STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 00 B. WING	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - RICHMOND CARE CENTER	1042 OAK DR RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00440019, IN00439896, IN00437595, IN00435225 and IN00434048. Complaint IN00440019 - Federal/State deficiencies related to the allegations are cited at F-553 Complaint IN00439896 - Federal/State deficiencies related to the allegations are cited at F-684 Complaint IN00437595 - No deficiencies related to the allegations are cited. Complaint IN00435225 - No deficiencies related to the allegations are cited. Complaint IN00434048 - No deficiencies related to the allegations are cited. Survey dates: August 1, 2, & 5, 2024 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 3 Medicaid: 54 Other: 6 Total: 63 These deficiencies reflect State Findings cited in	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 in 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
Joanne L Denney	Executive Director	08/21/2024

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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	accordance with 410 IAC 16.2-3.1. Quality review completed on August 8, 2024.			
F 0553 SS=D Bldg. 00	483.10(c)(2)(3) Right to Participate in Planning Care §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.			

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	Based on interview and record review, the facility failed to complete care plan meetings for residents and their representatives for 2 of 3 residents reviewed for care plan meetings (Resident F and Resident D). Findings include: 1. Review of the record for Resident F, on 8/1/24 at 1:23 p.m., indicated the diagnoses included, but were not limited to, cerebral palsy, autistic disorder, seizures, anxiety, depression, adult failure to thrive, and intellectual disabilities. Resident F was admitted on 3/13/24. The resident and the resident's representative had two care plan meetings on 1/2/24 and 6/13/24. 2. The clinical record for Resident D was reviewed on 8/2/24 at 12:00 p.m. The diagnoses included, but were not limited to, unspecified intellectual disabilities, essential hypertension, and depression. The clinical record indicated Resident D had a care plan meeting on 12/12/23. No other care plan meetings were documented after that date. A care plan meeting document provided by the Director of Nursing Services (DNS), on 8/2/24 at 2:30 p.m., indicated a care plan meeting was held with Resident D and her representative on 12/12/23. During an interview with the Executive Director (ED), on 8/2/24 at 11:40 a.m., indicated care plan meetings were held as often as needed and quarterly. The ED indicated social services were responsible to ensure care plan meetings were completed quarterly.	F 0553	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?* Care plan scheduled with residents noted have been scheduled. *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 have the potential to be affected. SSD or designee completed audit of all residents to ensure care plans scheduled with family. Resident received invites. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.* An annual care plan meeting calendar will be put in place. IDT in-serviced on 8/20/22 for care plan invitations with family and residents. *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?* SS or designee will audit monthly for 6 months to ensure all residents and family are invited to care plans. Any negative findings	08/22/2024

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	A Care Planning-Resident Participation policy provided by the Unit Manager, on 8/2/24 at 12:15 p.m., indicated the following, "...8. The facility will honor requests for care plan meetings and acknowledge requests for revisions to the person-centered plan of care. 9. The facility will honor the resident's right to participate in establishing the expected goals and outcome of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. 10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative. This citation relates to Complaint IN00440019. 3.1-3(n)(3)		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, we will continue audits based on IDT recommendation.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to notify a resident's infectious disease	F 0684	*What corrective actions will be accomplished for those residents found to have been affected by*	08/22/2024

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	physician of lab results, as ordered, and obtain a lab, as ordered by the pharmacy, prior to continuing administration of an antibiotic for 1 of 3 residents reviewed for skin conditions. (Resident E) Findings include: The clinical record for Resident E was reviewed on 8/1/24 at 12:35 p.m. The diagnoses included, but were not limited to, osteomyelitis, type 1 diabetes mellitus, peripheral vascular disease, and peripheral neuropathy. He was admitted to the facility on 6/1/24 after a hospitalization involving osteomyelitis of the right foot. He was discharged from the facility on 7/19/24. The 5/20/24, ED (emergency department) note from the 5/20/24 through 6/1/24 hospital notes indicated, "presenting to ED with pain and bleeding from right foot wounds. Also associated with right calf pain similar to pain when he had his peripheral vascular stent placed one year ago....He c/o [complains of] foot wound for past couple of weeks, has been trying to manage on his own at home...Assessment/Plan 1. Osteomyelitis of foot...XR [x-ray] right foot showed osteomyelitis involving fifth toe proximal phalanx base as well as head and neck of fifth toe metatarsal." The 6/1/24, hospital discharge instructions indicated, "Instructions From Your Care Team 1. Will need Ceftriaxone and Vancomycin for 6 weeks. Last dose will be on 7/2/24. 2. Will need weekly CBC [complete blood count,] CMP [comprehensive metabolic panel] and Vancomycin trough while on antibiotics. Please fax results to [name of infectious disease physician's] office at [fax number of infectious disease physician.] The Medications section of the discharge instructions		*the deficient practice?* Resident E no longer resides in 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. Audit of all residents with skin conditions on antibiotics to ensure ATB completed as ordered.* *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.* All licensed staff were educated on laboratory services. An audit was conducted for all residents with skin conditions on antibiotics to ensure labs were obtained ad results were communicated to the ordering physician. *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?* The results of these audits will be reviewed at QAPI for 6 months Any negative findings 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, we will	

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	indicated to administer 12.5 ml of Vancomycin 100 mg/mL IV (intravenously) every 12 hours with the last dose to be administered on 7/2/24. The Education Materials section of the hospital discharge instructions indicated, "You have a condition called osteomyelitis. This is a bone infection caused by bacteria or fungi. It may have spread through the blood from one area of your body to the bone....Home Care: Take your medicine exactly as directed." The 6/1/2024, 5:55 p.m. facility progress note indicated, "Patient arrived at facility at/around 1500 [3:00 p.m.] Patient was transported via ambulance from [name of hospital.] Patient arrived via stretcher with no assistance with transfer, patient stood on left foot to pivot from stretcher to bed. Patient is a&ox3 [alert and oriented times 3,] cont [continent] of b/b bowel/bladder,] Patient is non weight bearing on right foot due to 5th toe amputation. Patient currently has a patent picc [peripherally inserted central catheter] line in upper right extremity, he is now taking multiple iv atb [antibiotics] see orders. Patient is nwb [non weight bearing] on right foot, and needs a f/u [follow up] appointment with surgeon made for 6/7/2024...Patient had 2 ivs infiltrate at hospital in forearm of left arm this arm is painful to touch at this time. Patients right foot has dressing on, patient declined for me to look at it at this time d/t [due to] already being in pain, nurse reported this to following nurse. Nurse noted to call surgeon if patient has increased redness, swelling, drainage at incision site, fever of 100.4 or greater, chills, increased fatigue or tiredness...Patient-oriented to room and call light, patient oriented to bathroom with wheelchair. Patient is now resting comfortably in bed." The facility's physician orders, effective 6/3/24		continue audits based on IDT recommendation.	

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	through 6/26/24, indicated to obtain a weekly CBC, CMP, and Vancomycin Trough while on antibiotics, and the trough needed to be drawn at 11:30 a.m. Tuesday mornings. The orders, effective 6/26/24, indicated to obtain a weekly CBC, CMP, and Vancomycin Trough while on antibiotics, and the trough needed to be drawn at 11:30 a.m. Wednesday mornings. For both orders, the results were to be faxed to Resident E's infectious disease physician at the same fax number referenced in the hospital discharge instructions. The orders, effective 6/2/24 to 6/12/24, indicated to administer 1.25 gram of Vancomycin IV 1250 mg/250ML (milligrams/milliliters), use 1.25 gram via IV two times a day. The orders, effective 6/12/24 to 7/1/24, indicated to administer 1.25 gram of Vancomycin 1500mg/15ml via IV two times a day. The orders, effective 7/1/24 to 7/8/24 indicated to administer Vancomycin 1500 mg via IV every 8 hours. The June, 2024 and July, 2024 MARs (medication administration records) indicated the above 7/1/24 Vancomycin order for every 8 hours was administered twice on 7/1/24, 7/3/24, and 7/5/24, and three times on 7/2/24, 7/4/24, 7/6/24 (first administration of the day references progress note regarding administration while away from facility), 7/7/24, and once on 7/8/24. All CBC, CMP, and Vancomycin Trough lab results for Resident E's entire stay were provided by the DON (Director of Nursing) on 8/2/24 at 10:30 a.m. There were results for the following dates: 6/4/24, 6/12/24, 6/18/24, 6/26/24, and 7/2/24. The 7/2/24 Vancomycin trough result was high at 26.5 ug/mL (microgram per milliliter.) The reference range was 10-20 ug/mL.			

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	A telephone interview was conducted with the Certified Medical Assistant from Resident E's Infectious Disease Physician on 8/2/24 at 1:53 p.m. She indicated they were not notified of Resident E's high Vancomycin trough result from 7/2/24 or any of his other Vancomycin trough, CBC, or CMP results. She stated, "I have never received any from them." Reviewing the lab results was important, because "that's how we keep an eye on the patient....We have nothing in his chart on lab results." As far as the Vancomycin being given until 7/8/24, Resident E's last order from his Infectious Disease Physician was from prior to him leaving the hospital, on 6/1/24, and it was to stop the Vancomycin on 7/2/24 and pull the PICC (peripherally inserted central catheter) after the last dose. An interview was conducted with the facility's Medical Director on 8/2/24 at 3:05 p.m. He indicated it was possible the 7/2/24 Vancomycin lab result was drawn after a dose of Vancomycin, at the wrong time. They have pharmacy manage Vancomycin dosing, because they should be using a software-based area under the curve calculation to determine dosing. The facility should have administered Resident E's Vancomycin based on the orders transmitted to them by the pharmacy. As far as he was concerned, pharmacy should be managing the Vancomycin and the facility trusted them to do that. On 8/5/24 at 10:35 a.m., the Director of Nursing (DON) provided documentation she indicated as all the pharmacy documentation regarding Resident E's Vancomycin management. The documentation included a 6/8/24 Vancomycin Recommendation that read, "6/4 trough is slightly low at 9.6 starting Monday 6/10 please increase			

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	dose to: Vancomycin 1500 mg every 12 hours. Draw trough 30 minutes prior to dose on 6/12/24." The documentation included a 6/30/24 Recommendation that read, "6/27 trough is on the low end for osteomyelitis at 10.1. Please INCREASE frequency to every 8 hours. New order: Vancomycin 1500 mg q8h [every 8 hours] starting on 7/2/24. Draw trough 30 minutes prior to dose on 7/3/24." The 6/30/24 recommendation was the last pharmacy recommendation included in the documentation. There was no recommendation included regarding the 7/2/24 high Vancomycin lab result. The June, 2024 MAR indicated the above 6/8/24 pharmacy recommendation to increase the dose to 1500 mg every 12 hours starting 6/10/24 did not start until 6/12/24. The clinical record did not include, nor did the facility provide, a 7/3/24 Vancomycin trough result, as pharmacy recommended be obtained prior to 7/3/24 administration or any subsequent Vancomycin trough results. The July, 2024 MAR indicated the last dose of Vancomycin administered to Resident E was on 7/8/24. The 7/8/24 Grievance Form for Resident E indicated the detail of the complaint/grievance was a medication issue, not ordered correctly, in regards to antibiotic medication. On 8/2/24 at 2:49 p.m., an interview was conducted with RN (Registered Nurse) 2, who administered Resident E's last dose of Vancomycin on 7/8/24. She indicated she entered the final Vancomycin order into the electronic health record and could not recall if there was an end date but didn't think			

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	there was. Prior to administering Vancomycin, she always checked the most recent lab results. She was the one who figured out his Vancomycin trough levels were too high. An interview was conducted with the DON on 8/5/24 at 10:27 a.m. She indicated the Vancomycin continued until 7/8/24, but there was no Vancomycin trough result from 7/3/24 as recommended by pharmacy. She was on vacation the previous week, and when she returned, on 7/8/24, Resident E had filed a grievance asking about the Vancomycin, so she looked into it and discontinued it. The Laboratory Services and Reporting policy was provided by the DON on 8/2/24 at 10:30 a.m. It indicated the following, "Policy Explanation and Compliance Guidelines: 1. The facility must provide or obtain laboratory services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services....6. All laboratory reports will be dated and contain the name and address of the testing laboratory and will be filed in the resident's clinical record. 7. Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside the clinical reference range." The Medication Issues of Particular Relevance in Older Adults pharmacy policy was provided by the DON on 8/5/24 at 10:35 a.m. The Parenteral Vancomycin Monitoring section indicated, "Use must be accompanied by monitoring of renal function tests (which should be compared with the baseline) and by serum medication concentrations. Serious adverse consequences may occur insidiously if adequate monitoring does not occur....Adverse Consequences - May			

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	cause or worsen hearing loss and renal failure." The Medication Administration policy was provided by the DON on 8/5/24 at 10:35 a.m. It indicated, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. This citation relates to Complaint IN00439896. 3.1-37(a)			