DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	10/05/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00391323. Complaint IN00391323 - Substantiated. Federal/state deficiencies related to the allegations are cited at F740. Survey dates: October 5, 2022 Facility number: 000165 Provider number: 155264 AIM number: 100288220 Census Bed Type: SNF/NF: 80 Total: 80 Census Payor Type: Medicare: 6 Medicaid: 57 Other: 17 Total: 80 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 11, 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 continuously improve the quality of care and to comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to this survey.	
F 0740 SS=G Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn Adams	Executive Director	10/28/2022

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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	the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to ensure that a resident received behavioral health services and initiation of psychiatric follow-up per the plan of care that resulted in Resident B experiencing increased depression, anxiety, paranoia, and ultimately being hospitalized in an inpatient psychiatric unit related to having suicidal and homicidal ideations for 1 of 3 residents reviewed for behavioral health. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/5/22 at 12:30 p.m. The diagnoses included, but were not limited to, bipolar disorder, depressive episodes, generalized anxiety disorder, chronic pain syndrome, insomnia, and suicidal ideations. Resident B was admitted to the facility on 6/23/22. An admission Minimum Data Set (MDS) assessment, dated 6/30/22 indicated Resident B was cognitively intact, marked "yes" for feeling down, depressed, or hopeless, feeling bad about yourself, trouble concentrating on things, and thoughts that you would be better off dead, or hurting yourself in some way within the past 12 to 14 days of assessment. A hospital psychiatry progress note, dated 6/20/22, indicated the following, "" ...Chief complaints: Bizarre behavior, hallucinations,	F 0740	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident B : 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 psychiatric diagnosis have the potential to be affected by the same alleged deficient practice. Initial audit: The facility completed reviews of all current residents to identify those residents with psychiatric diagnosis to ensure the resident had behavioral services provided per their plan of care and physician orders. (Attachment 1)	11/04/2022

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	anxious, scared, depressed, changes appetite [sic], inability to care self [sic] ...The patient seen today face-to-face during inpatient rounds. During my visit, patient reports feeling "scared" and anxious. Reports a lot of depression and it is "terrible" because of "life." ...Seemed confused and disorganized ...Patient also reports hearing voices saying she is a "daughter of a dead b****." ...Plan is to discharge patient to ECF [extended care facility] ...Assessment & Plan ...Continue counseling and safety precautions per physician order ...."" A care plan, dated 6/24/22, indicated the following, " ...I am at risk for psychosocial well-being concern r/t [related to] Severe depression, anxiety, confusion and inability to care for self at home ...Interventions ...Observe me for psychosocial and mental status changes - document and report as indicated ...." A care plan, dated 6/24/22, indicated the following, " ...Potential for drug related complications associated with use of psychotropic medications related to: Anti-Anxiety medication, Anti-Depressant medication, and Anti-psychotic medication ...Interventions ...Refer to psychologist/psychiatrist for medication and behavior intervention recommendations ...." A care plan, dated 7/6/22, indicated the following, " ...I sometimes have behaviors which include pushing other residents in wheelchairs and assisting residents with meals. She believes she works here and is upset about not getting smoke breaks ...Interventions ...Please refer me to my psychologist/psychiatrist as needed ...." A progress note, dated 7/5/22 at 10:21 a.m., indicated the following, "...Res [Resident B]		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 Nurse Management staff were educated on the guideline for Behavioral Services to include but not limited to residents received behavioral services and initiation of psychiatric follow up per plan of care and physician orders. (Attachment 2) On-going monitoring: DNS or Designee will monitor all new admissions, readmissions and new orders for psychiatric diagnosis' through the daily clinical review to ensure orders and consents for behavior services are in place per plan of care and physician orders. (Attachment 3) These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿	

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	walking down halls with no mask on. Stated she was looking for scissors to cut her; aide said res [resident] walked into kitchen and got scissors out of there and staff took them away from her." A progress note, dated 7/5/22 at 11:00 a.m., indicated a care plan meeting was held. Resident B did not attend the meeting per the family request due to "her psychological mental status at this time." The progress note indicated the Director of Social Services (DSS) was to call [name of inpatient psychiatric facility] to see if resident would be admitted for evaluation. There was no follow-up in the progress notes that the inpatient psychiatric facility was notified to see if Resident B could be evaluated. A progress note, dated 7/5/22 at 7:15 p.m., indicated Resident B had called 9-1-1 and informed them that she had been locked in her room by the staff. Resident B was previously pacing the hallway and pushing other residents in their wheelchairs down the hall. The interventions that the nursing staff attempted were deemed as "ineffective." A Psychosocial assessment, dated 7/7/22, indicated the following, "" ...She [Resident B] does have a cognitive deficit aeb [as evidenced by] not being able to "remember" how to get dressed ...Resident was also exit seeking, thus being placed on memory care unit ...3b. Additional Comments ...Resident will need medication management for psychotropic drugs and is currently managed by in house NP [Nurse Practitioner] ...." A progress note, dated 7/21/22 at 11:52 p.m., indicated the following, "" ...Resident stating she		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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hasn't "slept in days". C/O [complaints of] increased anxiety. Resident asking to move to group home saying "I'm bored" ....""

A Medication Administration Note, dated 7/27/22 at 11:18 a.m., indicated a behavior was observed but didn't indicate what the behavior was, the intervention attempted for the behavior exhibited, or follow up to the behavior documented.

Behavior Charting, dated 8/5/22 at 12:17 p.m., indicated Resident B was refusing care and interventions were ineffective.

An emergency department note, dated 8/11/22, indicated the following diagnoses for Resident B: injury of head, laceration of scalp, and paranoia.

A Medication Administration Note, dated 8/12/22 at 10:18 a.m., indicated there was a behavior observed but didn't indicate what the behavior was, the intervention attempted for the behavior exhibited, or follow up to the behavior documented.

A Neurologic Focused Evaluation, dated 8/14/22, indicated Resident B was alert but anxious and that was listed as an abnormality.

A progress note, dated 8/16/22 at 8:26 a.m., indicated the following, " ...Case worker and daughter feel res [Resident B] is in an active psychosis state at this time. Res [Resident] voiced to them there was an underground route trying to keep her here ...Explained [name of] Director of Memory Care was who she needed to speak with; emailed [initials of Director of Memory Care] message, name, and phone number of caseworker ...."

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	There was no follow-up documented regarding the progress note from 8/16/22 at 8:26 a.m. A Medication Administration Note, dated 8/17/22 at 9:15 a.m., indicated a behavior was observed with Resident B refusing care. There was no follow up to the behavior documented. A progress note, dated 8/18/22 at 6:14 p.m., indicated the following, " ...resident daughter came for visit and she noted her mom talking way different taking [sic] like paranoid, self harming, resident thinking somebody hitting me and she said looks [sic] my hands have all bruise [sic] but not there and she said I kill my self [sic], I am going to take poison so daughter talk with [name of physician] about what resident thinking and [name of physician] Oder [sic] send it out to ER [emergency room]. Daughter going with resident ...." There were no notes indicating Resident B was seen by a psychologist and/or a psychiatrist during her stay at the facility. An interview conducted with Family Member 8 on 10/5/22 at 12:00 p.m., indicated she was a Nurse Practitioner. Resident B was delusional and experiencing psychosis leading up to her hospitalization. She had no visits from a mental health professional the entire time she was at the facility. She went to visit Resident B, the day of hospitalization, and she noticed crosses drawn on notebooks in Resident B's room. Resident B was talking about wanting to obtain an attorney about bailing her out like she was in prison. She would visit Resident B one to two times weekly and noticed an increase of Resident B being depressed. Family Member 8 requested to speak with the Director of Nursing (DON), and she had			

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	never heard from them. The day that she went out to the hospital she threatened to commit suicide. Resident B commented about her "lawyer" telling her to take papers and light them on fire in the trash can. This would set the facility on fire and "kill everyone". If that didn't work, she was going to hang herself with a sheet. Resident B had all of her belongings in plastic bags and told Family Member 8 that she had a "surprise" in one of the bags. Family Member 8 decided at that time that it was best for Resident B to go out to the hospital for an evaluation because it was affecting the safety of the other residents and Resident B. An interview conducted with Resident B, on 10/5/22 at 12:45 p.m., indicated she went to the hospital for having increased depression. The facility made her "suicidal". When she went to the hospital from the facility, they adjusted her medication and she felt "much better" after that. An interview conducted with the Director of Memory Care, on 10/5/22 at 1:50 p.m., indicated she doesn't recall reaching out to [name of inpatient psychiatric facility] for Resident B. There was a psychiatric provider that would provide services, but they got replaced with another provider, but she was unable to recall when the previous provider stopped coming to the facility and when the new provider took over for mental health services. The Director of Memory Care interacted with Resident B on several occasions, and she did have episodes of paranoia and anxiety. She believed the Director of Social Services might have been involved with Resident B as well. An interview conducted with the Executive Director (ED) on 10/5/22 at 3:18 p.m., indicated a new mental health services provider was signed			

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on to start on June of 2022 but they were late initiating that process. So, that contract was terminated. There was a new company that they have contracted with for mental health services, and they are seeing residents currently. The previous mental health services provider was difficult with communication and would not go with what the facility wanted in regard to what resident needed to be seen. They would go by their own schedule and recommendations. Resident B was followed by Psychiatrist 10 at the Psychiatric Hospital prior to admitting to the facility and he does like for his patients to be followed by anyone for medication management besides himself. The facility was checking to see if Resident B's case manager was involved with taking her to visits with a psychiatrist/psychologist while she was at the facility.

A behavioral health note titled "hospital course", dated 8/19/22, indicated the following, "...who was brought to [name of hospital emergency room] reporting suicidal ideation with a plan to hang herself. The ECF [extended care facility] reported the patient endorsing SI [suicidal ideation] with a plan to hang herself after an argument with her daughter. Patient also reportedly stopped eating and drinking and seemed confused when evaluated by provider in ED [emergency department]...per the patient's daughter the patient has been exhibiting bizarre behaviors, disorganized thought process, paranoia and increased confusion...Subsequently, Psychiatry was consulted and the patient was admitted Geropsychiatry on 08/18/2022 with a diagnosis of bipolar disorder, current episode mixed, severe with psychotic features as inpatient status...."

A history and physical note, dated 8/19/22,

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indicated the following, "...During psychiatric triage...Patient was defensive, guarded and blaming others. She says yes to anxiety and depression. She is delusional and paranoid. Daughter voiced concern about patient's safety...Patient is unreliable, seemed confused, depressed, flat and withdrawn...."

A policy titled "Behavior Management Plan", revised 02/2017, was provided by the ED on 10/5/22 at 3:20 p.m. The policy indicated the following, " ...Residents who exhibit behavioral concerns may require a behavior management plan to ensure they are receiving appropriate services and interventions to meet their needs. The interdisciplinary team, including the family member, should develop a behavioral plan for each resident with identified behaviors through the RAI [Resident Assessment Instrument] process ...The plan should include the recreation schedule, non-pharmacological interventions, and environmental adjustments needed to help the resident meet his or her highest practicable well-being ...1. Upon admission of a new resident, the Unit Coordinator or designee will determine if the resident's behaviors warrant a behavior management plan ...4. Behaviors should be documented clearly and concisely by facility staff. Documentation should include specific behaviors, time and frequency of behaviors, observation of what may be triggering behaviors, what interventions were utilized, and the outcomes of the interventions ...5. Behaviors should be identified and approaches for modification or redirection should be included in the comprehensive plan of care ...."

This Federal tag relates to Complaint IN00391323.

3.1-37(a)

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