3 grams (GM) intravenously (IV) every 8 hours for osteomyelitis to the left foot until 6/18/25. The May 2025 Medication Administration Record (MAR) indicated Ampicillin-Sulbactam was not signed out on the following dates: 5/15/25 at 6:00 a.m. and 10:00 p.m. 5/16/25 at 6:00 a.m. 5/18/25 at 10:00 p.m. During an interview on 5/20/25 at 2:00 p.m., the DON indicated she could not find any documentation indicating why the Ampicillin antibiotics were not given. This citation relates to Complaint IN00458815. 3.1-37(a)