

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Fountainview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 609 W Tanglewood LN Mishawaka, IN 46545	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966</p> <p>Based on record review and interview, the facility failed to ensure a resident's abnormal vital signs were reported to the physician, for 1 of 3 residents reviewed for nursing services. (Resident B).</p> <p>Finding includes:</p> <p>On 4/1/24 at 1:45 P.M., Resident B's clinical record was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, toxic encephalopathy, anemia, atrial fibrillation , heart failure, hypertension, orthostatic hypotension, and paraplegia.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 2/23/24, indicated the resident was cognitively intact, required extensive assistance with most activities of daily living, utilized an indwelling catheter, and required a wheelchair for locomotion.</p> <p>Current Physician's Orders indicated the following:</p> <p>Midodrine HCL 5 MG, 3 times daily for hypotension</p> <p>Amiodarone HCL 100 MG, 2 times daily for systolic congestive heart failure, dated 3/1/24 Ceftriaxone Sodium 1 gram injection every 24 hour for 7 days for urinary tract infection and leukocytosis (high white blood cell count), dated 3/7/24.</p> <p>Resident B's vital signs record indicated, on 3/7/24 at 12:28 A.M., the blood pressure was 117/48 and the pulse was 82 and regular. At 9:17 A.M., the blood pressure was 76/42 and the pulse was 108 and irregular.</p> <p>On 4/4/24 at 1:10 P.M., during an interview with the Nurse Practitioner, she indicated she was in early morning on 3/7/24 to do rounds. She had ordered routine labs on 3/6/24 and noted Resident B's labs to be abnormal and suggestive of likely urinary tract infection, so she ordered repeat blood testing and also a urine test. The Nurse Practitioner indicated she started the resident on an antibiotic at that time, but was unaware of the abnormal blood pressure and elevated irregular pulse. The Nurse Practitioner indicated the abnormal vital signs should have been reported to her at that time. The resident was known to have low blood pressure and was taking Midodrine for the low blood pressure. Resident B did not normally have an irregular pulse, and the NP was not aware of the irregular pulse rate on 3/7/24.</p> <p>(continued on next page)</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>On 4/4/24 at 12:10 P.M., a policy titled, Notification of Change, dated 2023, was provided by the Director of Nursing. The policy indicated, The purpose of this policy is to ensure the facility promptly .consults with the resident's physician .when there is a change requiring notification .The facility must .consult with the resident's physician .when there is a .significant change in the resident's physical .status .Circumstances that require a need to alter treat. This may include: .Exacerbation of a chronic condition .</p> <p>This citation relates to Complaint IN00430498.</p> <p>3.1-5(a)(2)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966</p> <p>Based on interview and record review, the facility failed to ensure a wound vac care plan was created for 1 of 3 residents reviewed for wounds, (Resident B).</p> <p>Finding includes:</p> <p>On 4/1/24 at 1:45 P.M., Resident B's clinical record was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, toxic encephalopathy, anemia, atrial fibrillation , heart failure, hypertension, orthostatic hypotension, and paraplegia.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 2/23/24, indicated the resident was cognitively intact, required extensive assistance with most activities of daily living, utilized an indwelling catheter, and required a wheelchair for locomotion. The Resident was admitted to the facility with 1 stage 3 pressure ulcer, 1 stage 4 pressure ulcer, and 2 unstageable pressure ulcers.</p> <p>A Wound Nurse Progress Note, dated 2/20/24 at 6:12 P.M. as an admission assessment, indicated the resident was admitted to the facility with a wound vac to the right buttock and had multiple wounds noted.</p> <p>Resident B's medical record indicated no care plan had been created for the wound vac intervention.</p> <p>During an interview, on 4/3/24 at 1:42 P.M., the MDS nurse indicated there was not a care plan initiated for Resident B's wound vac intervention.</p> <p>On 3/3/24 at 2:35 P.M., the policy titled, Comprehensive Care Plans, dated 2023 was provided by the Director of Nursing and indicated this was the policy currently used by the facility. The policy indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .The comprehensive care plan will describe, at a minimum ,the services that are to be furnished to attain or maintain the resident's highest practicable physical .wellbeing .</p> <p>This citation relates to Complaint IN00430498.</p> <p>3.1-30(a)</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>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966</p> <p>Based on record review and interview, the facility failed to reassess a resident after a change in condition, for 1 of 3 residents who were reviewed for nursing services. (Resident B)</p> <p>Finding includes:</p> <p>On 4/1/24 at 1:45 P.M., Resident B's clinical record was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, toxic encephalopathy, anemia, atrial fibrillation , heart failure, hypertension, orthostatic hypotension, and paraplegia.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 2/23/24, indicated the resident was cognitively intact, required extensive assistance with most activities of daily living, utilized an indwelling catheter, and required a wheelchair for locomotion.</p> <p>Current Physician's Orders indicated the following:</p> <p>Midodrine HCL 5 MG, 3 times daily for hypotension</p> <p>Amiodarone HCL 100 MG, 2 times daily for systolic congestive heart failure</p> <p>Ceftriaxone Sodium 1 gram injection every 24 hour for 7 days for urinary tract infection and leukocytosis (high white blood cell count), dated 3/7/24.</p> <p>Resident B's vital signs record indicated, on 3/7/24 at 12:28 A.M., the blood pressure was 117/48 and the pulse was 82 and regular. At 9:17 A.M., the blood pressure was 76/42 and the pulse was 108 and irregular. There were no further vital sign readings documented.</p> <p>An emergency room (ER) report, dated 3/7/24 at 8:16 P.M., indicated the resident was admitted to the ER for Chief Complaint of confusion and possible infection.</p> <p>On 4/3/24 at 2:00 P.M., during an interview with the Director of Nursing, she indicated she interviewed LPN 3, when she was made aware that LPN 3 did not document any follow up vital signs for Resident B on 3/7/24. LPN 3 said she did repeat the vital signs for the resident, found them to be within normal limits, but failed to complete the documentation. LPN 3 never returned to work after 3/7/24 to complete a late vital signs entry in the resident's electronic medical record. The Director of Nursing indicated Resident B's vital signs should have been monitored through the day. The facility did not have a policy to address when or if abnormal vital signs should be repeated or monitored.</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>Note: The nursing home is disputing this citation.</p>	<p>On 4/4/24 at 1:10 P.M., during an interview with the Nurse Practitioner (NP), the NP indicated she was in the facility early morning on 3/7/24 to do rounds. She had ordered routine labs on 3/6/24 and noted Resident B's labs to be abnormal and suggestive of likely urinary tract infection, so ordered repeat blood testing and also a urine test. The Nurse Practitioner indicated she started the resident on an antibiotic at that time, but was unaware of the abnormal blood pressure and elevated irregular pulse. The Nurse Practitioner indicated the abnormal vital signs should have been reported to her at that time. The resident was known to have low blood pressure and was taking Midodrine for the low blood pressure. Resident B did not normally have an irregular pulse, and she was not aware of the irregular pulse rate on 3/7/24. The NP indicated she would have expected the nurse to repeat and monitor the abnormal vital signs, though the resident had showed no outward signs of infection or confusion at the time of her assessment.</p> <p>Review of [NAME] Advisor, dated 2023, indicated under, Blood pressure decrease .Nursing Considerations, in regard to geriatric patients, indicated, . hypotension is a reading below 90/60 mm HG or a drop of 30 mm Hg from the patient's baseline .Check vital signs frequently to determine whether low blood pressure is constant or intermittent . Regarding an irregular pulse, .Check vital signs frequently to detect .hypotension .</p> <p>This citation relates to Complaint IN00430498.</p> <p>3.1-37(a)</p>		