

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Lincoln Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 402 19th Street Tell City, IN 47586	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46882</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident was treated with dignity for 2 of 2 residents reviewed for choices. One resident continued to receive styrofoam dishes after a suicide watch was discontinued. A CNA (Certified Nursing Aide) was standing up to feed a resident and asked the nurse What do you want me to do with her? when she was done. (Resident 37, Resident 26)</p> <p>Findings include:</p> <p>1. On 4/17/24 at 8:38 A.M., Resident 37 was observed sitting on the side of her bed while staff were putting TED (Thrombo-Embolic Deterrent) hose on her legs. Her breakfast tray containing Styrofoam dishes was sitting on the bedside table.</p> <p>On 4/17/24 at 8:53 A.M., Resident 37's clinical records were reviewed. Diagnosis included, but were not limited to depression and anxiety. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 1/19/24 indicated Resident 37 was cognitively intact.</p> <p>Progress Notes:</p> <p>4/16/2024 8:52 A.M. General Note</p> <p>Note Text: suicide watch over this day. Res [Resident] has not threatened to harm self during watch not attempt [sic] to hurt self. Continue to await final UA [urinalysis] results. No c/o [complaint] voiced this am [sic].</p> <p>During an interview on 4/17/24 at 8:42 A.M., QMA (Qualified Medication Aide) 19 indicated Resident 37 was receiving Styrofoam dishes because she was on 15 minute checks and suicide watch, but that had been discontinued so we just need to contact dietary to cancel the Styrofoam dishes.</p> <p>During an interview on 4/18/24 at 8:21 A.M., Resident 37 indicated she didn't like the Styrofoam dishes.</p> <p>46416</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 4/19/24 at 7:30 A.M., Certified Nurse Aide (CNA) 80 was observed in the main dining room standing next to and feeding Resident 26.</p> <p>On 4/19/24 at 7:42 A.M., CNA 80 was observed pushing Resident 26 out of the dining room up to a nurse and asking What do you want me to do with her?</p> <p>On 4/18/24 at 10:04 A.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety, weakness and Alzheimer's disease. Resident 26 was admitted on [DATE] .</p> <p>The most recent Quarterly MDS Assessment, dated 1/19/24, indicated Resident 26's cognition was severely impaired and she was an extensive assist of 2 staff for bed mobility and toileting, an extensive assist of 1 staff for transfers, and supervision of 1 staff for eating.</p> <p>A Nutritional Assessment Report (NAR), dated 4/4/24 indicated Resident 26 had a significant weight loss and it was recommended the resident would eat meals in the dining room, need assistance to eat, and should be changed to a weekly weight.</p> <p>During an interview on 4/19/24 at 9:03 A.M., the Director of Nursing (DON) indicated she would expect staff to sit when feeding a resident. At that time, she indicated she wouldn't consider the statement made by CNA 80 a dignity concern, but would talk to staff and inservice them on using the proper names and not her when discussing the resident's care.</p> <p>A current nondated Promoting/Maintaining Resident Dignity Policy was provided on 4/19/24 at 11:00 A.M., by the Regional Consultant and indicated . It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity . 5. When interacting with a resident, pay attention to the resident as an individual . 10. Speak respectfully to residents; avoid discussions about residents that may be overheard .</p> <p>3.1-3(t)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38770</p> <p>Based on interview and record review, the facility failed to notify the ombudsman of transfer or discharge for 3 of 4 residents reviewed for hospitalization s. (Resident 23, Resident 25, Resident 35)</p> <p>Findings include:</p> <p>1. On 4/16/24 at 11:02 A.M., Resident 23's clinical record was reviewed. Resident 23 was sent to the hospital on 4/9/24.</p> <p>Resident 23's clinical record lacked documentation that notification of the hospitalization was sent to the ombudsman.</p> <p>2. On 4/16/24 at 10:44 P.M., Resident 35's clinical record was reviewed. Resident 35 was sent to the hospital on 12/22/23.</p> <p>Resident 35's clinical record lacked documentation that notification of the hospitalization was sent to the ombudsman.</p> <p>46416</p> <p>3. On 4/17/24 at 10:30 A.M., Resident 25's clinical record was reviewed. Diagnoses included, but was not limited to, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and diabetes mellitus type II.</p> <p>Progress Notes indicated Resident 25 was hospitalized [DATE] through 7/10/23.</p> <p>A completed Notice of Transfer or Discharge Form was provided by the Director of Nursing (DON) on 4/18/24 at 2:55 P.M., with a transfer or discharge date of [DATE] (sic).</p> <p>On 4/19/24 at 9:57 A.M., the Regional Consultant indicated notification to the ombudsman could not be located for Resident 23, Resident 25, or Resident 35.</p> <p>On 4/19/24 at 4:10 P.M., the state ombudsman indicated via email that notification reports for July 2023, December 2023, or any months in 2024 had not been received from the facility.</p> <p>During an interview on 4/22/24 at 8:55 A.M., the Administrator indicated no one at the facility was sending the discharges to the ombudsman.</p> <p>A current, nondated Discharge Planning Policy was provided by the DON on 4/22/24 at 10:44 A.M., and indicated . the facility must notify the Office of the State Long-Term Care Ombudsman of all resident discharges from the facility. Social Services will notify the Ombudsman of all discharges, which are not due to an issue of a 30-day notice, by means of a monthly summary containing at minimum: the residents name, discharge date , and discharge location .</p> <p>(continued on next page)</p>		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-12 (a)(6)(A)(iv)

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45933</p> <p>Based on interview and record review, the facility failed to ensure MDS (Minimum Data Set) Assessments were accurate for 4 of 19 residents in the initial sample. The MDS Assessment failed to indicate residents had a PASRR (preadmission screening and resident review) II. The MDS failed to indicate a resident received hospice services. (Resident 1, Resident 31, Resident 39, Resident 51)</p> <p>Findings include:</p> <p>1. On 4/17/24 at 8:43 A.M., Resident 39's clinical record was reviewed. Diagnosis included, but were not limited to, epilepsy, developmental disorder of speech and language, spastic quadriplegic cerebral palsy, and severe intellectual disabilities.</p> <p>The most recent Annual MDS, dated [DATE], indicated Resident 39 did not have the following: .currently considered by the state level II PASRR [preadmission screening and resident review] process to have serious mental illness and/or intellectual disability or a related condition.</p> <p>On 11/5/21 a PASRR level II was completed by [name of company] and indicated the PASRR was valid for the duration of Resident 39's stay.</p> <p>During an interview on 4/22/24 at 9:23 A.M., the MDS Coordinator indicated social services previously completed that portion of the MDS, and due to the lack of a social services coordinator, it was an entry error.</p> <p>46416</p> <p>2. On 4/16/24 at 9:19 A.M., Resident 51's clinical record was reviewed. Diagnoses included, but were limited to, chronic obstructive pulmonary disease (COPD), stroke, and hemiplegia (paralysis) on the left side.</p> <p>The most recent Quarterly MDS Assessment, dated 3/29/24, indicated Resident 51 was not receiving hospice care.</p> <p>Current Physician's Orders included, but were not limited to, the following: (Hospice Company Name), ordered 1/5/2024</p> <p>Resident 51's clinical record included a current hospice care plan, revised 1/4/24.</p> <p>During an interview on 4/22/24 at 9:25 A.M., the MDS Coordinator indicated hospice should have been marked and she missed it.</p> <p>46882</p> <p>3. On 4/16/24 at 10:51 A.M., Resident 31's clinical records were reviewed. Diagnosis included, but was not limited to bipolar disorder and major depressive disorder.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/19/24 at 8:54 A.M., the most current Annual MDS Assessment, dated 7/1/23, indicated Resident 31 was marked no for having a PASSAR II.</p> <p>On 4/22/24 at 8:15 A.M., the Business Office Manager provided a copy of the PASSAR II that was in Resident 31's chart.</p> <p>During an interview on 4/22/24 at 9:23 A.M., the MDS Coordinator indicated that marking Resident 31 did not have a PASSAR II was an error. She indicated Social Services normally filled that section out, and since the facility currently did not have a Social Worker, she filled it out.</p> <p>4. On 4/16/24 at 12:54 P.M., Resident 1's clinical records were reviewed. The diagnosis included, but was not limited to paranoid schizophrenia.</p> <p>The most current Annual MDS (Minimum Data Set) Assessment, dated 6/3/23, indicated Resident 1 was marked No for having a PASSAR II.</p> <p>On 4/22/24 at 8:15 A.M., the Business Office Manager provided a copy of the PASSAR II that was in Resident 1's chart.</p> <p>During an interview on 4/22/24 at 9:23 A.M., the MDS Coordinator indicated that marking Resident 1 did not have a PASSAR II was an error on her part. She indicated Social Services normally filled that section out, and since the facility currently did not have a Social Worker, she filled it out.</p> <p>During an interview on 4/22/24 at 9:23 A.M., the MDS Coordinator indicated she did not have an MDS Policy. She indicated she use the RAI (Resident Assessment Instrument) Manual as the policy.</p> <p>3.1-31(i)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>45933</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided in accordance with the written plan of care for 2 of 2 residents reviewed for smoking. A resident smoked in a non-designated smoking area. Staff failed to lock up residents smoking materials.(Anonymous Resident, Resident 1)</p> <p>Findings include:</p> <p>1. During an interview on 4/17/24 7:37 A.M., an Anonymous Resident indicated cigarettes are kept in the resident's room and supervision is not needed to smoke.</p> <p>During an observation on 4/19/24 at 1:42 P.M., an Anonymous Resident was unsupervised on the front porch. At that time, the resident lit a cigarette.</p> <p>On 4/16/24 at 10:30 A.M., the Resident's clinical record was reviewed. Diagnoses included, but was not limited to, diabetes mellitus, hypertension, seizure disorder, and chronic obstructive pulmonary disorder.</p> <p>The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 3/10/24, indicated the Anonymous Resident was cognitively intact and had shortness of breath.</p> <p>A current smoking and safety assessment, dated 3/6/24, indicated that the resident used tobacco products and followed the facility's policy on location of smoking.</p> <p>A current at risk for smoking related injury care plan, initiated 7/18/23, included, but was not limited to, the following interventions, .Assure smoking material is extinguished prior to patient leaving smoking area . Observe patient for unsafe smoking behaviors or attempts to obtain smoking material from outside sources. Immediately inform facility management .Patient not to have cigarettes or smoking material on person . Storage of smoking materials per Living Center policy .</p> <p>During an interview on 4/22/24 at 8:42 A.M., LPN (Licensed Practical Nurse) 16 indicated Resident's should go out the back door to smoke, and Residents should not smoke on the front porch unless they are supervised. At that time, she indicated the Anonymous Resident could keep possession of the smoking materials. After the care plan was reviewed, LPN 16 indicated the Anonymous Resident's smoking materials must be held by staff.</p> <p>46882</p> <p>2. On 4/16/24 at 8:50 A.M., Resident 1 was observed sitting outside to the left of the door smoking, sitting on rollator walker with no smoking apron on and no staff present.</p> <p>On 4/17/24 at 10:02 A.M., Resident 1 was observed ambulating down the hall with a rollator walker, stopping at nurse's desk to sign smoking sign out sheet. At that time, he indicated he was going outside to smoke.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/22/24 at 8:42 A.M., Resident 1 was observed standing at nurse's desk with rollator walker and coat on signing smoking sign out sheet. He did not ask nurse for cigarettes. Resident 1 was observed getting on the elevator. Resident 1 was observed walking down hall on 1st floor to door to smoking area, putting code in, and walking outside without supervision and without a smoking apron. Resident 1 was observed sitting on rollator walker outside to the left of the door lighting a cigarette.</p> <p>On 4/16/24 at 12:54 P.M., Resident 1's clinical records were reviewed. Diagnosis included, but were not limited to paranoid schizophrenia, dementia, extrapyramidal movement disorder, and epilepsy.</p> <p>The most current Quarterly MDS (Minimum Data Set) Assessment, dated 3/2/24 indicated Resident 1 was moderately cognitively impaired, and needed supervision of one for bed mobility, transfers, eating and toilet use.</p> <p>A current Smoking Care Plan dated 3/19/12 was provided on 4/19/24 at 10:15 A.M. Interventions included, but were not limited to the following:</p> <p>Patient not to have cigarettes or smoking material on person, date initiated 12/3/21</p> <p>Supervision and wear apron, revision on 5/13/22</p> <p>During an interview on 4/16/24 at 9:03 A.M., Resident 1 indicated he could go outside to smoke by himself whenever he chose. He indicated he kept his cigarettes in a blue bag in his rollator walker and kept cigars in his dresser.</p> <p>During an interview on 4/16/24 at 9:14 A.M., RN 24 indicated there was a sign out sheet at the nurse's desk for smokers to sign out, but they don't have to sign back in. She indicated the smokers go outside to smoke by themselves.</p> <p>During an interview on 4/22/24 at 8:42 A.M., LPN 16 indicated most of the time cigarettes for the smokers were kept at the nurse's desk. She indicated if a resident was cognitively intact they could keep their cigarettes with them. She indicated Resident 1 could keep his cigarettes with him. When asked to look at Resident 1's Smoking Care Plan, LPN 16 indicated the care plan said the resident was not to have cigarettes on his person.</p> <p>On 4/19/24 at 11:00 A.M., a Comprehensive Care Plan Policy, dated February 2023, was provided by the Regional Consultant which indicated .Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p> <p>3.1-35(a)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38770</p> <p>Based on interview and record review, the facility failed to provide care plan conferences quarterly for 2 of 5 residents reviewed for unnecessary medications. (Resident 35, Resident 52)</p> <p>Findings include:</p> <p>1. On 4/18/24 at 12:50 P.M., Resident 35's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and anxiety disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/11/24, indicated a severe cognitive impairment.</p> <p>Resident 35's most recent care plan meeting was held 12/13/23.</p> <p>Resident 35's clinical record lacked a care plan meeting since 12/13/23.</p> <p>On 4/15/24 at 12:39 P.M., the Administrator indicated there was no current Social Services Director (SSD) as the most recent one quit in January 2024. She indicated the Activities Director was assuming the role of care plan meeting coordinator until a new SSD could be found.</p> <p>45933</p> <p>2. On 4/17/24 at 11:00 A.M., Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, Alzheimer's disease, and anxiety disorder.</p> <p>The most recent Quarterly MDS, dated [DATE], indicated a severe cognitive impairment.</p> <p>The clinical record lacked a care plan conference between 9/19/23 and 3/12/24.</p> <p>During an interview on 4/22/24 at 8:55 A.M., the Administrator indicated social services arranged the care plan conferences, but the activity director had been helping set the conferences up due to the facility not having a social services provider. At that time, she indicated she was unsure of how often care plan conferences should be completed.</p> <p>On 4/22/24 at 11:21 A.M., the Regional Consultant provided an undated Care Planning-Resident Participation policy that indicated, .10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes .</p> <p>3.1-35(c)(2)(C)</p> <p>3.1-35(d)(2)(B)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416</p> <p>Based on observation, interview, and record review, the facility failed to provide care, consistent with professional standards of practice, to prevent pressure ulcers and promote healing of existing pressure ulcers for 2 of 2 residents reviewed for pressure ulcers. Residents admitted with a deep tissue injury (DTI) and incontinence associated dermatitis (IAD) worsened and resident developed a stage IV pressure ulcer on the right heel. (Resident 64, Resident 23)</p> <p>Findings include:</p> <p>1. On 4/16/24 at 10:52 A.M., Resident 64's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure, weakness, and atrial fibrillation. Resident 64 was admitted on [DATE].</p> <p>The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/25/24, indicated Resident 64 was cognitively intact and an extensive assist of 2 staff for bed mobility, transfers, and toileting. Resident 26 noted to have a foley catheter, colostomy, and 1 unstageable pressure ulcer.</p> <p>Current Physician Orders included, but were not limited to, the following:</p> <p>Cleanse right heel open area with wound cleanser, pat dry, Apply Manuka (honey alginate) cut to size and cover with border dressing every night shift daily, every other day (sic), ordered 4/4/24</p> <p>Cleanse wound to coccyx with wound cleanser and pat dry. Apply Honey alginate (Manuka) cut to size, cover with bordered foam dressing every night and as needed for soiling or dislodgement, ordered 4/11/24</p> <p>House shake three times a day for wound care, ordered 3/13/24</p> <p>Juven oral packet, give 1 packet by mouth two times a day at 7:00 A.M. and 8:00 P.M., ordered 3/13/24</p> <p>A current Pressure Ulcer Care Plan, dated 3/24/24, included, but was not limited to, the following interventions:</p> <p>juven and house shake for wound healing as ordered, initiated 3/14/24</p> <p>turning and repositioning every 2 hours and as needed, initiated 3/24/24</p> <p>Skin and wound notes from admission on 2/8/24 through 4/17/24 were reviewed and indicated the following:</p> <p>Wound 1</p> <p>On 2/14/24 at 1:30 P.M., Patient was seen today for a DTI (damage of underlying soft tissue of skin from pressure and/or shearing) on her sacrum acquired by the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Location: coccyx (back of body above buttocks). Size: 0 centimeter (cm) x 0 cm x 0 cm. Initial weekly wound assessment of DTI pressure present on admission to sacrum/coccyx area completed 2/14/24 by Wound Nurse Practitioner (NP) and facility Wound Nurse. Wound appears with deep red/purple area. No drainage. Recommended TRIAD (sterile coating used on broken skin to keep it covered and protected from incontinence) cream to area every shift, leave open to air.</p> <p>On 2/21/24 at 11:24 A.M., Patient was seen today for a DTI on her sacrum acquired by the hospital.</p> <p>Location: sacrum. Primary Etiology: Pressure. Stage/Severity: DTI. Wound Status: Improving without complications. Size: 1 cm x 0.5 cm x 0 cm. Recommended cleansing with soap and water, pat dry, apply triad to base of the wound, leave open to air, and change twice daily and as needed. The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit.</p> <p>On 2/26/24 at 10:20 A.M., Noted: discolored area to coccyx was being treated with Triad hydrophilic wound dress external paste. Wound noted to open. Wound measurement 2.0 cm x 2.0 cm x < 0.1 cm. Wound cleansed. Wound bed covered with Xeroform cut to size, covered with bordered foam gauze dressing.</p> <p>On 2/28/24 at 9:18 A.M., Patient was seen today for a DTI on her sacrum acquired by the hospital. Deep tissue pressure injury (DTPI) location: coccyx Size: 4 cm x 2 cm x 0.1 cm with moderate amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of sacral wound completed 2/28/24 by Wound NP and facility Wound Nurse. Patient had unstageable (full thickness tissue loss but depth of ulcer can not be determine) DTI to sacrum. Recommended use of Honey alginate (Manuka) to wound bed, secure with silicone border foam dressing related to fragile skin and moderate drainage, change daily. Rest in bed with low air loss mattress, turn and reposition protocol. Heel protector to right foot, heels floated.</p> <p>On 3/6/24 at 3:13 P.M., Patient was seen today for a DTI on her sacrum acquired by the hospital. DTPI location: coccyx Size: 5 cm x 3 cm x 0.1 cm with moderate amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of sacral wound completed 3/6/24 by Wound NP and facility Wound Nurse. Patient had unstageable DTI to sacrum. Recommend continuing the use of Honey alginate (Manuka) to wound bed, secure with silicone border foam dressing related to fragile skin and moderate drainage, change daily. Rest in bed with low air loss mattress, turn and reposition protocol. Heel protector to bilateral feet, heels floated.</p> <p>On 3/13/24 at 9:45 A.M., Patient was seen today for a DTI on her sacrum acquired by the hospital. DTPI location: coccyx Size: 4 cm x 2.5 cm x 0.1 cm with moderate amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of unstageable sacral wound completed 3/13/24 Wound NP and facility Wound Nurse. Recommended continuing the use of Honey alginate (Manuka) to wound bed, secure with silicone border foam dressing related to fragile skin and moderate drainage, change daily. Rest in bed with low air loss mattress, turn and reposition protocol. Heel protector to bilateral feet, heels floated.</p> <p>On 3/20/24 at 12:58 P.M., Patient was seen today for a DTI on her sacrum acquired by the hospital.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Lincoln Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 402 19th Street Tell City, IN 47586	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>DTPI location: coccyx Size: 3.5 cm x 3 cm x 0.1 cm with moderate amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of unstageable sacral wound completed 3/20/24 by Wound NP and facility Wound Nurse. Wound is stalled with moderate amount of serosanguineous drainage. Recommended continuing the use of Honey alginate (Manuka) to wound bed, secure with silicone border foam dressing related to fragile skin and moderate drainage, change daily. Rest in bed with low air loss mattress, turn and reposition protocol. Heel protector to bilateral feet, heels floated. Reviewed results of prealbumin, dietician notified. Juven and mighty shakes ordered with meals to aid in wound healing.</p> <p>On 3/27/24 at 11:08 A.M., Patient was seen for a DTI on her sacrum acquired by the hospital. This is now an unstageable. She always lays on her bottom. DTPI location: coccyx Size: 4 cm x 3.5 cm x 0.1 cm with moderate amount of serosanguineous drainage. Weekly wound assessment of unstageable sacral wound completed 3/27/24 by Wound NP and facility Wound Nurse. Wound was stalled with moderate amount of serosanguineous drainage, 100% slough to wound bed, wound debrided. Recommended continuing the use of Honey alginate (Manuka HD) to wound bed, secure with silicone border foam dressing related to fragile skin and moderate drainage, change daily. Turn and reposition every 2 hours from side to side. Rest in bed with low air loss mattress, heels floated. Juven twice daily and mighty shakes ordered with meals to aid in wound healing.</p> <p>On 4/2/24 at 11:45 A.M., Patient was seen for a DTI on her sacrum acquired by the hospital. She always lays on her bottom. DTPI location: coccyx Size: 4 cm x 3.5 cm x 1.5 cm with moderate amount of serosanguineous drainage. Community acquired pressure to sacral area. Improving despite measurements. Sacral wound culture showed Staph Aureus (is a type of germ that about 30% of people carry in their noses). Receiving doxycycline 100 (milligrams) mg twice daily for 10 days. PCP noted rectal fistula with drainage upon inspection. Will continue use of Dakin's moistened fluffed gauze to wound bed, secure with bordered gauze, change every shift.</p> <p>On 4/10/24 at 12:35 P.M., Patient was seen for a DTI on her sacrum acquired by the hospital. On 3/27/24, this is now an unstageable. She always lays on her bottom. On 4/10/24, her sacrum was now a stage IV (The Center for Medicare and Medicaid Services defined a Stage 4 pressure ulcer as: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). DTPI location: coccyx Size: 4 cm x 3.3 cm x 1.2 cm with moderate amount of serosanguineous drainage. Improving despite measurements. Continue doxycycline 100 (milligrams) mg twice daily. Wound measurements were done by 2 different nurses which may explain the difference in calculations. Denies any pain. Will change treatment to Manuka (honey alginate) to wound bed, secure with bordered gauze, and change daily.</p> <p>On 4/17/24 at 1:27 P.M., Patient was seen for a DTI on her sacrum acquired by the hospital. On 3/27/24, this is now an unstageable. She always lays on her bottom. On 4/10/24, her sacrum was a stage IV. DTPI location: Coccyx Size: 4 cm x 3 cm x 1.2 cm with moderate amount of serosanguineous drainage. Improving despite measurements. Denies any pain. Changed treatment to Manuka (honey alginate) to wound bed, secure with bordered gauze, and change daily.</p> <p>Wound 2</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/27/24 at 4:34 P.M., Patient noted for new Pressure ulcer. Location: right heel. Size: 2.8 cm x 2 cm x 0.1 cm. Pressure ulcer staging: Stage II (The Center for Medicare and Medicaid Services defined a Stage 2 pressure ulcer as: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister). Recommended xeroform to wound bed, secure with silicone border foam dressing, change every other day (QOD), to wear derma saver boots to bilateral feet while in bed. turn and reposition every 2 hours from side to side. Rest in bed with low air loss mattress, heels floated. Juven twice daily and mighty shakes with meals ordered to aid in wound healing.</p> <p>On 4/2/24 at 11:45 A.M., History of Present Illness (HPI) does not indicate resident has pressure on her right heel, but addresses it in the wound assessment. Pressure ulcer location: right heel. Size: 3 cm x 2 cm x 0.1 cm with scant amount of serous drainage. Unstageable pressure area to right heel. Weekly wound assessment of pressure areas to right heel and sacral area completed 4/3/24 by Wound NP and facility Wound Nurse. Recommended Manuka (honey alginate) cut to size to wound bed, secure with bordered gauze. Heels floated, rest in bed with low air loss mattress, turn and reposition protocol. Appetite was good, received supplements and Juven to aid in healing.</p> <p>On 4/10/24 at 10:36 A.M., Patient was seen on 4/10/24, her right heel now a stage IV. Pressure ulcer location: right heel. Size: 2 cm x 1.5 cm x 0.1 cm with scant amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of pressure areas to right heel and sacral area completed 4/10/24 by Wound NP and facility Wound Nurse. Wound measurements were done by 2 different nurses which may explain the difference in calculations. Recommended cleanse with wound cleanser, apply Manuka (honey alginate) cut to size to wound bed, secure with bordered gauze. Heels floated, rest in bed with low air loss mattress, turn and reposition protocol. Appetite is good, received supplements and Juven to aid in healing.</p> <p>On 4/17/24 at 1:27 P.M., Patient was seen on 4/10/24, her right heel now a stage IV. Pressure ulcer location: right heel. Size: 0.8 cm x 1.2 cm x 0.1 cm with scant amount of serosanguineous drainage. Improving without complications. Weekly wound assessment of pressure areas to right heel and sacral area completed 4/17/24 by Wound NP and facility Wound Nurse. Recommended cleanse with wound cleanser, apply Manuka (honey alginate) cut to size to wound bed, secure with bordered gauze. Heels floated, rest in bed with low air loss mattress, turn and reposition protocol. Appetite is good, received supplements and Juven to aid in healing.</p> <p>On 4/17/24 at 10:38 A.M., wound care performed by the facility Wound Nurse and Wound Nurse Practitioner (NP) was observed. The Wound Nurse indicated Resident 26 came to facility with the sacral wound but it was not getting better. She indicated the Primary Care Physician (PCP) recently noticed drainage from rectal fistula and indicated it was feeding it. The Wound NP indicated the right heel was a facility acquired stage IV pressure ulcer. She measured the wound as length 1.2 x width 1.8cm x depth 0.1 cm, sprayed it with lidocaine and debrided the wound. Then she performed wound care on the sacral wound. She measured it as length 4.5 cm x width 3cm. She indicated it was looking better, sprayed lidocaine and debrided the wound. Both wounds lacked signs and symptoms of redness, odor, drainage, and swelling and were dressed as ordered prior to and after wound care. The observations at that time did not meet defining criteria for a stage IV wound.</p> <p>On 4/19/24 at 7:30 A.M., Resident 64 was observed laying on her back asleep in her bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/19/24 at 7:45 A.M., Resident 64 was observed with the head of her bed elevated, sitting in bed, and eating breakfast. At that time, staff indicated her meal ticket did not say Resident 64 was to have any supplements, so she doesn't know if she was supposed to have some or not. Resident noted to have heel protectors on both feet and heels floating. She was covered with sheet and blanket up to her waist.</p> <p>During a continuous observation on 4/19/24 from 8:05 A.M. to 10:15 A.M., the following was observed:</p> <p>On 4/19/24 at 8:05 A.M., Resident 64 was observed sitting in her bed as she was when she was eating breakfast.</p> <p>On 4/19/24 from 8:39 A.M. to 9:51 A.M., Resident 64 was observed with her eyes closed, sitting in her bed as she was when she was eating breakfast.</p> <p>On 4/19/24 at 9:51 A.M., Certified Nurse Aide (CNA) 34 went into room and answered the call light of Resident 64's roommate. She did not attend to Resident 64 who was observed sitting in her bed as she was when she was eating breakfast.</p> <p>On 4/19/24 at 9:57 A.M., Qualified Medication Aide (QMA) 19 entered the room and talked to Resident 26's roommate. She did not attend to Resident 64 who was observed sitting in her bed as she was when she was eating breakfast.</p> <p>On 4/19/24 at 10:00 A.M., CNA 34 walked past Resident 64's room. She was observed sitting in her bed as she was when she was eating breakfast.</p> <p>On 4/19/24 at 10:03 A.M., QMA 19 came into Resident 64's room to give roommate medication but did not attend to Resident 64 who was observed sitting in her bed as she was when she was eating breakfast.</p> <p>On 4/19/24 at 10:05 A.M., CNA 34 walked past Resident 64's room who was observed sitting in her bed as she was when she was eating breakfast.</p> <p>On 4/19/24 at 10:07 A.M., CNA 34 and QMA 19 walked past Resident 64's room who was observed sitting in her bed as she was when she was eating breakfast.</p> <p>On 4/19/24 at 10:15 A.M., Resident 64 was observed sitting in her bed as she was when she was eating breakfast.</p> <p>During an interview on 4/22/24 at 8:51 A.M., Licensed Practical Nurse (LPN) 16 indicated she came to the facility with the coccyx wound, but it kept getting worse until the PCP found the rectal fistula and they figured out that was where the drainage was coming from. Now it's getting better. The wound on her heel started here possibly from her rubbing her heels on her sheets while she was laying in bed.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Lincoln Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 402 19th Street Tell City, IN 47586	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/22/24 at 8:56 A.M., CNA 80 indicated she was aware that Resident 64 had pressure ulcers. She wasn't sure what they were doing for them because the nurses provided the treatments. At that time, she indicated she liked to sit in her bed but did get into her wheelchair at times.</p> <p>During an interview on 4/22/24 at 9:12 A.M., the Director of Nursing (DON) indicated Resident 64's wounds would stay staged as stage IV until they heal, despite improvement. At that time, she indicated staff were repositioning her off her wound and keeping heel boots on, and floating her heels while she was in bed.</p> <p>38770</p> <p>2. On 4/16/24 at 11:02 A.M., Resident 23's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, traumatic brain injury, and anxiety. The most recent Quarterly and State Optional MDS Assessment, dated 3/24/24, indicated a severe cognitive impairment, and one stage 3 pressure ulcer present on re-entry. Resident 23 required extensive assistance of two staff for bed mobility and transfers. Resident 23 returned from a hospitalization on [DATE].</p> <p>Physician orders included, but were not limited to:</p> <p>Cleanse sacral area with wound cleanser, pat dry, apply polymem pink (an absorbent dressing) to skin breakdown and redness, cover with sacral border dressing and notify MD of deterioration daily, once a day, dated 4/13/24.</p> <p>Lantiseptic Skin Protectant Ointment 50 % (Skin Protectant) apply to buttocks topically every day and night shift for redness, dated 2/22/24.</p> <p>A current risk for pressure ulcers care plan, updated on 3/5/24 to reflect a current stage 3 sacral pressure ulcer, included but was not limited to, the following interventions:</p> <p>Treatments as ordered, dated 1/11/24.</p> <p>Turning and repositioning every 2 hours and as needed, dated 1/11/24.</p> <p>Skin and wound notes from the Nurse Practitioner (NP) included, but were not limited to, the following:</p> <p>1/24/24 Bilateral buttocks with IAD. Cleanse with soap and water, apply barrier cream to base of the wound, leave open to air, change twice a day and as needed.</p> <p>1/31/24 Bilateral buttocks with IAD measuring 0x0x0 (cm). Cleanse with soap and water, apply barrier cream to base of the wound, leave open to air, change twice a day and as needed.</p> <p>2/7/24 Bilateral buttocks with IAD measuring 0x0x0 (cm). Cleanse with soap and water, apply barrier cream to base of the wound, leave open to air, change twice a day and as needed.</p> <p>2/14/24 Bilateral buttocks with IAD measuring 0x0x0 (cm). Cleanse with soap and water, apply barrier cream to base of the wound, leave open to air, change twice a day and as needed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2/28/24 Stage 3 pressure ulcer to sacrum measuring 5x5x0.1 (cm). Cleanse with soap and water, apply barrier cream to base of the wound, leave open to air, change twice a day and as needed. (A Stage 3 pressure ulcer as defined by the Center for Medicare and Medicaid Services is full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). The observation at that time did not meet defining criteria for a stage 3 wound.</p> <p>3/6/24 Stage 3 pressure ulcer to sacrum measuring 6x3x0.1 (cm). Cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered gauze and change twice a day and as needed.</p> <p>3/13/24 Stage 3 pressure ulcer to sacrum measuring 6x6x0.1 (cm). Cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered gauze and change twice a day and as needed.</p> <p>3/20/24 Stage 3 pressure ulcer to sacrum measuring 7x6x0.1 (cm). Cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered gauze and change twice a day and as needed.</p> <p>3/27/24 Stage 3 pressure ulcer to sacrum measuring 6x5x0.1 (cm). Cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered gauze and change twice a day and as needed.</p> <p>4/17/24 Stage 3 pressure ulcer to sacrum measuring 4x1.5x0.1 (cm). Cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered gauze and change daily and as needed.</p> <p>Skin only evaluations from the wound nurse included, but were not limited to, the following:</p> <p>2/22/24 Open lesion needs review. Right buttock measuring 3.5x1.3 (cm).</p> <p>4/4/24 Stage 3 pressure ulcer to buttocks measuring 6x4.5x0.1 (cm).</p> <p>Hospital records dated 4/10/24 indicated Resident 23 was admitted to the hospital on 4/9/24 with an existing sacral pressure ulcer measuring 3x3x<0.1.</p> <p>Resident 23's clinical record lacked a re-entry sacral wound assessment on 4/12/24.</p> <p>On 4/17/24 at 9:34 A.M., the NP and wound nurse were observed to perform a dressing change for Resident 23's sacral pressure ulcer. The area measured 4x1.5 (cm). The wound nurse cleansed the wound with wound cleanser, pat dried the area, applied two medihoney pads that the wound nurse indicated contained calcium alginate also, and applied a foam border. At that time, the NP indicated she wanted the order changed to use medihoney, as the facility did not use polymem dressings that was currently ordered.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/18/24 at 9:40 A.M., Licensed Practical Nurse (LPN) 42 was observed to perform a dressing change for Resident 23's sacral pressure ulcer. At that time, she indicated the order had been updated that morning and would be using medihoney on the wound. LPN 42 removed the soiled dressing, dated 4/17/24, cleansed the area with wound cleanser and let air dry. LPN 42 then placed two pads of medihoney dressing on top of each other on the wound bed. The red areas surrounding the wound were not covered with medihoney. A foam border was placed over the entire area. At that time, LPN 42 indicated the medihoney should cover all red areas per the order. At that time, the wound was observed as open with area in the middle beefy red. The surrounding area was pink and very little pink drainage was observed.</p> <p>On 4/18/24 at 10:00 A.M., Resident 23's record was reviewed a second time. Current orders included, but were not limited to, the following:</p> <p>Cleanse sacral area with wound cleanser, pat dry, apply honey alginate to skin breakdown and redness, cover with border foam dressing and notify MD of deterioration daily, dated 4/18/24.</p> <p>On 4/18/24 at 10:50 A.M., the wound nurse indicated she believed Resident 23 has had a recent decline in overall status, although no decline had been identified in any other areas other than the pressure areas. She indicated Resident 23 was totally dependent on staff for all activities of daily living (ADLs) and had been that way for a long time now. She indicated the area on the sacrum had been there for over a year now, and had healed and re-opened.</p> <p>On 4/19/24 at 6:30 A.M., Resident 23 was observed lying on her back in bed.</p> <p>During a continuous observation on 4/22/24, Resident 23 was not turned/repositioned from 4:35 A.M. until 6:50 A.M.</p> <p>On 4/22/24 at 10:25 A.M., a non-dated current Pressure Injury Prevention policy was provided and indicated Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them</p> <p>3.1-40(a)(1)</p> <p>3.1-40(a)(2)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent accidents for 1 of 3 residents reviewed for falls. Interventions put into place after falls were not evaluated and modified and interventions were not followed for a resident at risk for falls resulting in multiple falls. (Resident 26)</p> <p>Finding includes:</p> <p>On 4/15/24 at 9:47 A.M., Resident 26 was observed laying in her lowered (but not lowest position)bed. Her call light was wrapped around hook on the wall above the head of bed. Resident 26 indicated she wanted to get out of bed.</p> <p>On 4/15/24 at 9:50 A.M., Resident 26 told staff, I need to get up. I have a hair appointment at 10. Staff told the resident, Hang on, let me check. and left the room. Resident uncovered, sat bedside, was restless, and repeating, I need to get up.</p> <p>On 4/15/24 at 9:54 A.M., staff came back to the room and notified resident that her hair appointment wasn't until the next day and left the resident's room.</p> <p>On 4/15/24 2:14 P.M., Certified Nurse Aide (CNA) 52 was observed putting Resident 26 in bed and telling the resident, Stay in bed. Try to get some sleep. The call light was not moved from the hook above the head of the bed where it was observed earlier.</p> <p>On 4/15/24 at 2:18 P.M., Resident 26 was observed getting out of her bed, stood by her wheelchair, and started to get in it. Once alerted, CNA 52 came back into the room, helped the resident get back in her wheelchair, and took the resident up to sit by the nurse's station.</p> <p>On 4/18/24 at 1:19 P.M., Resident 26 was observed sleeping in bed and her call light was laying over the raised bedside table with the button laying towards the roommate.</p> <p>On 4/19/24 at 7:49 A.M., CNA 80 was observed taking Resident 26 to her room from the dining room in her wheelchair and laying her down in her bed without toileting the resident. Her call light was laying on the floor between her and her roommate's bed. The bed was in lowered, but not in lowest position.</p> <p>On 4/19/24 at 8:20 A.M., the Director of Nursing entered Resident 26's room, lowered the bed to the lowest position while resident was asleep, and placed her call light in reach.</p> <p>On 4/18/24 at 10:04 A.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety, weakness and Alzheimer's disease. Resident 26 was admitted on [DATE].</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/19/24, indicated Resident 26's cognition was severely impaired and she was an extensive assist of 2 staff for bed mobility and toileting, an extensive assist of 1 staff for transfers. Resident 26 had 2 or more falls, 1 with injury.</p> <p>A current Falls Care Plan, dated 11/26/23 included, but was not limited to, the following interventions:</p> <p>15 minute checks x 3 days, initiated 3/21/24</p> <p>call light within reach, initiated 11/26/23</p> <p>resident to be in low bed, initiated 12/8/23</p> <p>Toilet plan: Toilet before and after meals, at bedtime and every 2 hours through night and as needed, 12/1/23</p> <p>Wearing of appropriate footwear, 11/26/23</p> <p>Fall Risk Assessments were reviewed from 11/22/23 through 4/16/24 and all of them indicated resident to be a high risk for falls.</p> <p>Progress notes were reviewed and included, but were not limited to, the following:</p> <p>On 12/6/23 at 9:47 P.M., Behavior Charting: Resident got up unassisted and was in hallway. Staff immediately went to get resident and assisted her into w/c [wheelchair]. Resident confused. Brought up by nurses desk. Repeatedly asking staff about writing them a check and when she can leave. Repeatedly standing up unassisted. Keeps stating she needs to leave because she has to go to work tomorrow. Unable to redirect. Resident had just been toileted and assisted back to bed .</p> <p>On 12/7/23 at 9:41 A.M., Change of Condition: Resident continues to be restless at night, goes to sleep and does not stay. Has been getting up unassisted and ambulating, gait very unsteady. Resident continues to be irritated in am (morning). Does have dementia .</p> <p>On 12/30/23 at 11:30 A.M., Change of Condition: Resident has been having increased episodes of confusion and anxiety. Has fell several times due anxiousness. When having periods of anxiety has become harder to redirect .</p> <p>On 1/7/24 at 6:30 P.M., Behavior Charting: Resident ambulated into dining room using bedside table for support. Resident attempting to open door to stairwell. Resident spilled liquids and bucket of colored pencils onto the floor while wheeling bedside table through dining room .</p> <p>Falls were reviewed from admission on 11/22/23 through 4/18/24. Resident 26 had the following 7 falls:</p> <p>Fall 1</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/1/23 at 9:30 A.M. Unwitnessed fall. Resident was sitting on the floor in her room in front of her wheelchair. Resident incontinent of urine at time of fall. Alert with confusion. Noted reddened area, measuring 4 (centimeters) cm x 2.6 cm to right clavicle area. A right clavicle and right shoulder STAT (immediately) x-ray was ordered and showed no fracture. Falls Care Plan was updated with an intervention to toilet resident before and after meals, at bedtime and every 2 hours through night and as needed, initiated 12/1/23.</p> <p>Fall 2</p> <p>On 12/7/23 at 8:30 P.M. Unwitnessed fall. Resident noted to be sitting on the floor on her bottom between her bed and her roommate's bed. When asked what happened, resident stated, I fell on my butt. Bed was in low bed position at time of fall. Falls Care plan was updated with an intervention to be in low bed, initiated 12/7/24.</p> <p>Fall 3</p> <p>On 12/29/23 at 6:55 P.M. Unwitnessed fall. Resident noted to be on the floor, barefoot, and on her bottom between resident's bed and roommate's bed. Upon speaking with roommate, roommate states that resident got up and stood next to her bed and then started to fall, grabbing the bedside table and taking it down with her. Resident often stands up without assistance. Confused at all times. Disoriented. Exhibits behaviors often. Intervention: 15 minute checks for 3 days (12/29/23 6:55 P.M. through 1/1/24 6:55 P.M.) 15 minute checks for this fall were reviewed and indicated they were performed every 15 minutes from 7:00 P.M. on 12/29/23 to 6:45 P.M. on 12/31/23. Then they weren't done until 1:15 A.M., 1:30 A.M., and 1:45 A.M., on 1/1/24 then not again until 5:45 A.M. and stopped.</p> <p>Fall 4</p> <p>On 12/29/23 at 8:20 P.M. Unwitnessed fall. Resident had fallen on the floor between her wheelchair and the side of the bed facing the door. Resident attempts to get up on her own often. Resident has unsteady gait requiring 1 assist with transfers and wheelchair for ambulation. Neurological checks provided were reviewed, but started at 8:55 P.M. and then not done again until 9:50 P.M. Falls Care Plan was updated with an intervention for nonskid strips to floor by bed on door side, initiated 12/29/23.</p> <p>Fall 5</p> <p>On 12/29/24 at 9:50 P.M. Unwitnessed fall. Resident laying barefoot on the floor in front of her wheelchair in front of the door. The wheelchair was not locked. Resident has been restless this night. Standing up and walking without assistance. Falls Care Plan was updated with an intervention for Dycem to wheelchair set, initiated 12/29/23.</p> <p>Fall 6</p> <p>On 1/24/24 at 8:29 P.M. Unwitnessed fall. Resident was found yelling out for help sitting next to the bed on the floor. Resident stated she attempted to transfer from the wheelchair to her bed. Resident has dementia and history of falls. Falls Care Plan was updated with an intervention not to be alone in room sitting in wheelchair, initiated 1/24/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Fall 7</p> <p>On 3/20/24 at 1:55 P.M. Unwitnessed fall. Resident found sitting on the floor barefoot next to bed. Resident stated she rolled out of bed. Falls Care Plan was updated with an intervention of 15 minute checks for 3 days, initiated 3/20/24. Documentation of the 15 minute checks was requested but not provided for this fall.</p> <p>During an interview on 4/22/24 at 8:48 A.M., staff indicated they were not sure why Resident 26 fell often but she did get up by herself a lot and had to go to the bathroom quite often. At that time, they indicated they weren't sure if there was an intervention in place for that. The roommate will use her call light and alert us if she sees her getting up, we keep her bed lowered, and check on her.</p> <p>During an interview on 4/22/24 at 9:03 A.M., the DON indicated she did lower the bed Resident 26 was laying in earlier that morning because the bed was low but not in the lowest position. She expected it to be in the lowest position possible. At that time, she indicated she also laid the call light next to the resident within her reach. She indicated Resident 26 could not use her call light, but it should still be made available to the resident. She indicated she did expect interventions on care plan to be followed.</p> <p>A current Accidents and Supervision Policy, revised February 2023, was provided on 4/22/24 at 10:25 A.M., by the DON and indicated . Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s) 2. Evaluating and analyzing hazard(s) and risk(s) 3. Implementing interventions to reduce hazard(s) and risk(s) 4. Monitoring for effectiveness and modifying interventions when necessary . ensuring interventions are based on results of the evaluation . consistent with relevant standards, including evidence-based practice . educating staff . a. ensuring that interventions are implemented correctly and consistently b. evaluating the effectiveness of interventions c. modifying or replacing interventions as needed d. evaluating the effectiveness of new interventions .</p> <p>3.1-45(a)</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>46416</p> <p>Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing sheets contained the required information daily for 5 of 5 days reviewed during the survey.</p> <p>Findings include:</p> <p>On 4/15/24 at 8:30 A.M., a staffing sheet was observed posted in the front entrance of the facility on the wall. The posted nurse staffing sheet lacked the facility name and actual hours worked the nursing staff worked was not clear on the posting.</p> <p>On 4/16/24 at 9:30 A.M., a staffing sheet was observed posted in the front entrance of the facility on the wall. The posted nurse staffing sheet lacked the facility name and actual hours worked the nursing staff worked was not clear on the posting.</p> <p>On 4/17/24 at 9:31 A.M., a staffing sheet was observed posted in the front entrance of the facility on the wall. The posted nurse staffing sheet lacked the facility name and actual hours worked the nursing staff worked was not clear on the posting.</p> <p>On 4/18/24 at 3:00 P.M., a staffing sheet was observed posted in the front entrance of the facility on the wall. The posted nurse staffing sheet lacked the facility name, correct census, and actual hours worked the nursing staff worked was not clear on the posting.</p> <p>On 4/19/24 at 11:30 A.M., a staffing sheet was observed posted in the front entrance of the facility on the wall. The posted nurse staffing sheet lacked the facility name and actual hours worked the nursing staff worked was not clear on the posting.</p> <p>During an interview on 4/19/24 at 2:30 P.M., the Scheduler provided the posted nurse staffing sheets and indicated it has the shifts of days (first column), evenings (second column), and night shifts (third column) but they are too dark to be readable. She was unaware the facility name needed to be filled out, and the way the times were listed, they were not able to be deciphered as the actual hours worked of nursing staff. She indicated she erased the census on the 4/18/24 sheet but forgot to rewrite it correctly.</p> <p>A current posted nurse staffing policy, dated 11/28/17, was provided on 4/22/24 at 1:07 P.M., by clinical support and indicated . 1. The facility must post the following information on a daily basis: i) Facility name . iii) The total number and the actual hours worked by . licensed and unlicensed nursing staff directly responsible for resident care per shift iv) Resident census .</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>38770</p> <p>Based on observation, interview, and record review, the facility failed to ensure palatable food was served for 1 of 1 meal tray reviewed.</p> <p>Finding includes:</p> <p>During the course of the survey, the following anonymous resident interviews were obtained:</p> <p>The food is horrid and temperatures are not what they should be.</p> <p>Half of the food is not worth eating.</p> <p>On 4/16/24 at 11:03 A.M., during the resident council meeting, the following anonymous resident interviews were obtained:</p> <p>We (the residents) have complained about the food but were told it was because corporate did the menus and restricted what the facility could have a choice of.</p> <p>Everything is overcooked and dry.</p> <p>On 4/22/24 at 8:10 A.M., a meal tray was obtained that contained oatmeal, a sausage patty, and a piece of french toast. All food items were bland and tasteless. The french toast had hard edges.</p> <p>On 4/22/24 at 9:54 A.M., the Dietary Manager indicated there had been no complaints about the taste of the food to her knowledge. She indicated sometimes french fries and french toast were troublesome due to not being steam table friendly, and often dry out. She indicated if any residents complained about the taste of the food, they would be offered seasonings such as salt and pepper.</p> <p>On 4/22/24 at 11:03 A.M., a current non-dated Food Preparation policy was provided and indicated Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature . Using spices or herbs to season food in accordance with recipes</p> <p>3.1-21(a)(1)</p> <p>3.1-21(a)(2)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>38770</p> <p>Based on observation, interview, and record review, the facility failed to accurately document care planned interventions for a resident. Restorative walking nursing tasks were not completed as documented for 1 of 2 residents reviewed for Activities of Daily Living (ADLs). (Resident 18)</p> <p>Findings include:</p> <p>On 4/15/24 at 10:39 A.M., Resident 18 indicated the therapy department had told her she needed to use her walker and walk as much as possible, but would need a staff member to walk with her. She indicated she had asked staff to assist her in the past and was told they were too busy. She indicated she had not asked since, as she did not want to bother anyone.</p> <p>On 4/19/24 at 10:30 A.M., Resident 18's clinical record was reviewed. Diagnosis included, but were not limited to, renal failure, heart failure, and depression. The most recent Annual and State Optional MDS (Minimum Data Set) Assessment, dated 2/22/24, indicated no cognitive impairment, active range of motion (AROM) was completed 7 of 7 days during the look back period for at least 15 minutes a day, and walking was completed 6 of 7 days. Resident 18 required limited assistance of 1 staff with transfers.</p> <p>A current restorative program in AROM to maintain current strength and range of motion (ROM) care plan included, but was not limited to, the following intervention:</p> <p>Performing AROM exercises while sitting to bilateral upper and lower extremities, 10 reps each plane with assistance of 1 for guidance and cues, dated 3/15/22.</p> <p>A current restorative program in walking to maintain current ability in walking on and off the unit care plan included, but was not limited to, the following intervention:</p> <p>Monitor and report changes in ROM ability, dated 3/15/22.</p> <p>Walking, assistance of 1 staff, dated 3/15/22.</p> <p>Walking on and off unit using walker or push wheelchair with assistance of 1 for supervision and safety cues for 50 to 100 feet twice a day, dated 3/24/22.</p> <p>Resident 18's clinical record indicated on 4/18/24 she had spent 15 minutes walking a total of 150 feet, and had spent 15 minutes performing AROM to bilateral upper and lower extremities, signed by Certified Nurse Aide (CNA) 17 on 4/18/24 at 6:08 A.M.</p> <p>Resident 18's clinical record indicated on 4/19/24 she had spent 15 minutes walking a total of 25 feet, and had spent 15 minutes performing AROM to bilateral upper and lower extremities, signed by CNA 50 on 4/19/24 at 7:17 A.M.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/18/24 at 8:45 A.M., CNA 17 indicated she hadn't walked with Resident 18 yet that morning, but planned to later that day.</p> <p>On 4/19/24 at 12:30 P.M., Resident 18 indicated a member of the therapy staff had been in her room that morning and watched her go to the bathroom and back with her walker. She indicated she did not walk in the hall alone or with staff, and did not do any exercises.</p> <p>On 4/19//24 at 12:40 P.M., CNA 50 indicated she sometimes walked with Resident 18 before dialysis on Monday, Wednesday and Friday, and sometimes after. She indicated most of the time Resident 18 was gone for dialysis by the time she got there in the mornings. At that time, CNA 50 indicated she had not seen Resident 18 yet that day as she had already left for dialysis by the time she got there that morning.</p> <p>On 4/22/24 at 6:37 A.M., Qualified Nurse Aide (QMA) 9 indicated staff should document tasks after they are performed just in case it's not correct or changes before it was documented.</p> <p>On 4/22/24 at 10:25 A.M., a current non-dated Documentation in Medical Record policy was provided and indicated Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care</p> <p>3.1-50(a)(2)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>38770</p> <p>Based on observation, interview, and record review, the facility failed to ensure for 1 of 2 residents reviewed for pressure ulcers and 1 of 1 residents observed for incontinence care. Staff did not use Enhanced Barrier Precautions (EBP) for a resident with an open wound. Staff did not use hand hygiene between dirty and clean tasks, did not lather before placing hands under water when washing their hands. (Resident 23, Resident 32)</p> <p>1. On 4/16/24 at 11:02 A.M., Resident 23's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most recent Quarterly MDS Assessment, dated 3/24/24, indicated a severe cognitive impairment, and a stage 3 pressure ulcer.</p> <p>A current risk for pressure ulcer care plan included, but was not limited to, the following intervention:</p> <p>Enhanced Barrier Precautions (EBP): gown and glove use during high-contact resident care activities related to open wound, dated 3/26/24.</p> <p>On 4/22/24 at 10:25 A.M., a copy of Resident 23's current orders was provided and lacked an order for EBP.</p> <p>On 4/19/24 at 8:14 A.M., Certified Nurse Aide (CNA) 8 was observed to enter Resident 23's room without a gown or gloves. A sign for EBP indicated staff should use gown and gloves with high contact care was posted outside the resident's door, as well as a cart just outside the room with personal protective equipment (PPE). CNA 8 touched the resident's cheeks and forehead with bare hands, pulled up the floor mat from the side of the bed and put it up, and left the room. CNA 8 came back to the room again without a gown or gloves and touched the resident again on her neck, making contact with the resident and her uniform top.</p> <p>On 4/19/24 at 9:35 A.M., the Infection Preventionist indicated staff should put on a gown and gloves for all residents on EBP anytime there was resident contact.</p> <p>45933</p> <p>2. During an observation on 4/19/24 at 9:27 A.M., CNA (Certified Nurse Aide) 24 provided incontinence care on Resident 32. CNA 24 used her gloved hands to clean Resident 32's bottom after he had had a bowel movement. At that time, she removed her gloves, and failed to perform hand hygiene before she donned new gloves. Then, she applied cream to the resident and failed to perform hand hygiene before she donned new gloves. She fastened the resident's brief, then removed gloves, put the bed rail down, placed the wipes in the drawer, and washed her hands. CNA 24 failed to lather her hands with soap.</p> <p>During an interview on 4/19/24 at 9:47 A.M., the IP (Infection Preventionist) indicated staff should sanitize or wash hands between dirty and clean tasks and hands should be scrubbed and lathered for 40 seconds.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>On 4/10/24 at 11:00 A.M., the Regional consultant provided an undated Personal Protective Equipment policy that indicated, .Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene .</p> <p>On 4/19/24 at 11:00 A.M., the Regional consultant provided an undated Hand Hygiene policy that indicated, . 5. Hand Hygiene technique when using soap and water: Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers .</p> <p>On 4/22/24 at 10:25 A.M., a current non-dated Enhanced Barrier Precautions policy was provided and indicated An order for enhanced barrier precautions will be obtained for residents with any of the following . Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) .</p> <p>3.1-18(b)</p> <p>3.1-18(l)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416</p> <p>Based on observation, interview and record review, the facility failed to ensure the call system was accessible to residents while in their bed. Resident call lights were not within reach while they were in their beds for 1 of 1 residents reviewed for a urinary tract infection, 1 of 2 residents reviewed for pressure ulcers, and 1 random observation. (Resident 64, Resident 51, Resident 17)</p> <p>Findings include:</p> <p>1. On 4/19/24 at 7:45 A.M., Resident 64 was observed sitting up in bed eating and her call light was laying on the floor between her bed and her roommate's bed. At that time, [NAME], was helping Resident 64 with meal set up and then left the room without moving the call light from the floor.</p> <p>On 4/16/24 at 10:52 A.M., Resident 64's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure, weakness, and atrial fibrillation. Resident 64 was admitted on [DATE].</p> <p>The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/25/24, indicated Resident 64 was cognitively intact and an extensive assist of 2 staff for bed mobility, transfers, and toileting.</p> <p>A current Falls Care Plan, dated 2/9/24, included, but was not limited to, the following intervention:</p> <p>call light within reach, initiated 2/9/24</p> <p>2. During a random observation on 4/16/24 at 8:39 A.M., Resident 51 was laying in her bed and the call light was wrapped around the bed rail on left side and the button was on the outside of the bed rail. When asked if she could push her call light button, the resident tugged on the cord and indicated, I don't know where it is. Usually it's laying on the blanket by me. When the resident continued to pull on it, she pulled the end out of the wall trying to get to it and indicated again, I don't know where it is.</p> <p>On 4/16/24 at 8:41 A.M., Certified Nurse Aide (CNA) 52 was observed responding to the call light, plugged the end back into the wall, was told Resident 51 pulled it out trying to find it, but she didn't move the call light from the bed rail.</p> <p>During an interview on 4/22/24 at 8:40 A.M., CNA 80 indicated Resident 51 and Resident 64 could use their call lights and it should be within reach and easily accessible for resident's to push the button.</p> <p>46882</p> <p>3. On 4/15/24 at 9:34 A.M., Resident 17 was observed sitting up in a wheelchair, eyes closed, bedside table in front of her, and no call light within reach.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/16/24 at 11:35 A.M., Resident 17 was observed lying in bed, head of the bed elevated with call light lying on cabinet next to bed out of reach of resident.</p> <p>On 4/17/24 at 8:31 A.M., Resident 17 was observed sitting up in wheelchair eating breakfast with call light behind resident out of reach.</p> <p>On 4/17/24 at 10:49 A.M., Resident 17 was observed lying in bed with head of bed elevated watching television. Call light was observed lying on cabinet next to bed out of reach of resident. When the resident was asked if she had a call light close to her to use, she looked at the bed control and asked Is this it?</p> <p>On 4/16/24 at 10:30 A.M., Resident 17's clinical records were reviewed. Diagnosis included but were not limited to, displaced fracture of olecranon process of right ulna, dementia, and urinary tract infection.</p> <p>The current Quarterly, State Optional MDS (Minimum Data Set) Assessment, dated 2/23/24, indicated Resident 17 was severely cognitively impaired and required extensive assistance of two for bed mobility, transfers and toilet use and limited assistance of one for eating.</p> <p>The current care plan for I have an ADL [Activities of Daily Living] self care deficit related to (specify) impaired mobility, limited ROM, pain; fracture right ulna, dementia, dated 12/11/2023, included, but was not limited to the following intervention, call light within reach, dated 12/11/23.</p> <p>The current care plan for I am at risk for falls r/t [related to] history of repeated falls with fracture, dated 12/11/23, included, but was not limited to the following intervention, call light within reach, dated 12/11/23.</p> <p>During on interview on 4/18/24 at 8:21 A.M., CNA 50 indicated all the residents on Station 1 could use the call light.</p> <p>During an interview on 4/19/24 at 1:47 P.M., LPN 25 indicated call lights should be clipped to clothing or bed sheets within reach of the resident.</p> <p>On 4/19/24 at 11:00 A.M., a current Call Light: Accessibility and Timely Response Policy, dated February 2023, was provided by the Regional Consultant which indicated .5. Staff will ensure the call light is within reach of resident and secured, as needed .</p> <p>3.1-19(u)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Lincoln Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 402 19th Street Tell City, IN 47586	

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46882</p> <p>Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and visitors for 4 of 4 rooms on A and B Halls and 2 of 2 shower rooms on A and B Halls tested for hot water. The water temperatures were above 120 degrees and a raised toilet seat was stored on the floor. (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], A Hall shower room, and men's shower room)</p> <p>Findings include:</p> <p>1. On 4/16/24 at 9:15 A.M., the water temperature in room [ROOM NUMBER]'s bathroom felt hot. The temperature was 121.4 degrees with the thermometer.</p> <p>On 4/19/24 at 8:25 A.M., the water temperature in room [ROOM NUMBER]'s bathroom felt hot. The temperature was 125.5 degrees with the thermometer then immediately dropped back down stopping at 105 degrees.</p> <p>On 4/19/24 at 10:53 A.M., the water temperature in room [ROOM NUMBER]'s bathroom was 132.5 degrees with the thermometer. Administrator was notified and indicated she would notify the maintenance man immediately.</p> <p>On 4/19/24 12:28 P.M., the water temperature in room [ROOM NUMBER]'s bathroom was 101.1 degrees with the thermometer.</p> <p>During an interview on 4/19/24 at 12:31 P.M., Qualified Medication Aide (QMA) 37 indicated she had no problems with the water getting too hot or fluctuating today while giving showers on Cottonwood Lane Station B Hall. She indicated there was only one shower left to do.</p> <p>During an interview on 4/19/24 at 10:58 A.M., the resident in the adjoining room to room [ROOM NUMBER], who shared a bathroom, indicated he had never been burned by the hot water. He indicated he could take himself to the bathroom and if the water felt too hot he would turn the cold water on.</p> <p>45933</p> <p>2. During an observation on 4/15/24 at 9:45 A.M., an uncovered, raised toilet seat sat on the bathroom floor under the sink.</p> <p>The same was observed on 4/19/24 at 11:00 A.M.</p> <p>During an interview on 4/22/24 at 9:14 A.M., CNA (Certified Nurse Aide) 52 indicated she was unsure of how a raised toilet seat should be stored in the bathroom, but it should not be placed directly on the ground.</p> <p>3. On 4/15/24 between 12:07 P.M. and 12:14 P.M., the following water temperatures were obtained on the A Hall and B Hall:</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>room [ROOM NUMBER] (shared with room [ROOM NUMBER])-- 124.1 degrees Fahrenheit</p> <p>room [ROOM NUMBER] (shared with room [ROOM NUMBER])--124.5 degrees Fahrenheit</p> <p>Men's shower room-- 123.9 degrees Fahrenheit</p> <p>A hall shower room-- 122.2 degrees Fahrenheit</p> <p>During an interview on 4/15/24 at 12:26 P.M., CNA 48 indicated she noticed the water temperatures felt overly hot, but she had not reported it.</p> <p>On 4/15/24 between 12:53 P.M. and 12:58 P.M., the following water temperatures were obtained by the Maintenance Director on the A Hall and B Hall with the facility's thermometer:</p> <p>room [ROOM NUMBER]--124.8 degrees Fahrenheit</p> <p>room [ROOM NUMBER]--124.3 degrees Fahrenheit</p> <p>Men's shower room--118 degrees Fahrenheit</p> <p>A Hall shower room--123.4 degrees Fahrenheit</p> <p>On 4/19/24 between 11:00 A.M. and 11:05 A.M., the following temperatures were obtained on the A Hall and B Hall:</p> <p>room [ROOM NUMBER]--126 degrees Fahrenheit</p> <p>room [ROOM NUMBER]-- 110.5 degrees Fahrenheit</p> <p>Men's shower room-- 129.7 degrees Fahrenheit</p> <p>A Hall shower room-- 129.1 degrees Fahrenheit</p> <p>During an interview on 4/15/24 at 12:49 P.M., the Maintenance director indicated he randomly checks water temperatures in a few rooms a day. At that time he indicated he was unsure what the water temperature should be, and the thermometer was a brand new one. The thermometer's are used until the battery dies and then the facility replaced them.</p> <p>During an interview on 4/22/24 at 11:18 A.M., the Maintenance Director indicated a mixing valve had to be replaced last Thursday due to issues with the water temperatures. He indicated the water temperature should not be less than 100 degrees or more than 120 degrees.</p> <p>On 4/15/24 at 2:28 P.M., the Administrator provided the Safe Water Temperatures, revised February 2023 policy, that indicated, .5. Water temperatures will be set to a temperature of no more than 120 degrees F [Fahrenheit] .</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/22/24 at 10:25 A.M., the DON (Director of Nursing) provided an undated Safe and Homelike Environment policy that indicated, .Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living .</p> <p>3.1-19(e)</p>		