STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE – GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00377204. Complaint IN00377204 - Substantiated. Federal/state deficiencies related to the allegations are cited at F-684, F-689 & F-842. Survey dates: April 12 & 13, 2022 Facility number: 000165 Provider number: 155264 AIM number: 100288220 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 12 Medicaid: 51 Other: 22 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 20, 2022	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of correction was prepared and executed as a means to improve the quality of care and comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to this survey.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

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

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review the facility failed to implement plan of care and failed to monitor a resident's cardiac monitor for 1 of 3 residents reviewed for quality of care (Resident C). Finding include: Review of the record of Resident C on 4/12/22 at 2:32 p.m., indicated the resident's diagnoses included, but were not limited to, atrial fibrillation, non rheumatic aortic valve stenosis, right bundle branch block, chronic diastolic congestive heart failure, cerebral infarction, arteriosclerotic heart disease of native coronary and chronic obstructive pulmonary disease. The discharge orders and instructions from the Major Medical Hospital for Resident C, dated 10/9/21, indicated the resident was discharged with a cadionet/biotelemetry monitor. The cardiac monitor was to remain on the resident at all times unless changing the patch, charge the sensor every 3 days for about 1 1/2- 2 hours, charge the monitor every night, the device was water resistant not water proof, avoid spraying water directly onto the sensor and very hot showers. The discharge directions came with a phone number for arrhythmia services if there were any questions. The admission assessment for Resident C, dated 10/9/21, indicated the resident had a cardiac device of a heart monitor. The local hospital provider note for Resident C, dated 10/11/21, indicated the resident had an	F 0684	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident C: no longer resides at the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents with orders for specialty monitoring equipment have the potential to be affected by the same deficient practice. The facility completed an initial audit of all residents orders in the past 15 days to ensure any new orders for specialty monitoring equipment have been followed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education Licensed Nursing staff were educated on the guideline for following physician orders. See Attachment 1A On-going monitoring DNS or Designee will review physician orders daily during clinical review for initiating and following a physician's order for specialty monitoring equipment. These reviews to be conducted 5 times weekly x 4 weeks, then 3	05/06/2022

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	acute care visit due to post op cardiac valve replacement. The resident had a heart monitor in place for 30 days. The plan of care, dated 10/11/21, indicated the resident had impaired cardiovascular status related to arteriosclerotic heart disease, cardiac dysrhythmia's, hypertension and post-op cardiac surgery. There were no interventions listed. During an interview with Resident C's family on 4/12/22 at 3:10 p.m., indicated they had received a phone call from the Major Medical hospital cardiac monitoring department while Resident C resided at the facility and they reported they had not received recordings from the resident's heart monitor for 4 days. During an interview with the Director Of Nursing (DON) on 4/13/22 at 2:50 p.m., indicated there was no documentation the facility had a plan of care or monitoring of Resident C's heart monitor while he was at the facility. The DON indicated the admitting nurse should have implemented cardiac monitoring for the resident and implemented the hospital discharge orders. The DON indicated the protocol for heart monitors were the nurse would be checking the heart monitor at least once a shift and the CNA's should visualize the heart monitor when care was provided. This Federal tag relates to Compliant IN00377204. 3.1-37		times weekly x 4 weeks, then weekly x 4 months. See Attachment 1B How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0689 SS=D	483.25(d)(1)(2) Free of Accident			

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Bldg. 00	Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review the facility failed to complete follow up monitoring and implement appropriate interventions before and after residents fall for 2 of 4 residents reviewed for accidents (Resident C and Resident D). Findings include: 1.) Review of the record of Resident C on 4/12/22 at 2:32 p.m., indicated the resident's diagnoses included, but were not limited to, atrial fibrillation, non rheumatic aortic valve stenosis, right bundle branch block, chronic diastolic congestive heart failure, cerebral infarction, arteriosclerotic heart disease of native coronary and chronic obstructive pulmonary disease. The post fall evaluation for Resident C, dated 10/9/21 at 3:35 p.m., indicated the resident had a witnessed fall in his room. The resident tipping self back in chair. The reason for the fall was tipping self back in chair. The resident acquired a skin tear to his right elbow. The resident was sitting in a transport wheelchair and using feet to tip self backwards. The resident was instructed to not do that as it may result in going backwards onto the floor. The resident then tipped self again and went backwards in the chair to the floor. The resident's current medical condition was he was slightly confused.	F 0689	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident C: No longer resides at the facility Resident D: Clinical Record was reviewed and updated to reflect resident's risk for falls and interventions in place per plan of care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents at risk for falls or with actual fall events have the potential to be affected by the same deficient practice. Initial audit DNS or Designee completed a 15 day look back of all residents with fall events to ensure their clinical record had complete follow up monitoring and implementation of appropriate interventions before and after resident's fall. What measures will be put into place and what systemic changes	05/06/2022

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	The fall risk assessment for Resident C, dated 10/9/21 indicated the resident was at risk for falls. The Admission Minimum Data Set (MDS) assessment for Resident C, dated 10/16/21, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance of one person to transfer. The resident had a fall prior to admission to the facility and one fall at the facility. The plan of care for Resident C, dated 10/11/21, indicated the resident was at risk for falls related to new environment, medication use and post op surgery. There were no interventions implemented related to the transport wheelchair. During an interview with Resident C family on 4/12/22 at 3:10 p.m., indicated the resident had a fall out of a transport wheelchair and the facility continued to use the transport wheelchair after he had tipped back in onto the floor. During an interview with the Director Of Nursing (DON) on 4/13/22 at 2:50 p.m., indicated on 10/9/21 when Resident C began tipping himself back in the transport wheelchair instead of instructing the resident to stop doing it, the staff should have transferred him into a recliner or more stable chair. The DON indicated she was unable to find any fall follow up assessment after the resident fell and there was no intervention implemented after the resident fell. 2. The clinical record for Resident D was reviewed on 4/12/2022 at 3:32 p.m. The medical diagnoses included, but were not limited to, abnormalities of gait and mobility, muscle weakness, and benign proximal vertigo.		will be made to ensure that the deficient practice does not recur Education Licensed Nursing staff were educated on the Fall Prevention Program guideline to include but not limited to: documentation of Post fall assessment, physician and family notification, updating the plan of care with interventions. See Attachment 2A and Attachment 2B On-going monitoring DNS or Designee will review all fall events during clinical review to ensure post fall follow up is documented per the Fall Prevention Program Guidelines. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. See Attachment 2C How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	An Annual Minimum Data Set Assessment, dated 3/7/2022, indicated that Resident D had mild cognitive impairment, requires extensive assistance of one staff member for transferring, utilized a wheelchair for mobility, and had unsteady balance that was only able to stabilize with human assistance. An activities of daily livings care plan, dated 4/5/2021 with a revision date of 4/23/2021, indicated that Resident D requires assistance of 1-2 staff members as needed with transferring. A fall care plan, dated 4/5/2021 with a revision date of 4/23/2021, indicated that Resident D the intervention dated 1/10/2022 of ensuring the beside chair is not left in the reclining position. A nursing progress note, dated 1/10/2022 at 12:15 a.m., indicated that Resident D slid out of her chair to the floor on her buttocks and "Due to early hour family to be notified in the am." An associated nursing assessment, entitled "COMS - Post Fall Evaluation", was documented on 1/10/2022 at 12:15 a.m. An associated nursing assessment, entitled "Fall Risk Emulations - V 2" was documented on 1/10/2022 at 12:15 a.m. The assessment scored Resident D at a 7 as a low/moderate risk. A nursing progress note, dated 1/10/2022 at 1:08 p.m., indicated Resident D has no pains or changes due to sliding off chair. No further nursing notes or nursing assessments for post fall were documented.			

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	An interview with the Director of Nursing (DON) on 4/13/2022 at 2:50 p.m., indicated that after a fall the nursing staff should be assessing the resident at least once a shift for 72 hours. The staff should be documenting this in either an assessment or a progress note. She indicated there was only one follow up progress note for Resident D. A policy entitled, "Fall Prevention Program", was provided by the DON on 4/12/2022 at 3:40 p.m. The policy indicated that when a resident experiences a fall, the facility will: assess the resident, complete a post-fall assessment, complete an incident report, notify the physician and family, review the resident's care plan and update as indicated, document all assessments and actions, and obtain witness statements in the case of injury. This Federal tag relates to Compliant IN00377204. 3.1-45(a)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted			

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	professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or			

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	(iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review the facility failed to document new admission residents personal belongings on the inventory sheet for 2 of 3 residents reviewed for items (Resident E and Resident F). Finding include: Review of the record of Resident E on 4/13/22 at 10:35 a.m., indicated the resident's diagnoses included, but were not limited to, cellulitis of the right leg, kidney failure and anxiety. The resident was admitted to the facility on 2/23/22 and discharged 3/11/22. The resident's inventory sheet was blank. Review of the record of Resident F on 4/13/22 at 10:45 a.m.., indicated the resident's diagnoses included, but were not limited to, degeneration of the lumbar, muscle weakness, emphysema, anxiety and depression. The resident was admitted to the facility on 3/3/22 and discharged	F 0842	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident E: No longer resides at the facility Resident F: No longer resides at the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents that reside at the facility have the potential to be affected by the same deficient practice. Initial audit Medical Records or designee completed an audit of all current resident medical records to ensure all residents have a	05/06/2022

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	on 3/7/22. The resident's personal belonging inventory sheet was blank. Interview with the Director Of Nursing on 4/13/22 at 11:15 a.m., indicated the CNA's were responsible to document Resident E and Resident F's personal belonging on their inventory sheet. The resident's personal inventory list policy provided by the Administrator on 4/13/22 at 2:20 p.m., indicated the assessment guidelines may include, but were not limited to, the need for clothing, protection of valuable items, need for the resident to have familiar items in his/her environment and the ability to take care of their personal belongings. The purpose of the policy was to protect the resident's personal property and prevent loss. The procedure included, but were not limited to, document all items on thee resident's inventory list and have the resident or resident representative sign the completed inventory list. The Federal tag relates to Complaint IN00377204. 3.1-50(a)		completed Inventory Sheet on record. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education Licensed Clinical Staff, C.N.A. Staff and Medical Records were educated on the guideline for Residents Personal Belongings to include the process for completion of Inventory Sheet. On-going monitoring Medical Records or Designee will complete an audit of all newly admitted residents for completion of an Inventory Sheet. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	