

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Valparaiso Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 251 Sturdy Rd Valparaiso, IN 46383	

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)
<p>F 0572</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents a notice of rights, rules, services and charges.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788</p> <p>Based on record review and interview, the facility failed to ensure a resident was informed of resident rights and facility rules upon admission for 1 of 1 resident reviewed for resident rights. (Resident 225)</p> <p>Finding includes:</p> <p>During an interview on 9/30/24 at 10:34 a.m., Resident 225 indicated she was admitted to the facility on [DATE] and had not received any orientation yet. No one had gone over resident rights with her, and she was not aware of any of the rules of the facility.</p> <p>The record for Resident 225 was reviewed on 10/1/24 at 2:59 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, bipolar disorder, and hypertension. The resident was admitted to the facility on [DATE] and was listed as her own responsible party.</p> <p>A Consent to Treatment Form, dated 9/10/24, had been signed by the resident. There was a lack of any documentation that resident rights or the rules of the facility had been discussed with the resident.</p> <p>During an interview on 10/2/24 at 11:39 a.m., the Administrator indicated staff had just gone over the admission paperwork with the resident today, including resident rights. The Admissions Director was on unexpected leave and the staff covering were still trying to catch up.</p> <p>3.1-4(a)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>45666</p> <p>Based on observation, record review, and interview, the facility failed to notify the physician timely related to ongoing respiratory symptoms and the inability to obtain a sample for ordered laboratory testing for 1 of 1 resident reviewed for respiratory care. (Resident 16)</p> <p>Finding includes:</p> <p>Resident 16 was observed on 10/1/24 at 11:30 a.m. in one of the activity/dining room areas in the Memory Care Unit in a wheelchair at a table with other residents. She was actively coughing.</p> <p>Resident 16's record was reviewed on 10/3/24 at 10:43 a.m. Diagnoses included, but were not limited to chronic obstructive pulmonary disease, vascular dementia with behavioral disturbance, and psychotic disorder with hallucinations.</p> <p>The Quarterly Minimum Data Set assessment, dated 7/18/24, indicated the resident was severely cognitively impaired for daily decision making.</p> <p>A Nurses' Note, dated 9/8/2024 at 3:48 p.m., indicated the resident had a productive cough with some phlegm. The resident was negative for Covid-19 infection and the Physician was notified.</p> <p>A Nurses' Note, dated 9/9/2024 at 7:18 a.m., indicated the Physician ordered a chest x-ray for cough and congestion with diminished lung sounds on lower lobes.</p> <p>A Nurses' Note, dated 9/11/2024 at 9:01 a.m., indicated the resident continued with occasional cough.</p> <p>A Nurses' Note, dated 9/24/2024 at 10:57 p.m., indicated the resident continued with non-productive cough with nasal drainage.</p> <p>A Nurses' Note, dated 9/25/2024 at 11:56 p.m., indicated new orders were received for a urinalysis with culture and sensitivity (UA with C&S) to follow.</p> <p>A Physician's Order, dated 9/25/24, indicated obtain a urinalysis with culture and sensitivity to follow.</p> <p>A Nurses' Note, dated 9/26/2024 at 12:32 a.m., indicated an attempt was made to obtain the UA and C&S per straight catheter, but was unsuccessful as the resident was incontinent of urine. The resident continued to have non-productive cough.</p> <p>A Nurses' Note, dated 9/26/2024 at 2:39 p.m., indicated an attempt was made to obtain a UA and C&S per straight catheter, but was unsuccessful. The resident continued with a non-productive cough with no nasal drainage.</p> <p>There was no documentation available regarding a UA with C&S on 9/27/24.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Nurses' Note, dated 9/28/2024 at 2:20 p.m., indicated the resident continued to have an occasional non-productive cough and staff was unable to get a urine sample from the resident.</p> <p>There was no documentation available regarding a UA with C&S on 9/29/24.</p> <p>A Nurses' Note, dated 9/30/2024 at 2:08 a.m., indicated unable to collect urine specimen at this time related to incontinence.</p> <p>A Nurses' Note, dated 9/30/2024 at 5:37 a.m., indicated the resident had drainage noted to bilateral eyes and the Physician was notified.</p> <p>A Nurses' Note, dated 9/30/2024 at 5:56 a.m., indicated staff was unable to collect a urine specimen at the time related to incontinence.</p> <p>A Nurses' Note, dated 9/30/2024 at 5:25 p.m., indicated staff was unable to collect a urine specimen at the time related to incontinence.</p> <p>A Nurses' Note, dated 10/1/24 at 11:22 p.m., indicated the resident continued with cough and mild nasal drainage. The resident became combative and staff were unable to collect a urine sample.</p> <p>There was no documentation the physician was notified of the continued respiratory symptoms from 9/9/24 when the x-ray was ordered until 9/25/24 when the UA with C&S was ordered. There was no documentation the physician was notified of the inability to obtain a urine sample to send for the UA with C&S from 9/25/24 until 10/2/24, when the order was discontinued.</p> <p>During an interview on 10/4/24 at 8:55 a.m., the Director of Nursing indicated the staff were supposed to get the UA with C&S per the Physician's Order, but were unable to obtain the sample due to incontinence. The order was discontinued on 10/2/24 when the physician was notified it had not been obtained.</p> <p>3.1-5(a)(3)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>32582</p> <p>Based on observation, record review and interview, the facility failed to ensure residents received medications as ordered related to following blood pressure parameters prior to administration for 1 of 5 residents reviewed for unnecessary medications (Resident 59) and 1 of 2 residents reviewed for pain. (Resident 177) The facility also failed to assess and monitor a skin discoloration for 1 of 3 residents reviewed for non-pressure skin conditions. (Resident 71)</p> <p>Findings include:</p> <p>1. The record for Resident 59 was reviewed on 10/2/24 at 9:12 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, and diabetes mellitus.</p> <p>The Annual Minimum Data Set assessment, dated 8/7/24, indicated the resident was cognitively intact and received hemodialysis.</p> <p>A Physician's Order, dated 5/17/24, indicated to give midodrine (a medication used to treat low blood pressure) 5 milligrams (mg) three times a day for hypotension (low blood pressure). Hold for systolic (top number) blood pressure (BP) greater than 120 (millimeters of mercury) or diastolic (bottom number) greater than 90.</p> <p>The August and September 2024 Medication Administration Records (MAR) indicated the midodrine was administered outside of the parameters on the following dates and times:</p> <p>8/2/24 at 1:00 p.m.: BP 128/67</p> <p>8/10/24 at 1:00 p.m.: BP 126/74</p> <p>8/30/24 at 1:00 p.m.: BP 133/65</p> <p>9/24/24 at 1:00 p.m.: BP 124/68</p> <p>A Physician's Order, dated 6/10/24, indicated to give hydralazine (medication used to treat high blood pressure) 50 mg, three times a day on Tuesday, Thursday, Saturday and Sunday. Hold for systolic BP less than 120 or diastolic BP less than 50.</p> <p>The August 2024 MAR indicated the hydralazine was administered outside of the parameters on the following dates and times:</p> <p>8/17/24 at 10:00 p.m.: BP 118/58</p> <p>8/25/24 at 9:00 a.m.: BP 101/62</p> <p>8/25/24 at 1:00 p.m.: BP 112/68</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Physician's Order, dated 8/27/24, indicated to give hydralazine 50 mg, three times a day on Tuesday, Thursday, Saturday and Sunday. Hold for systolic blood pressure less than 140 or diastolic BP less than 50.</p> <p>The September 2024 MAR indicated the hydralazine was administered outside of the parameters on the following dates and times:</p> <p>9/7/24 at 9:00 a.m.: BP 125/60</p> <p>9/7/24 at 10:00 p.m.: BP 121/60</p> <p>During an interview on 10/3/24 at 9:43 a.m., the Director of Nursing indicated the above medications were given outside of the ordered parameters.</p> <p>32664</p> <p>2. Record review for Resident 177 was completed on 10/1/24 at 1:45 p.m. Diagnoses included, but were not limited to, hypertension, hypotension, lymphedema, and depression.</p> <p>The October 2024 Physician's Order Summary indicated an order for midodrine hydrochloride (treats low blood pressure). Give 5 mg (milligrams) by mouth three times a day, hold for a systolic (top number of blood pressure reading) above 120.</p> <p>The September 2024 Medication Administration Record (MAR) indicated the midodrine was administered and not held as ordered on the following dates and times:</p> <p>9/1/24 at 12:00 p.m., blood pressure (BP) 128/81</p> <p>9/6/24 at 6:00 a.m., BP 127/69</p> <p>9/9/24 at 12:00 p.m., BP 131/71</p> <p>9/12/24 at 6:00 a.m., BP 127/68</p> <p>9/19/24 at 6:00 p.m., BP 132/77</p> <p>9/23/24 at 12:00 p.m., BP 128/71</p> <p>During an interview on 10/1/24 at 3:38 p.m., the Director of Nursing (DON) indicated the midodrine was administered on the above dates and times when the blood pressure was out of parameters. The medication should have been held.</p> <p>45666</p> <p>3. On 9/30/24 at 10:08 a.m., Resident 71 was observed self-propelling in a wheelchair down the hall in the locked memory care unit. There was a discoloration approximately the size of a quarter observed above her left elbow.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/3/24 at 2:42 p.m., Resident 71 was observed self-propelling in a wheelchair down the hall in the locked unit. There was a discoloration approximately the size of a quarter observed above her left elbow.</p> <p>Resident 71's record was reviewed on 10/2/24 at 10:50 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, psychotic disorder with delusions, and generalized anxiety disorder.</p> <p>The Admission Minimum Data Set assessment, dated 8/10/24, indicated the resident was severely cognitively impaired for daily decision making.</p> <p>A Physician's Order, dated 8/12/24 at 7:00 a.m., indicated a weekly skin review assessment every Monday during day shift.</p> <p>The Weekly Skin Review, dated 9/30/24 at 2:35 p.m., indicated the resident had no new skin issues.</p> <p>During an interview on 10/04/24 at 9:04 a.m., the Director of Nursing indicated she had staff measure the bruised area after notification of the discoloration.</p> <p>3.1-37(a)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>45666</p> <p>Based on observation, record review, and interview, the facility failed to ensure an indwelling Foley (urinary) catheter tubing and collection bag was kept off the floor for 1 of 1 resident reviewed for urinary catheters. (Resident 276)</p> <p>Finding includes:</p> <p>Resident 276 was observed on 10/2/24 at 10:49 a.m. The resident was lying in her bed, which was lowered to the ground with a fall mat on the left side of the bed. The catheter collection bag was lodged underneath the bed lying directly on the fall mat with the catheter tubing also on the ground.</p> <p>Resident 276's record was reviewed on 10/2/24 at 10:33 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder and dementia.</p> <p>The Admission Minimum Data Set assessment, dated 9/26/24, was still in progress.</p> <p>The Baseline Care Plan, dated 9/26/24, indicated the resident was a new admission to the secured unit. She required a Hoyer mechanical lift with 2 person assist, bed in lowest position, bilateral floor mats, and indwelling Foley catheter care every shift.</p> <p>During an interview on 10/2/24 at 11:29 a.m., RN 1 indicated the catheter should not have been on the floor. Someone must have lowered the bed after care and did not place the collection bag in a basin.</p> <p>During an interview on 10/2/24 at 11:48 a.m., the Director of Nursing indicated she had no further information to provide.</p> <p>A policy titled, Catheter Care, and noted as current, indicated .Policy Explanation .10. Ensure drainage bag and catheter tubing are not touching the floor to assist in decreasing risk of UTI.</p> <p>3.1-41(a)(2)</p>		