| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155138 | A. BUILDING 00<br>B. WING | 11/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER | 2860 CHURCHMAN AVE<br>INDIANAPOLIS, IN 46203 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00393298 and IN00393440.<br><br>Complaint IN00393298 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00393440 - Unsubstantiated due to lack of evidence.<br><br>Survey dates: November 1, 2, 3, 7, 9, and 10, 2022<br><br>Facility number: 000063<br>Provider number: 155138<br>AIM number: 100266210<br><br>Census Bed Type:<br>SNF/NF: 72<br>Total: 72<br><br>Census Payor Type:<br>Medicare: 3<br>Medicaid: 69<br>Total: 72<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed November 15, 2022. | F 0000 | Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Annual Survey ending on 11/10/2022. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. | |
| F 0656<br>SS=D<br>Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Ashley Lory | RN, RDCO | 12/02/2022 |

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| | the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or | | | |

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| | arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>Based on observation, interview, and record review, the facility failed to ensure a person-centered comprehensive care plan was developed and implemented for 1 of 2 residents (Resident 29) reviewed for limited range of motion requiring the use of a splint and for 1 of 2 residents (Resident 34) reviewed for transmission-based precautions.<br><br>Findings include:<br><br>1. On 11/2/22 at 10:55 a.m., observed Resident 29 resting in her bed after the nursing staff completed the resident's morning care. The nursing staff applied a splint onto Resident 29's right hand and wrist area.<br><br>On 11/3/22 at 11:30 a.m., observed Resident 29 resting in her bed after the nursing staff completed the resident's morning care. The nursing staff had applied a splint onto Resident 29's right hand and wrist area.<br><br>On 11/7/22 at 3:07 p.m., observed Resident 29 sitting in her electric wheelchair near the nurse's station. Resident 29 had a splint in place at the right and left hand and wrist areas.<br><br>On 11/9/22 at 1:54 p.m. Resident 29's clinical record was reviewed. The diagnoses included, but were not limited to, quadriplegia (paralysis of all four limbs) and injury at C6 level of cervical spinal cord (affects the cord near the base of the neck that can result in loss of sensation or function of everything in the body from the top of the ribcage on down, including all four | F 0656 | 1. Immediate action(s) taken for the resident(s) found to have been affected include:<br>Care plan(s) of the resident identifier(s) RI#(s) 29 and 34 were reviewed and updated as indicated.<br>2. Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>3. Actions taken/systems put into place to reduce the risk of future occurrence include:<br>All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility's policy and procedure for developing Comprehensive Care Plans.<br>4. How the corrective action(s) will be monitored to ensure the practice will not recur:<br>Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator(s). All care plans will be updated as indicated.<br>The Director of Nursing Services (DNS), or designee, will complete random weekly audits of care plans for six (6) consecutive weeks. Random audits will be completed to ensure that | 12/13/2022 |

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| | extremities).<br><br>On 11/4/22, the Physician orders included, but were not limited to, "hand splint with meals...resident requires total assist with transfer, bed mobility, toileting, dressing/grooming and bathing ADLs [activity of daily living] r/t [related to] complete quadriplegia due to C6 cervical spinal injury..."<br><br>On 11/7/22, the Physician orders were updated to include "splint to left wrist on when up in chair."<br><br>On 11/9/22, the Physician orders were updated to include "splint on right wrist when up in chair."<br><br>The Quarterly MDS (Minimum Data Set) assessment, dated 9/17/22, indicated Resident 29 was cognitively intact and had limited range of motion of all extremities.<br><br>The clinical record lacked a person-centered comprehensive care plan that addressed the bilateral splints for Resident 29's hand and wrist areas.<br><br>During an interview on 11/2/22 at 11:00 a.m., Resident 29 indicated she had a C6 level of cervical spinal cord injury which resulted in quadriplegia. Resident 29 had worn splints for her right and left arm and wrist areas for "years." The splints were to be put on in the morning and taken off at bedtime.<br><br>During an interview on 11/7/22 at 4:11 p.m., the Corporate Compliance Director indicated Resident 29's clinical record lacked a comprehensive care plan that addressed Resident 29's bilateral splints for her hands and wrist areas. Resident 29 had utilized splints for both arms and wrist areas since | | comprehensive care plans are developed for residents.<br>Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.<br>Audit results will be shared with the Resident/Family Group Council for comment and suggestions. | |

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|---|---|---|---|---|
| | 2016 and should have had splint care plans in place since that time.<br><br>2. On 11/2/22 at 11:15 a.m., observed Resident 34's room door to be closed. Observed a sign posted on the door which read "Contact isolation." Next to the door was a plastic bin that contained PPE (personal protective equipment) supplies (gowns, gloves, and masks).<br><br>On 11/3/22 at 10:56 a.m., observed Resident 34's room door to be closed. Observed a sign posted on the door which read "Contact isolation." Next to the door was a plastic bin that contained PPE supplies.<br><br>On 11/7/22 at 3:16 p.m., observed Resident 34's room door to be closed. Observed a sign posted on the door which read "Contact isolation." Next to the door was a plastic bin that contained PPE supplies.<br><br>On 11/3/22 at 11:00 a.m., Resident 34's clinical record was reviewed. The diagnosis included, but was not limited to, Candida auris (fungus which grows as yeast that is spread by direct contact).<br><br>The Physician orders, dated 8/30/22 with no end date noted, indicated Resident 34 was to be in contact isolation for Candida auris.<br><br>The Quarterly MDS (Minimum Data Set) assessment, dated 9/12/22, indicated Resident 34 was cognitively intact.<br><br>The clinical record lacked a person-centered comprehensive care plan that addressed the contact isolation for Resident 34.<br><br>During an interview on 11/2/22 at 11:00 a.m., LPN | | | |

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| | (Licensed Practical Nurse) 2 indicated Resident 34 was in contact isolation due to Candida auris. Everyone who entered Resident 34's room was to wear a gown, gloves, and mask.<br><br>During an interview on 11/2/22 at 11:22 a.m., Resident 34 indicated he had been in contact isolation "for a while" because of a yeast infection.<br><br>During an interview on 11/7/22 at 10:30 a.m., CNA (Certified Nursing Assistant) 1 indicated Resident 34 was in isolation.<br><br>During an interview on 11/7/22 at 10:49 a.m., the DNS (Director of Nursing Services) indicated Resident 34 was in isolation due to colonized Candida auris and would require long term isolation. Staff were to wear gowns, gloves and masks when providing personal care to Resident 34. A comprehensive Candida auris isolation care plan should have been developed and implemented when Resident 34 was diagnosed with the infection and subsequently placed into isolation on 8/30/22.<br><br>On 11/7/22 at 11:30 a.m., the DNS provided a copy of the Comprehensive Care Plans policy, dated 2022, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...to develop and implement a comprehensive person-centered care plan for each resident...that includes measurable objectives and timeframe to meet a resident's medical, nursing, and mental and psychosocial needs...care plan will be reviewed and revised by the interdisciplinary team..."<br><br>On 11/9/22 at 10:00 a.m., the CDC (Center for Disease Control and Prevention) guidance located at | | | |

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| | https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html, updated on 7/12/22, for Candida auris was reviewed. A review of the guidance indicated, "...contact precautions or enhanced barrier precautions [infection control intervention designed to reduce transmission of multi-resistant organisms (MDROs)] in nursing homes...involve gown and glove use during high-contact resident care activities for residents known to be colonized...can last indefinitely due to the type of infection..."<br><br>3.1-35(b)(1) | | | |
| F 0727<br>SS=D<br>Bldg. 00 | 483.35(b)(1)-(3)<br>RN 8 Hrs/7 days/Wk, Full Time DON<br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>Based on record review and interview, the facility failed to provide 8 continuous hours of Registered Nursing (RN) services seven days a week for 3 of 31 days reviewed.<br><br>Finding includes:<br><br>On 11/3/22 at 3:30 P.M., the Director of Nursing | F 0727 | 1. Immediate action(s) taken for the resident(s) found to have been affected include:<br>No residents were identified.<br>2. Identification of other residents having the potential to be affected was accomplished by:<br>No residents were identified or | 12/13/2022 |

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| | provided the daily staffing sheets. A review of the October daily staffing sheets indicated the following:<br><br>On 10/6/22, the report lacked documentation to indicate any RN coverage was provided.<br><br>On 10/15/22, the report indicated an RN was in orientation on the floor but lacked any other documentation to indicate valid RN coverage was provided.<br><br>On 10/16/22, the report indicated an RN was in orientation on the floor but lacked any other documentation to indicate valid RN coverage was provided.<br><br>During an interview on 11/7/22 at 10:25 A.M., the Administrator indicated that they followed the facility assessment for total direct care hours and that at least one RN was to be present daily.<br><br>During an interview on 11/7/22 at 11:15 A.M., with the DON indicated that a RN in orientation did not count towards the 8 hours of RN services.<br><br>On 11/9/22 at 11:05 A.M., the Administrator was unable to provide documentation of at least 8 hours of RN services on 10/6/22, 10/15/22, and 10/16/22.<br><br>3.1-17(b)(3) | | affected by the deficient practice.<br>3. Actions taken/systems put into place to reduce the risk of future occurrence include:<br>Education provided to Administrator and Director of Nursing Services on the policy, Nursing Services and Sufficient Staff.<br>4. How the corrective action(s) will be monitored to ensure the practice will not recur:<br>The schedule will be checked daily for 8-hour RN coverage by the DON/designee. Adjustments will be made accordingly. A calendar will be used as an audit tool to be sure of daily coverage. Recruiting efforts have been increased to obtain additional Registered Nurses. This will be a continued practice by the facility. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. | |
| F 0921<br>SS=D<br>Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. | F 0921 | 1. Immediate action(s) taken for | 12/13/2022 |

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| | Based on observation, interview, and record review, the facility failed to provide a clean and sanitary environment for residents for 1 of 20 rooms observed during the initial pool. (Room 15, Resident 32, Resident 61)<br><br>Findings include:<br><br>On 11/1/22 at 11:04 a.m., during a tour of the facility, observed a brown liquid substance on the commode in Room 15. Room 15 was shared room by two residents, Resident 32 and Resident 61. The brown substance was in the commode and on the back of the seat of the commode. A thick formed brown substance was observed on the floor next to the commode. Several brown splash areas were observed on the wall and on the underside of the toilet seat cover.<br><br>On 11/2/22 at 1:00 p.m., observed a brown substance on the commode in Room 15. The brown substance was in the commode and on the back of the seat of the commode. A thick brown formed substance was observed on the floor next to the commode. Several brown splash areas were observed on the wall and on the underside of the toilet seat cover.<br><br>On 11/3/22 at 11:05 a.m., observed a brown substance on the commode in Room 15. The brown substance was in the commode and on the back of the seat of the commode. The brown substance was observed on the floor at the side of the commode. Several areas of pea sized liquid brown splash areas were observed on the wall and on the underside of the toilet seat cover.<br><br>On 11/3/22 at 2:07 p.m., observed a brown substance between the commode seat and the commode lid in Room 15. Several areas of pea | | the resident(s) found to have been affected include:<br>The bathroom for Resident # 32 and 61 was cleaned immediately.<br>2. Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>3. Actions taken/systems put into place to reduce the risk of future occurrence include:<br>An in-service education program was conducted by the Administrator and the Director of Nursing Services with all licensed and non-licensed staff who have direct resident contact. The in-service addressed the importance of identifying bodily fluids and cleaning the area appropriately along with notifying the Environmental Services Supervisor or designee.<br>4. How the corrective action(s) will be monitored to ensure the practice will not recur:<br>The Administrator, or designee, will conduct a random audit of bathrooms used for five (5) resident rooms per unit, per week for four (4) consecutive weeks. Environmental Services records will be reviewed to ensure all bathrooms are cleaned daily. Findings of this audit will be discussed with the Resident Council.<br>This plan of correction will be | |

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| | sized liquid brown splash areas were observed on the wall. Resident 32 indicated she often had explosive diarrhea. "I wish they could get the toilet clean. Most of the time they do not clean the bathroom. Maybe one time a week."<br><br>On 11/7/22 at 8:30 a.m., observed a brown substance between the commode seat and commode lid in Room 15. The toilet seat had a liquid splatter of a brown substance. Several areas of pea sized brown liquid splatter were observed on the wall.<br><br>On 11/9/22 at 2:00 p.m., the clinical record of Resident 32 was reviewed. An Annual MDS (Minimum Data Set) assessment, dated 11/1/22, indicated Resident 32 had mild cognitive impairment.<br><br>During an interview on 11/7/22 at 9:30 a.m., the Administrator indicated Resident 32 often had explosive diarrhea. The Certified Nursing Assistants were usually good at cleaning up the bathroom after each episode of diarrhea.<br><br>On 11/3/22 at 1:40 p.m., the Administrator provided a policy titled Routine Bathroom Cleaning, dated July, 2019, and indicated it was the current policy being used by the facility. A review of the policy, indicated "Procedure...Clean walls...Clean entire toilet."<br><br>3.1-19(f) | | monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met | |
| F 9999<br><br>Bldg. 00 | 3.1-14 PERSONNEL<br>(q) Each facility shall maintain current and accurate personnel records for all employees. The | F 9999 | 1. Immediate action(s) taken for the resident(s) found to have been affected include: | 12/13/2022 |

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| | personnel records for all employees shall include the following:<br>(5) Professional licensure, certification, or registration number or dining assistant certificate or letter of completion if applicable.<br><br>This State rule was not met as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure that a CNA maintained a valid certification for 1 of 34 certified staff members reviewed for current and valid certification. (CNA 3)<br><br>Findings include:<br><br>On 11/9/22 at 10:15 A.M., the daily staffing sheets were reviewed for October 2022 and November 2022. The report indicated CNA 3 was on the schedule and worked the following dates: 10/3/22, 10/4/22, 10/5/22, 10/6/22, 10/7/22, 10/10/22, 10/11/22, 10/12/22, 10/13/22, 10/14/22, 10/17/22, 10/18/22, 10/20/22, 10/21/22, 10/24/22, 10/25/22, 10/26/22, 10/27/22, 10/28/22, 10/31/22, 11/1/22, 11/2/22, 11/3/22, 11/4/22, 11/7/22, and 11/8/22.<br><br>On 11/7/22 at 3:35 P.M., the employee license book was reviewed. CNA 3's CNA certification had expired on 9/28/22.<br><br>During an interview on 11/9/22 at 10:00 A.M., the Payroll Specialist indicated that CNA 3 had an expired certification, and that CNA 3 was currently not allowed on the schedule until the certification was renewed. CNA 3's certification expired on 9/28/22.<br><br>During an interview on 11/9/22 at 1:40 PM, the Administrator and the DON indicated that CNA 3 was on the schedule and had worked the above | | No residents were identified.<br>2. Identification of other residents having the potential to be affected was accomplished by:<br>No residents were affected by the deficient practice.<br>3. Actions taken/systems put into place to reduce the risk of future occurrence include:<br>Education was provided to the Director of Nursing and Director of Clinical Education on maintaining documentation on all current certifications for Certified Nursing Assistants and Licensed Personnel.<br>4. How the corrective action(s) will be monitored to ensure the practice will not recur:<br>Licenses and certifications will be checked monthly by the Director of Clinical Education. The DCE will send reminders to staff to ensure notification of completing renewal. A monthly audit tool will be used to ensure compliance. Any licensed or certified staff member that doesn't renew by expiration date will be removed from the schedule until renewal is completed. This will be a continued practice by the facility. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155138 | A. BUILDING 00<br>B. WING | 11/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER | 2860 CHURCHMAN AVE<br>INDIANAPOLIS, IN 46203 |

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|---|---|---|---|---|
| | dates as indicated by the daily staffing sheets and should not have been working after her certification expired on 9/28/22.<br><br>On 11/10/22 at 11:10 AM, the Administrator provided a copy of CNA 3's certification which indicated it expired on 9/28/22.<br><br>On 11/10/22 at 11:10 AM, the Administrator provided a copy of CNA 3's job description. The job description was signed and dated on 10/13/20 and stated under the Qualifications section, "Must be a Certified Nursing Aide (CNA) in good standing with the state. Must maintain a current certification in the state throughout employment." | | | |