STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155367	A. BUILDING 00 B. WING	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE -SYCAMORE VILLAGE CARE CENT	2905 W SYCAMORE ST KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00439869, IN00443079, IN00446650 and IN00448981. Complaint IN00439869-Federal/State deficiencies related to the allegations are cited at F755. Complaint IN00443079-No deficiencies related to the allegations are cited. Complaint IN00446650-No deficiencies related to the allegations are cited. Complaint IN00448981-No deficiencies related to the allegations are cited. Survey dates: December 12, 13, 16, 17, 18, and 19, 2024. Facility number: 000258 Provider number: 155367 AIM number: 100289160 Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 1 Medicaid: 84 Other: 11 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	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 continuously 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Hestand RN	Director of Nursing	01/13/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Quality review was completed on December 30, 2024.			
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on interview and record review, the facility failed to ensure the SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) forms were accurately completed for 2 of 3 residents discharged from Medicare services and remained in the facility. (Resident 45 and 91) Findings include: 1. The Advance Beneficiary Notice of Non-coverage (ABN) form for Resident 45 was reviewed on 12/13/24 at 2:03 p.m. On 10/8/24, the facility provided Resident 45 the ABN form which indicated their coverage was ending on 10/10/24. The form was blank in response to the options of coverage for physical therapy and occupational therapy. The blank section of the ABN form read as follows: "Read this notice to make an informed decision about your care, ask any questions and choose an option below about whether to receive therapy. Check only one box. We cannot do this for you." There were no options chosen for this section of the form. 2. The ABN form for Resident 91 was reviewed on 12/13/24 at 2:03 p.m. On 12/4/24, the facility provided Resident 91 the	F 0582	**F 582 D Medicaid/Medicare Coverage/Liability Notice** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 45 Resident clinical record was reviewed and reflects resident current services and plan of care. Resident 91 Resident clinical record was reviewed and reflects resident current services and 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** Initial audit : Facility completed a 14 day look back of all ABNs completed during that time frame to ensure the SNF-ABN(Skilled Nursing Facility Advanced Beneficiary Notice) forms are accurately completed for residents discharged from Medicare services and remain in the facility.	01/13/2025

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BRICKYARD HEALTHCARE -SYCAMORE VILLAGE CARE CENT	2905 W SYCAMORE ST KOKOMO, IN 46901

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	ABN form which indicated their coverage was ending on 12/2/24. The form was blank in response to the options for remaining in the facility. The blank section of the SNF ABN form read as follows: "Read this notice to make an informed decision about your care, ask any questions and choose an option below. Check only one box. We cannot do this for you." There were no options chosen for this section of the form. During an interview, on 12/16/24 at 10:48 a.m., the Business Office Manager (BOM) indicated the Social Service department was responsible for assisting the residents to complete the forms. The Business Office would only assist with completion of the forms if Social Services was not present at the time the forms were to be completed. She indicated if one form had an option chosen, then she would assume all the forms would have an option chosen. During an interview, on 12/16/24 at 10:53 a.m., the Social Service Director indicated one of the three options for coverage should have been chosen and should not have been blank. A current facility policy, titled "Advance Beneficiary Notices," dated 2024 and received from the Executive Director on 12/19/24 at 12:15 p.m., indicated "...Contents of the form shall comply with related instructions and regulations regarding the use of the form...The Business Office Manager, or designee, is responsible for issuing notices...Documentation shall comply with		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : Business office manager and Social Services were educated on the guidelines for Advance Beneficiary Notices to include but not limited to ensuring the SNF-ABN(Skilled Nursing Facility Advanced Beneficiary Notice) forms are accurately completed for residents discharged from Medicare services and remain in the facility. On-going monitoring : ED or designee will audit the ABN process weekly to ensure the forms are accurately completed for residents discharged from Medicare services and remain in the facility. These reviews to be conducted weekly x 8 weeks, then twice a month x2 months then monthly x 2 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	

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	form instructions...A notice must be completed before delivery...." 3.1-4(f)(3)		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 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments Based on interview and record review, the facility failed to ensure Preadmission Screening and Record Review (PASARR) evaluations were updated and accurate for 2 of 4 residents reviewed for PASARR. (Resident 95 and 52) Findings include: 1. The clinical record for Resident 95 was reviewed on 12/16/24 at 8:56 a.m. The diagnoses included, but were not limited to, major depressive disorder, post-traumatic distress disorder, insomnia, and anxiety disorder. A PASARR notice of level I screen outcome, dated 10/23/24, indicated a Level II screen was not required. The rational for the determination indicated there was no evidence of a serious mental health condition. The PASARR level I screen indicated major depressive disorder was listed as a current mental health condition and the current mental health medications prescribed were duloxetine and bupropion for depression. The PASARR did not include the diagnoses of anxiety disorder, post-traumatic stress disorder, or insomnia.	F 0644	F 644 D Coordination of PASARR and Assessments **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 95 no longer resides at the facility Resident 52 A review was completed of residents clinical record and updated to include review of medication, diagnosis, mood and behavior and updated level 1. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: the facility completed a review of all residents to ensure Preadmission screening and record review (PASARR) evaluation are updated and accurate.	01/13/2025

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	Physician's orders, dated 11/12/24, indicated Resident 95 was taking Buspirone 5 mg (milligrams) for anxiety disorder and trazadone 50 mg for insomnia. During an interview, on 12/18/24 at 11:57 a.m., the Social Service Director indicated the PASARR did not include the diagnoses of anxiety, post-traumatic stress disorder, or insomnia and was missing the medications buspirone and trazadone. 2. The clinical record for Resident 52 was reviewed on 12/16/24 at 2:44 p.m. The diagnoses included, but were not limited to, anxiety disorder, post-traumatic distress disorder, depression, and adjustment disorder. A notice of PASARR level 1 screen outcome, dated 10/24/24, indicated no level 2 was required and no mental illness was suspected. The current mental health medications included aripiprazole (an antipsychotic medication) and duloxetine (an antidepressant medication). If changes occur or new information refuted these findings, a new screen must be submitted. Physician's orders, with a start date of 11/18/24, indicated clonazepam and buspirone (antianxiety medications) and zolpidem tartrate (a hypnotic medication for sleep). Clonazepam, buspirone and zolpidem were not included on the PASARR mental health medication section. During an interview, on 12/17/24 at 10:24 a.m., the Social Service Director indicated another PASARR would be completed if new psychotropic medications were added and another PASARR was not completed.		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Education : Social Services and designee were educated on the guideline for Resident Assessment -Coordination with PASARR Program to include but not limited to review of all residents to ensure Preadmission screening and record review (PASARR) evaluation are updated and accurate. On-going monitoring : Social Services or designee will review new admission, change in psych meds and dx, or change in condition related to mental health. 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	

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	A current facility policy, titled "Resident Assessment - Coordination with PASARR Program," dated 2024 and received from the Executive Director on 12/17/24 at 10:35 a.m., indicated "...All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening...Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a positive serious mental disorder or intellectual disability arises later...Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure the physician ordered parameters to hold blood pressure medications were followed for 1 of 1 resident reviewed for quality of care. (Resident 87) Finding includes: The clinical record for Resident 87 was reviewed on 12/16/24 at 8:35 a.m. The diagnoses included, but were not limited to, essential primary hypertension, type 2 diabetes mellitus with diabetic chronic kidney disease, chronic kidney disease stage 3, and dementia. A physician's order, dated 5/9/24 and	F 0684	**F 684 D Quality of Care** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 87: Clinical record was reviewed and reflects physician orders are being followed as prescribed. **How other residents having the potential to be affected by the**	01/13/2025

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	discontinued 12/5/24 at 5:15 p.m., indicated to give diltiazem (a blood pressure medication) by mouth two times a day and to hold the medication for a systolic blood pressure less than 120. A physician's order, dated 12/6/24, indicated to give lisinopril (a blood pressure medication) by mouth one time a day and to hold the medication for a systolic blood pressure less than 120. A Medication Administration Record (MAR), dated October 2024, indicated diltiazem was given on 10/23/24 with a systolic blood pressure of 117. A Medication Administration Record (MAR), dated November 2024, indicated diltiazem was given on 11/22/24 with a systolic blood pressure of 109. A MAR, dated December 2024, indicated diltiazem was given, on 12/4/24, with a diltiazem was given on 12/4/24 with a systolic blood pressure of 105, on 12/5/24 with a systolic blood pressure of 115, and lisinopril was given on 12/15/24 with a systolic blood pressure of 118. During an interview, on 12/19/24 at 9:39 a.m., the Dementia Unit Manager 8 and LPN 9 indicated a check mark on the MAR indicated the medication had been given. If the blood pressure was below the ordered parameter, then the medication should have been held and marked with a code 3 or 7 to show it had not been given. A current facility policy, titled "Medication Administration," received from the Director of Nursing (DON) on 12/19/24 at 12:02 p.m., indicated "...When applicable, hold medication for those vital signs outside the physician's prescribed parameters...."		**same deficient practice will be identified and what corrective action will be taken** Initial audit : facility completed an audit of all residents receiving medication with an ordered vital sign parameter (Blood pressure and Heart Rate) to ensure the Providers order was 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 Clinical staff (RN/LPN/QMA) were educated to include but not limited to ensuring the physician ordered parameters to hold blood pressure medication are followed. On-going monitoring: DNS or designee will observe medication administration to include those residents that receive mediation with parameters to ensure orders are followed. These reviews to be conducted 4 times weekly x 4 weeks, then 2 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**	

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	3.1-37(a)		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 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on interview and record review, the facility failed to ensure an admission weight was obtained for 2 of 5 residents reviewed for nutrition. (Resident D and H) Finding includes: 1. The clinical record for Resident D was reviewed on 12/16/24 at 9:10 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, muscle wasting and atrophy, and chronic heart failure. A weight summary indicated Resident D weighed 284 pounds on 11/11/24. This was the first weight the facility recorded in the electronic medical record (EMR). Resident D was admitted on 11/6/24. The resident was not weighed until 5 days after admission. The facility's clinical admission assessment, dated 11/6/24, included a spot to enter the weight. There was no weight entered. 2. The clinical record for Resident H was reviewed	F 0692	F 692 D Nutrition/Hydration status maintenance **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident D: Clinical record has been reviewed and reflects resident current weight and nutritional needs. Resident H: 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** Initial audit: facility completed a 7 day look back of new admissions to ensure all residents have a weight on file within 48 hours of admission or documentation to	01/13/2025

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	on 12/16/24 at 10:45 a.m. The diagnoses included, but were not limited to, muscle wasting and atrophy, essential hypertension, and morbid obesity. A weight summary indicated Resident H weighed 306 pounds on 12/13/24. This was the first weight the facility recorded in the EMR. Resident H was admitted on 12/7/24. The resident was not weighed until 6 days after admission. The facility's clinical admission assessment, dated 12/9/24, included a spot to enter the weight. There was no weight entered. During an interview, on 12/19/24 at 9:56 a.m., Licensed Practical Nurse (LPN) 6 indicated the first day a resident was admitted an admission weight would be obtained. During an interview, on 12/19/24 at 10:16 a.m., Regional Dietician 11 indicated if the resident had a history of heart failure an admission weight would be obtained the day they were admitted. During an interview, on 12/19/24 at 11:25 a.m., LPN 7 indicated the day a resident was admitted, the facility would obtain an admission weight. The facility did not have a policy which addressed admission weights. 3.1-46(a)(1)		support other. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : Clinical staff (Nurses and aides) educated on the guideline for Weight Monitoring to include but not limited to obtaining residents weight upon admission. On-going monitoring: DNS or designee will audit new admissions within 24 hours of admission to ensure weight is obtained timely upon admission. 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.	

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F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview and record review, the facility failed to ensure policy and procedures were followed for medications administered through a gastrostomy tube (g-tube) for 1 of 1 resident reviewed for a gastrostomy tube. (Resident 67) Finding includes: During an observation, on 12/17/24 at 1:58 p.m., Registered Nurse (RN) 5 opened a medication capsule and poured the medicine into an unmeasured cup of water. RN 5 entered Resident 67's room and placed the cup with the medication, a piston (used to delivery medication into the g-tube) and a 10 milliliter (ml) syringe of normal saline solution on the bedside table. She removed the cap of the prefilled normal saline syringe and placed the end of the syringe to the g-tube port. RN 5 pushed the normal saline into the residents g-tube port, then took the larger piston and filled the piston with the medication. She then quickly pushed the medication into the g-tube. The clinical record for Resident 67 was reviewed on 12/13/24 at 11:35 a.m. The diagnoses included, but were not limited to, gastrostomy tube (g-tube) and dysphagia (difficulty swallowing). A physician's order, dated 8/20/24, indicated to check placement of the g-tube prior to medication administration and to flush the g-tube with 30 ml of water before and after the medication administration. A physician's order, dated 9/26/24, indicated to give gabapentin (a medication used for nerve	F 0693	**F 693 D Tube Feeding Management/Restore Eating Skills** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 67: residents clinical record was reviewed, and no negative trends identified. RN 5 : completed 1:1 education on the guideline for administering medication, checking placement and flushes via g-tube. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit : facility completed and audit to identify residents that receive medication and flushes via g tube. Initial observation completed to ensure accuracy of procedure. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Nursing staff educated	01/13/2025

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	pain) 400 milligram (mg) capsule via g-tube three times a day. During an interview, on 12/17/24 at 1:58 p.m., RN 5 indicated she flushed the g-tube with the prefilled normal saline solution syringe to make sure the tube was not clogged. She forgot to check placement or residual prior to the giving the medication. During an interview, on 12/17/24 at 2:14 p.m., the Director of Nursing (DON) indicated a prefilled normal saline solution syringe should not be used on a g-tube. The nurse should use water before and after the medication was given through a g-tube and not use normal saline. A current facility policy, titled "Medication Administration via Enteral Tube," dated 2024 and received from the DON indicated "...Verify physician orders for medication and enteral tube flush amount...Enteral tube placement must be verified prior to administering any fluids or medication...Flush enteral tube with at least 15 ml of water prior to administering medication unless otherwise ordered by prescriber. Dilute the solid or liquid medication...Flush tube again with at least 15 ml water taking into account resident's volume status...Flush the tube with a final flush of at least 15 ml of water to ensure drug delivery and clear the tube...." 3.1-44(a)(2)		on the guideline for Medication Administration via Enteral Tube to include but not limited to verification of placement and flushes. On-going monitoring : DCE or designee will completed medication pass observations of residents with g-tubes to ensure proper procedure is followed. These reviews to be conducted 3 times weekly x 4 weeks, then 2 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.	
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails Based on observation, interview and record review, the facility failed to ensure a physician's order, a care plan, a signed consent, and an	F 0700	**F 700 Bedrails** **What corrective actions will be**	01/13/2025

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	155367	A. BUILDING 00 B. WING	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE -SYCAMORE VILLAGE CARE CENT	2905 W SYCAMORE ST KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	assessment was obtained prior to the use of side rails for 1 of 7 residents reviewed for accidents. (Resident 95) Finding includes: During an observation and interview, on 12/12/24 at 10:07 a.m., Resident 95 was in his room lying in bed with bilateral side rails attached to the bed. He indicated the side rails were on the bed when he moved in, and he believed the side rails were to keep him from rolling out of the bed. The facility did not have him sign a consent for the use of the side rails. During an observation, on 12/13/24 10:14 a.m., Resident 95 was lying in bed with bilateral side rails attached to the bed. During an observation, on 12/16/24 at 11:31 a.m., Resident 95 was sitting up on the side of his bed with bilateral side rails attached to the bed. The clinical record for Resident 95 was reviewed on 12/16/24 at 8:56 a.m. The diagnoses included, but were not limited to, muscle wasting and atrophy, cellulitis of left lower limb, acquired absence of left great toe, and impaired balance. A physician's order, an informed consent, and an assessment for the use of the side rails were not found in the resident's medical record. A care plan, dated 11/17/24 and last revised 11/22/24, indicated Resident 95 had a self-care performance deficit. Interventions included, but were not limited to, providing limited assistance with bathing, dressing, toileting, personal hygiene, transfers, and bed mobility.		**accomplished for those residents found to have been affected by the deficient practice?** Resident 95 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** Initial audit : Facility completed an audit of all residents to ensure those with bedrails or assist devices on the bed have a physician's order, care plan and signed consent and assessment completed prior to utilization. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : Clinical staff were educated on the guideline for proper use of bed rails to include but not limited to ensuring a physician's order, care plan and signed consent and assessment are completed prior to utilization. On-going monitoring: DNS or designee will observe new admissions and room changes to ensure they are not placed in a bed with existing bed rails/assist	

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	Resident 95's care plans did not include the current use of the side rails. During an interview, on 12/16/24 at 2:19 p.m., the Director of Nursing (DON) indicated an assessment, and consent should be completed before side rails are attached to a resident's bed. Resident 95 was placed into a bed which already had the side rails attached and the facility did not obtain the consent and assessment. A current facility policy, titled "Proper Use of Bed Rails," dated 2024 and received by the Executive Director (ED) on 12/17/24 at 12:16 p.m., indicated "...It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. If bed rails are used, the facility ensures correct installation use and maintenance of the rails...Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars...." 3.1-45(a)(1)		bars or other devices without following the guideline. These reviews to be conducted 3 times weekly x 4 weeks, then 2 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.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to ensure pharmaceutical services were obtained and maintained timely to support a resident's healthcare needs for 1 of 5 residents reviewed for pain management. (Resident E) Finding includes: An Indiana Department of Health intake form indicated Resident E was made to detox from his medications. There was no physician's order to stop the medication, and the resident was discharged from the facility without his Multiple	F 0755	F 755 D Pharmacy Services/Procedures/Pharmacist/ Records **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 **How other residents having the**	01/13/2025

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	Sclerosis (a disease in which the immune system eats away at the protective covering of nerves) medication. The clinical record for Resident E was reviewed on 12/17/24 at 9:15 a.m. The diagnoses included, but were not limited to, Multiple Sclerosis, anxiety disorder, and muscle spasms of back. A Preadmission Screening and Resident Review (PASRR), dated 6/7/24, indicated Resident E would need support from staff to take his medications safely and correctly. A hospital history and physical, dated 6/13/24, indicated Buprenorphine (an opioid medication used to treat opioid use disorder, acute pain, and chronic pain) was on Resident E's current medication list. The resident was admitted to the facility from the hospital on 6/14/24. The hospital discharge orders, dated 6/14/24, indicated to continue to administer Buprenorphine 8 milligram (mg), 0.5 tablet three times a day. A physician's order, dated 6/17/24, indicated Resident E was to receive Buprenorphine 8 mg, 0.5 tablet three times a day for Multiple Sclerosis. The Medication Administration Record (MAR) indicated the Buprenorphine 0.5 tablet three times a day was not administered in the afternoon or evening of 6/27/24. A physician's order, dated 6/28/24, indicated Resident E was to take Buprenorphine 8 mg, 1.5 tablets one time a day.		**potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that receive pharmacy provided medication have the potential to be affected. An initial review of all residents was completed to ensure medications were in stock as prescribed. **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 were educated on the guideline for Pharmacy Services to include but not limited to the facility and pharmacy are responsible for ensuring that orders received are processed, reconciled and medications are administered per providers orders to meet the needs of the residents. On-going monitoring: DNS or designee will complete medication pass observations to include mediations are available as ordered. These reviews to be conducted 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the**	

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	A physician's order, dated 7/8/24, indicated Resident E was to take Buprenorphine 8 mg and to give 4 mg three times a day. A nursing progress note, dated 7/9/24, indicated the medication had been held due to the administration instructions had been changed. A nursing progress note, dated 7/14/24 at 3:40 p.m., indicated the facility was out of the Buprenorphine. A nursing progress note, dated 7/16/24, indicated Resident E had asked about being out of his medication. The facility contacted the pharmacy and was informed a new prescription was needed before the pharmacy could fill the order. A nursing progress note, dated 7/17/24, indicated the Nurse Practitioner (NP) 10 agreed to send a new order of Buprenorphine with enough doses to last until 7/31/24. NP 10 was seeing other patients and would not send the order until the evening. The medication would not be available until 7/18/24. A nursing progress note, dated 7/21/24, indicated the facility received a fax from the pharmacy and the order for the medication needed clarified. A nursing progress note, dated 7/24/24, indicated the medication was unavailable and could not be administered. A nursing progress note, dated 7/25/24, indicated Resident E requested to be discharged early. The resident was discharged from the facility on 7/25/24. The medical record for Resident E indicated 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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	resident missed 19 days of Buprenorphine. A facility discharge summary, dated 7/25/24, indicated medications were sent home with Resident E. The facility was to print and attach a copy of discharge medications to Resident E's discharge packet. A copy of the discharge medication list was not found in the discharge packet provided by the facility for review and no appointment for the pain clinic had been made. During an interview, on 12/17/24 at 11:47 a.m., the Director of Nursing (DON) indicated she was unaware the medication order of Buprenorphine was to be given for the resident's Multiple Sclerosis. During an interview, on 12/19/24 at 1:33 p.m., the Executive Director (ED) indicated the facility did not have any further information to submit regarding Resident E's medication or the facility being unable to obtain the medication from the pharmacy. A current facility policy, titled "Pharmacy Services," dated 2024 and received from the DON on 12/19/24 at 8:35 a.m., indicated "...It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with the state and federal requirements, and reflect current standards of practice...The process (including documentation, as applicable) of receiving and interpreting prescriber's orders; acquiring, receiving...reconciling...distributing, administering...of all medications...The facility will provide pharmaceutical services to include procedures that ensure accurate acquiring, receiving, dispensing, and administering of all			

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	routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice...The licensed pharmacist will collaborate with facility leadership and staff to coordinate pharmaceutical services within the facility, guide development and evaluation of pharmaceutical services procedures, and help the facility identify, evaluate, and resolve pharmaceutical concerns which affect resident care, medication care, or quality of life...The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs, goals and quality of life that are consistent with current standards of practice and meet state and federal requirements. The pharmacist, in collaboration with the facility and medication director, should include within its services to...Develop mechanisms or communicating, addressing, and resolving issues related to pharmaceutical services...Strive to assure that medications are requested, received, and administered in a timely manner as ordered by the authorized prescriber (in accordance with state requirements), including physicians, advanced practice nurses, pharmacists, and physician assistants...The pharmacist, in collaboration with the facility and medical director, may include other aspects of pharmaceutical services such as...Development of procedures and guidance in relation to medication issues...." This citation relates to Complaint IN00439869. 3.1-25(a) 3.1-25(g)(1) 3.1-25(g)(2) 3.1-25(g)(3)			

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F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure compromised controlled substance medications were not stored in the medication cart for 2 of 4 medication carts observed for medication storage. (North cart and South cart) Findings include: 1. During an observation, on 12/18/24 at 10:45 a.m., the North medication cart had five compromised controlled substance cards. a. The clinical record for Resident 14 was reviewed on 12/18/24 at 11:35 a.m. The diagnoses included, but were not limited to, insomnia and anxiety disorder A card of quviviq (for insomnia) 25 milligram (mg) tablet for Resident 14 had clear tape covering the back of the number 6 slot. b. The clinical record for Resident 42 was reviewed on 12/18/24 at 11:40 a.m. The diagnoses included, but were not limited to, pain and anxiety. A card of oxycodone (for pain) 10 mg tablet for Resident 42 had a slit on the back of the card in the number 22 slot. A card of alprazolam (for anxiety) 1 mg tablet for Resident 42 had a slit on the back of the card in the number 23 slot. c. The clinical record for Resident 51 was reviewed on 12/18/24 at 11:47 a.m. The diagnoses included, but were not limited to, pain.	F 0761	**F 761 Label/store Drugs and Biologicals** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** North and South Cart: both carts have been audited for storage of controlled substances to ensure packaging is not compromised. Observed issues were corrected at the time of survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit : facility completed and audit of all medication cart narcotic storage units to ensure packaging is not compromised. **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 staff (RN/LPN/QMA) were educated on the guideline for medication storage to include but no limited to ensuring packaging is not	01/13/2025

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	A card of Norco (for pain) 10-325 mg tablet had a slit on the back of the card in the number 8 slot. d. The clinical record for Resident 23 was reviewed on 12/18/24 at 11:55 a.m. The diagnoses included, but were not limited to, pain. A card of tramadol (for pain) 50 mg tablet had a slit on the back of the card in the number 30 slot. During an interview, on 12/18/24 at 12:00 p.m., LPN 13 indicated there should not be tape or slits on the back of the cards. She did not look at the back of the cards when counting the narcotics. 2. During an observation, on 12/18/24 at 12:15 p.m., the South medication cart had one compromised controlled substance card. The clinical record for Resident 75 was reviewed on 12/18/24 at 12:35 p.m. The diagnoses included, but were not limited to, insomnia and anxiety disorder A card of Clonazepam (for anxiety) 0.5 mg had a slit on the back of the card in the number 29 slot. During an interview, on 12/18/24 at 12:00 p.m., Licensed Practical Nurse (LPN) 12 indicated the pills should not be taped or opened on the back of the cards. The pills should be destroyed by two nurses. During an interview, on 12/18/24 at 12:30 p.m., the Director of Nursing (DON) indicated the staff should not tape the backs of the narcotics cards. The pills needed to be destroyed. A current policy, titled "Controlled Substance		compromised. On-going monitoring : DNS or designee will audit medication cart narc boxes to ensure packaging is not compromised. These reviews to be conducted 3 times weekly x 4 weeks, then 2 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.	

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	Administration & Accountability," dated 2024 and received from the DON on 12/19/24 at 9:43 a.m., indicated "...Obtaining/Removing/Destroying Medication...The entire amount of controlled substances obtained or dispensed is accounted for. Two licensed staff must witness any disposal or destruction of a controlled substance and document same on the Drug Disposition Record, Control Drug Record, or via the automated dispensing system...." 3.1-25(n) 3.1-25(o)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure staff wore PPE (personal protective equipment) and to ensure the correct isolation signs were posted for 2 of 3 residents reviewed for transmission-based precautions. (Resident 67 and 61) Finding includes: 1. During an observation, on 12/17/24 at 1:58 p.m., Registered Nurse (RN) 5 entered Resident 67's room to administer medication. The resident was in enhanced barrier precautions. RN 5 did not put on a gown when entering the room. The clinical record for Resident 67 was reviewed on 12/13/24 at 11:35 a.m. The diagnoses included, but were not limited to, hypoxia, cardiomegaly, anxiety disorder, pressure ulcers, gastrostomy tube (g-tube), and dysphagia (difficulty swallowing). A physician's order, dated 8/20/24, indicated	F 0880	F 880 Infection Prevention and Control **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** RN: 1:1 education completed regarding proper use of PPE Resident 67: Clinical record was reviewed and reflects residents current care needs to include Enhanced Barrier Precautions. Proper signage is posted outside residents room. Resident 61: Clinical record was reviewed and reflects that condition resolved and resident no longer required Contact Isolation or EPB. Signage removed from outside of room and plan of care updated.	01/13/2025

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	enhanced barrier precaution with a sign outside the resident's room and to wear a gown and gloves for high contact resident care. A care plan, dated as revised on 10/25/24, indicated Resident 67 required enhanced barrier precautions. Interventions included, but were not limited to, follow enhanced barrier precaution guidelines as ordered, PPE for high-contact resident care and for residents with urinary catheters and feeding tubes. During an interview, on 12/17/24 at 1:58 p.m., Registered Nurse (RN) 5 indicated she should have put on an isolation gown. During an interview, on 12/17/24 at 2:35 a.m., Licensed Practical Nurse (LPN) 4 indicated a gown and gloves were required when providing care to Resident 67. Staff providing direct care to the resident was responsible to wear the proper PPE.2. During observations, on 12/12/24, 12/13/24, and 12/17/24, no enhanced barrier precautions (EBP) sign was noted outside Resident 61's room per the physician's order. During observations, on 12/18/24 and 12/19/24, both an enhanced barrier precautions and Contact Precaution signs were noted in the hallway outside the resident's door. The clinical record for Resident 61 was reviewed on 12/16/24 at 10:09 a.m. The diagnoses included, but were not limited to, enterocolitis due to clostridium difficile (C-diff), urinary tract infection, retention of urine, and benign prostatic hyperplasia with lower urinary tract symptoms. A current physician's order, dated 8/20/24, indicated enhanced barrier precautions were to be		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: Facility completed an audit of residents that require isolation precautions and enhanced barrier precautions to ensure proper signage is posted at entrance to the room. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Facility staff were educated on the guideline for Isolation Precautions and Enhanced Barrier Precautions to include but not limited to follow proper use of PPE, accurate signage posted outside of the room. On-going monitoring : DCE or designee will audit and complete observations of proper use of PPE for residents that have orders for Isolation or EBP. These reviews to be conducted 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not**	

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BRICKYARD HEALTHCARE -SYCAMORE VILLAGE CARE CENT	2905 W SYCAMORE ST KOKOMO, IN 46901

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	in place and a sign was to be outside the resident's room. A physician's order, initiated on 11/7/24 and completed on 12/7/24, indicated the resident was to be on contact precautions for enterocolitis due to clostridium difficile. A care plan, initiated 8/20/24, indicated Resident 61 required enhanced barrier precautions. Interventions included, but were not limited to, follow enhanced barrier precaution guidelines as ordered. During an interview, on 12/17/24 at 11:25 a.m., Licensed Practical Nurse (LPN) 2 indicated Resident 61 should be on contact precautions and a sign should be up outside the resident's door. During an interview, on 12/18/24 at 1:25 p.m., the Director of Nursing (DON) indicated both contact precaution and enhanced barrier precautions signs were in place outside of Resident 61's door. The enhanced barrier precautions sign was placed to the left of the door and the contact precaution sign was placed to the right over a personal protective equipment (PPE) cart. She indicated staff were to follow the contact precautions. During an interview, on 12/19/24 at 9:42 a.m., CNA 2 indicated Resident 61 was on contact precautions and staff were to wear gowns and gloves every time they entered the room. During an interview, on 12/19/24 at 9:45 a.m., LPN 3 indicated there was a current physician's order for enhanced barrier precautions. The order for contact precautions was completed on 12/7/24 and the contact precaution sign should not be outside the resident's door.		**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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155367	A. BUILDING 00 B. WING	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE -SYCAMORE VILLAGE CARE CENT	2905 W SYCAMORE ST KOKOMO, IN 46901

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	A current facility policy, titled "Enhanced Barrier Precautions," dated 3/20/24 and received from the Executive Director (ED) on 12/17/2024 at 4:04 p.m., indicated "...Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and gloves use during high contact resident care activities...An order for enhanced barrier precautions will be obtained for residents with any of the following...wounds...feeding tubes...Implementation of Enhanced Barrier Precautions...PPE for enhanced barrier precautions...when performing high-contact care activities...High-contact resident care activities include...Device care or use...feeding tubes...Wound care...." A current facility policy, titled "Transmission-Based (Isolation) Precautions," dated May 2024 and received from the DON on 12/19/24 at 12:02 p.m., indicated "..."contact precautions" refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment...Initiation of Transmission-Based Precautions...signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room...." 3.1-18(b)			