STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING 00 B. WING	06/01/2023

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

(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 the Investigation of Complaint IN00408725. Complaint IN00408725 - Federal/State deficiencies related to the allegations are cited at F656. The deficient practice was corrected on 4/24/23, prior to the start of the survey, and was therefore Past Noncompliance. Survey date: May 31 and June 1, 2023 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 1 Medicaid: 75 Other: 1 Total: 77 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 8, 2023.	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 a Complaint Survey on June 1, 2023. 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 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §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

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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 - (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 (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). (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or			

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	arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure the plan of care was implemented for 1 of 3 residents reviewed. Physician's orders for insulin were not followed. (Resident B) Findings include: On 5/31/23 at 11:00 a.m., the Interm DON indicated on 4/21/23 at 11:40 a.m., RN 1 had made a medication error . The Interim DON indicated RN 1 gave Resident B 60 units of Humalog (short acting insulin) instead of Lantus (slow acting insulin). After the administration of the incorrect insulin, Resident B was given some juice and Resident B indicated he was beginning to feel funny. Emergency services were called and a blood sugar (BS) was taken prior to transfer to hospital and it was 199. The clinical record for Resident B was reviewed on 5/31/23 at 1:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus, morbid obesity, and chronic respiratory failure. A review of Resident B's insulin orders, included, but were not limited to: - Glargine Solution (Lantus) Injection (insulin) 100 units subcutaneous two times a day, initiated 8/17/22. - Humalog Solution 100/ml inject per sliding scale, initiated 4/4/23. The After Care Summary from the hospital for Resident B indicated, it was noted to be a non emergency visit. Resident B was to remain in the	F 0656	Resident B plan of care continues to be followed. All other residents who receive insulin have the potential to be affected. All residents who receive insulin were reviewed and orders have been followed for insulin administration. Education provided by the Director of Clinical Education to Nurses and QMAs with insulin administration on Medication Administration Policy. The DCE or designee will continue to monitor 3 Nurses/QMAs (with insulin certification) on insulin administration weekly for 8 weeks. All deficient practices will be reported to the DNS/designee immediately and deficiencies will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues are identified, audits will continue based on IDT recommendation, otherwise will review on a PRN basis.	06/27/2023

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	emergency room for 4 hours to recheck his blood sugars. On 6/1/23 at 2:30 p.m., the Medication Administration Policy, undated, was reviewed. The Interim DON indicated this was the policy currently in use. The policy included, but was not limited to, to compare medication source with MAR (Medication Administration Record) to verify resident name, medication name, form, dose, route, and time. The deficient practice was corrected by 4/24/23 after the facility implemented a systemic plan that included the following actions: nursing staff in-service regarding medication administration with sign-in sheets, verification of medication administration skills by written exam and demonstration, ongoing monitoring/auditing of insulin administration, and referral to the QAPI program for follow-up and continued monitoring. This Federal tag relates to complaint IN00408725. 3.1-35(g)(2)			