STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Portage Care Center	3175 Lancer St Portage, IN 46368

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on record review and interview, the facility failed to ensure medical appointments were completed in a timely manner for 1 of 1 resident reviewed for a medical referral. (Resident B) Finding includes: The record for Resident B was reviewed on 8/20/24 at 3:40 p.m. Diagnoses included, but were not limited to, stroke, aphasia (a language disorder) following a stroke, hemiplegia and hemiparesis (muscle weakness and paralysis) following a stroke affecting the left non-dominant side, seizures, and altered mental status. The resident was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) assessment, dated 7/26/24, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 3/8/24, indicated an appointment with the resident's Neurologist was to be scheduled in one month. An appointment was scheduled for 4/16/24 at 9:30 a.m. Nurses' Notes, dated 4/16/24 at 10:41 a.m., indicated the resident's appointment was rescheduled for 5/8/24 at 10:45 a.m. due to transportation did not show up for the appointment. The transportation company indicated the pick up time was entered in the portal at 5:00 p.m. on 4/15/24 and that did not give them enough time to see it. Nurses' Notes, dated 5/8/24 at 11:53 a.m., indicated the resident's daughter was contacted concerning the appointment with the Neurologist had been rescheduled. A transportation request was submitted. A Physician's Order, dated 5/8/24, indicated the resident was to see the Neurologist on 5/14/24 at 12:45 p.m. There was no documentation in the nursing progress notes on 5/14/24 to indicate the resident was seen by the neurologist. A Physician's Order, dated 6/7/24, indicated the resident was to see the Neurologist on 6/11/24 at 1:00 p.m. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	There was no documentation in the nursing progress notes on 6/11/24 to indicate the resident was seen by the neurologist. A Physician's Order, dated 8/15/24, indicated the resident was to be seen by the Neurologist on 8/19/24 at 9:30 a.m. There was no documentation in the nursing progress notes on 8/19/24 to indicate the resident was seen by the neurologist. Nurses' Notes, dated 8/20/24 at 8:49 a.m., indicated the resident's daughter was contacted to discuss the neurology appointment. An appointment was scheduled for 9/19/24. During an interview on 8/23/24 at 10:19 a.m., the C Wing Unit Manager indicated there had been issues getting the resident seen by the neurologist. For his first scheduled appointment, transportation did not show up. For the next appointment, his wheelchair did not fit through the door at the office, then they changed neurologists. Another time, he couldn't get off the transportation van, and his last appointment on 8/19/24 was supposed to be on 9/19/24. The Unit Manager indicated the resident had not been seen by a neurologist since admission. Facility Calendar Notes, provided by the C Wing Unit Manger, indicated on 4/16/24 transportation was unavailable and the appointment was rescheduled, on 5/14/24 the resident's wheelchair was not able to fit through the office doors and the resident would need to see a different neurologist, on 6/14/24 transport staff were unable to get the resident off of the van and the appointment was rescheduled, and on 8/19/24 there was an error with the appointment date. The resident's appointment was scheduled for 9/19 rather than 8/19/24. During an interview on 8/23/24 at 1:45 p.m., the Executive Director indicated alternative measures should have been attempted to get the resident seen by the neurologist. This citation relates to Complaint IN00441573. 3.1-37(a)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 10770 Based on record review and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing related to offloading heels when in bed for 1 of 5 residents reviewed for pressure ulcers. (Resident D) Finding includes: During random observations on 8/19/24 at 3:00 p.m. and 3:45 p.m., on 8/20/24 at 10:10 a.m., 3:07 p.m., and 3:55 p.m., and on 8/21/24 at 1:39 p.m. and 2:45 p.m., Resident D was observed lying in bed. At those times, the resident's heels were not offloaded while in the bed. The heels were lying directly on the mattress. On 8/22/24 at 2:55 p.m., the Wound Nurse removed the resident's sock so his pressure ulcer could be observed. The wound was located on the left heel and had black and dark maroon intact tissue to the wound bed. The surrounding skin was starting to flake off. There was no drainage noted. The record for Resident D was reviewed on 8/20/24 at 3:15 p.m. Diagnoses included, but were not limited to, urine retention, anemia, high blood pressure, obstructive uropathy (a disorder of the urinary tract that occurred due to obstructed urinary flow), anxiety, schizophrenia, mood disturbance, dementia, and depression. The 8/4/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had no pressure ulcers during the assessment reference period. A Care Plan, dated 8/12/24, indicated the resident had a pressure ulcer to the left heel. The approaches were to float the heels. A Change of Condition Note, dated 8/11/24 at 2:11 p.m., indicated the resident was noted to have a pressure related area to the right heel measuring 4 centimeters (cm) by 4 cm. The wound nurse was notified. A Wound Nurse Practitioner (NP) Note, dated 8/14/24 at 1:07 p.m., indicated the resident had a deep tissue injury (a form of pressure ulcer) to the left heel that measured 4 cm by 3.5 cm. The wound base had 100% of epithelial tissue (a layer of skin cells) and the wound edges were intact. The treatment recommendations were to apply skin prep to the base of the wound twice daily, leave open to air, and float the heels while in bed with the use of heel boots. Physician's Orders, dated 8/11/24, indicated to off load heels at bedtime for skin integrity. During an interview on 8/22/24 at 11:30 a.m., the Wound Nurse indicated the resident's heels should be offloaded all the time while in bed. During an interview on 8/22/24 at 2:00 p.m., the Executive Director had no additional information to provide. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-40(a)(2)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 10326 Based on observation, record review, and interview, the facility failed to ensure a call light was in reach and preventative fall measures were in use for residents who were identified as a fall risk for 2 of 5 residents reviewed for falls. (Residents C and D) Findings include: 1. During a random observation on 8/20/24 at 11:40 a.m., Resident C was in her room in bed. The resident's eyes were closed and her call light was observed on the floor underneath her bed. On 8/20/24 at 3:05 p.m., the resident remained in her bed and was watching television. The call light remained on the floor underneath the bed. At 3:12 p.m., a CNA entered the resident's room. The CNA exited the room after providing care. At 3:25 p.m., the resident was observed in bed and the call light was in reach. The record for Resident C was reviewed on 8/21/24 at 3:32 p.m. Diagnoses included, but were not limited to, repeated falls, anxiety, and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 5/17/24, indicated the resident was cognitively intact. The resident required substantial to maximum assistance with bed mobility and transfers. The resident had not had any falls since the prior assessment. A Care Plan, dated 1/3/23 and reviewed on 6/18/24, indicated the resident was at risk for falls related to a history of falls and weakness. Interventions included, but were not limited to, keep call light or personal items available and in easy reach. The Fall Risk Assessment, dated 8/13/24, indicated the resident was a fall risk. During an interview on 8/23/24 at 2:54 p.m., the Executive Director indicated the resident's call light should have been in reach. 10770 2. During random observations on 8/19/24 at 3:00 p.m. and 3:45 p.m., and on 8/20/24 at 10:10 a.m., 3:07 p.m., and 3:55 p.m., Resident D was observed lying in bed. At those times, the resident's bed was in a high position and there was no floor mat on the ground. The record for Resident D was reviewed on 8/20/24 at 3:15 p.m. Diagnoses included, but were not limited to, urine retention, anemia, high blood pressure, obstructive uropathy (a disorder of the urinary tract that occurred due to obstructed urinary flow), anxiety, schizophrenia, mood disturbance, dementia, and depression. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/4/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had no falls since the last assessment and had a urinary catheter. A Care Plan, initiated on 7/25/24, indicated the resident was at risk for falls related to confusion and poor safety awareness. The approaches were to have a mat beside the bed and keep the bed in a low position. Physician's Orders, dated 11/26/24, indicated a floor mat every shift for fall prevention. The Treatment Administration Record for the month of 8/2024, indicated the floor mat was signed out as being down and in place for the day shift on 8/19-8/20/24. During an interview on 8/22/24 at 9:55 a.m., CNA 1 indicated she was aware the resident was to have a floor mat beside the bed, and it was in the closet. During an interview on 8/22/24 at 10:05 a.m., the ACU Unit Manager indicated she was aware the resident needed a floor mat beside the bed and it was kept in the closet because his roommate was ambulatory and they did not want him to trip over it. During an interview on 8/22/24 at 2:00 p.m., the Executive Director indicated she had no additional information to provide. The current 2023 Accidents and Supervision policy, provided by the Executive Director on 8/22/24 at 11:42 a.m., indicated Implementation of Interventions-using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: e. Ensuring that the interventions are put into action. Monitoring and Modifications - Monitoring is the process of evaluation the effectiveness of care plan interventions. - Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: Ensuring that interventions are implemented correctly and consistently This citation relates to Complaint IN00438937. 3.1-45(a)(2)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 10770 Based on observation, record review, and interview, the facility failed to ensure Foley catheter bags and tubing were kept off of the floor for 1 of 1 resident reviewed for catheters. (Resident D) Finding includes: During random observations on 8/19/24 at 9:56 a.m. and 11:40 a.m., Resident D was observed sitting in a high back wheelchair. The bottom of the catheter bag was observed on the floor under the wheelchair. During a random observation on 8/21/24 at 1:39 p.m., the resident was observed in bed. The bed was very low to the ground and the catheter bag and tubing was observed laying on the floor mat. On 8/22/24 at 10:00 a.m., the resident was observed sitting in the high back wheelchair. At that time, the catheter bag was hanging right below the arm rest of the wheelchair and not below his waist. The record for Resident D was reviewed on 8/20/24 at 3:15 p.m. Diagnoses included, but were not limited to, urine retention, anemia, high blood pressure, obstructive uropathy (a disorder of the urinary tract that occurred due to obstructed urinary flow), anxiety, schizophrenia, mood disturbance, dementia, and depression. The 8/4/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making. The resident had a urinary catheter. A Care Plan, revised on 7/19/24, indicated the resident had a history of chronic/recurring urinary tract infections. The approaches were to keep the drainage bag of the catheter below the level of the bladder at all times and off the floor. A Care Plan, revised on 7/19/24, indicated the resident had an indwelling catheter related to urine retention and obstructive uropathy. The approaches were to keep the drainage bag of the catheter below the level of the bladder at all times and off the floor. A Physician's Order, dated 5/26/24, indicated Foley catheter, size 14 French and 10 cubic centimeter (cc)balloon. Physician's Orders, dated 8/6/24 and discontinued on 8/14/24, indicated Augmentin (an antibiotic medication) 500-125 milligrams (mg), give 1 tablet by mouth three times a day for ESBL (Extended-Spectrum Beta-Lactamase infection caused by bacteria that produce an enzyme that was resistant to many commonly used antibiotics) for 7 days. During an interview on 8/22/24 at 9:55 a.m., CNA 1 indicated she was aware the catheter bag and tubing were on the floor because the bed had to be in a low position. She was told by the Unit Manager to put the bag and tubing in a basin. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/24 at 10:05 a.m., the ACU Unit Manager indicated she observed the catheter bag and tubing on the floor mat and instructed the CNA to put it in a basin. The catheter bag was to be below the resident's waist. The current 2023 Indwelling Catheter Use and Removal policy, provided by the Executive Director on 8/22/24 at 3:00 p.m., indicated If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care polices and procedures that include but are not limited to: . d. Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures. Additional care practices include: e. Securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the waist . 3.1-41(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48383 Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 1 of 2 residents reviewed for respiratory care. (Resident 90) Finding includes: During random observations on 8/19/24 at 10:36 a.m. and 3:35 p.m., Resident 90 was observed wearing oxygen per nasal cannula at just under 3 liters per minute. During random observations on 8/22/24 at 9:56 a.m. and 11:12 a.m., the resident was observed wearing oxygen per nasal cannula. The oxygen flow rate was set right under 3 liters. During a random observation on 8/23/24 at 8:46 a.m., the resident was observed awake in bed. The resident was wearing oxygen per nasal cannula. The oxygen flow rate was set directly below 3 liters. The record for Resident 90 was reviewed on 8/19/24 at 10:45 a.m. Diagnoses included, but were not limited to, insomnia (difficulty sleeping), chronic obstructive pulmonary disease (COPD), and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 7/22/24, indicated the resident was cognitively intact for daily decision making and she wore oxygen. Physician's Orders, dated 4/30/24, indicated the resident was to have continuous oxygen at 2 liters per minute per nasal cannula. The Medication Administration Record (MAR), dated August 2024, indicated the oxygen was signed out as being given at 2 liters on the following dates: 8/19/24, 8/20/24, 8/21/24 and 8/22/24. During an interview on 8/22/24 at 9:35 a.m., the Executive Director (ED) indicated the resident's oxygen should have been on at the correct flow rate. During an interview on 8/22/24 at 10:22 a.m., QMA 1 indicated the oxygen ball should be directly in the middle of the 2 liter line if the resident was on 2 liters of oxygen. She had signed off in Resident 90's MAR that the oxygen was given at 2 liters per nasal cannula on 8/22/24 for the AM shift. 3.1-47(a)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 10770 Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to not sanitizing and disinfecting multiple resident use equipment for a random observation during medication pass. (Residents 71 and 53) Finding includes: During medication administration pass on 8/22/24 at 8:10 a.m., LPN 1 was observed checking Resident 71's blood pressure, pulse, and temperature with reusable instruments. After she had finished, she brought all of the items back to the medication cart and placed them to the side. The LPN did not sanitize the blood pressure machine and cuff, thermometer, or the pulse oximetry device. LPN 1 prepared, poured, and administered the resident's medication and left the room. She moved the medication cart across the hall to Resident 53's room. At 8:27 a.m., she took the blood pressure machine, thermometer, and pulse oximetry device into his room and checked his vital signs. The items had not been sanitized after they were previously used. After checking his vital signs, she brought all of the devices to the medication cart and cleaned them with a germicide wipe. During an interview at that time, LPN 1 was aware the reusable equipment was to be cleaned and sanitized after each use. During an interview on 8/22/24 at 2:00 p.m., the Executive Director had no additional information to provide. The current 2024 Cleaning and Disinfection of Resident-Care Equipment policy, provided by the Executive Director on 8/22/24 at 3:00 p.m., indicated Staff shall follow established infection control principles for cleaning and disinfecting reusable, non critical equipment. General guidelines include: . b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. d. Multiple resident use equipment shall be cleaned and disinfected after each use . 3.1-18(b)