STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155834	A. BUILDING 00 B. WING	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - WILLOW SPRINGS CARE CENTEI	2002 WEST 86TH STREET INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00386880, IN00387597, IN00384357, IN00384361 and IN00383761. Complaint IN00386880 - Substantiated. Federal/state deficiencies related to the allegations are cited at F0698 and F0842. Complaint IN00387597 - Substantiated. Federal/state deficiencies related to the allegations are cited at F0842. Complaint IN00384357 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00384361 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00383761 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 15, 16 and 17, 2022 Facility number: 013738 Provider number: 155834 AIM number: 100272170 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 4 Medicaid: 58 Other: 2 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation or execution of the plan of correction does not constitute admission or agreement or conclusion 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 prepared and executed solely because it is required by the position of federal and state law. The plan of correction is submitted to respond to allegations of noncompliance cited. 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 completed on August 25, 2022.			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to verify a dialysis order on the discharge form from the hospital, resulting in a resident not receiving dialysis services for 12 days for 1 of 3 residents reviewed for quality of care related to dialysis. (Resident C) Finding includes: In an interview on 08/15/22 at 10:50 a.m., Registered Nurse (RN) 1 indicated Resident C was not a patient of (name of dialysis company). The dialysis company did have a facility set up in Brickyard Healthcare's basement, but it was independently owned and not a part of the skilled facility. The process of becoming a patient of the dialysis company consisted of the hospital contacting the dialysis company and providing all the medical information which was then reviewed by the nephrologist and the nephrologist made the determination to accept the resident/patient. The process usually took 24 to 48 hours. The hospital did contact the dialysis company, but Resident C was not accepted as a patient by the dialysis company. She was unable to say why the resident was not accepted. In an interview on 08/15/22 at 11:38 a.m., the Director of Nursing indicated Resident C did not	F 0698	Resident C no longer resides at the facility. Resident who receive dialysis have the potential to be affected. An audit was completed to ensure residents with orders for hemodialysis received hemodialysis. Regional Director of Clinical Operations/ designee completed education with clinical managers on process of checking admission charts and validation of hemodialysis orders along with ensuring hemodialysis is set up appropriately. Admissions charts will be checked for hemodialysis orders and will validate resident is receiving hemodialysis per physician orders. Admissions charts will be checked 5 days a week for 4 weeks and then 3 times a week for 8 weeks. Results of these audits will be brought to QAPI meeting for 6	09/13/2022

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	attend dialysis. In an interview on 08/16/22 at 8:54 a.m., the Social Services Worker indicated she did not interact with dialysis. The only way she was made aware of a resident admitting on dialysis was from the Admission's Coordinator. In an interview on 08/16/22 at 12:06 p.m. the Executive Director indicated a referral was sent when a resident who required dialysis was expected to admit from the hospital. The skilled facility reviewed the referral, but the resident was not accepted until Physician 2 (the physician for the dialysis company) signed off/approved the dialysis. The facility might feel they can admit the resident, but if Physician 2 did not approve the dialysis, the facility could not admit the resident to dialysis. If the resident needed dialysis, the skilled facility would arrange dialysis with an outside company. The skilled nursing facility would evaluate the availability of dialysis chairs in the community, days when dialysis was needed and the times. If they had been made aware Resident C required dialysis, they would not have admitted her or they would have arranged for dialysis outside of the facility. Resident C was not on dialysis until she arrived at the facility and the family felt she should have been on dialysis. Had the facility known they would not have admitted her, or they would have arranged for the dialysis service with a provider outside of the facility. He indicated Resident C did receive dialysis while in the hospital, but the facility was not aware she had received the service while in the hospital. When it was determined Resident C needed dialysis she was sent to the hospital. In an interview on 08/16/22 at 12:20 p.m., the Admission Director indicated the facility were not		months to identify trends and to make recommendations. If issues/trends are identified, then audits will continue based on QAPI recommendation. If none noted, then will complete audits based on a prn basis. The date of compliance is September 13, 2022.	

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	notified the resident was on dialysis, instead she was informed the resident was refusing dialysis. When the skilled nursing facility followed up with the hospital, that was when the dialysis paperwork was sent to them. If the facility had received the dialysis information, they would not have admitted the resident. In an interview on 08/16/22 at 1:58 p.m., the Hospital Case Manager indicated Resident C was sent to the nursing facility on 07/16/22. She received communication from the facility indicating they had not been informed Resident C required dialysis. The information was sent to the facility on July 18, 2022 (2 days after the resident had already admitted to the skilled facility), as they were unable to fax the information on July 16, 2022 because the dialysis company was closed. The information was faxed to the facility, not the dialysis company. She indicated the facility was sent everything related to dialysis for Resident C on 07/11/22. On 07/13/22 the resident was accepted by the nursing facility and services were to include in-house dialysis. She did interview the hospital case workers and documentation indicating the facility was contacted but the social worker did not have the name of who she spoke with at the time. In an interview on 08/16/22 at 3:36 p.m. Licensed Practical Nurse (LPN) 3 indicated when a new resident was admitted to the facility the nurse would go through the orders and see what the patient needed. Once the orders were entered into the chart the nurse would contact the facility physician and notify them of the admission. At that time LPN 3 was provided with the discharge information from the hospital. She indicated from the diagnosis of end stage renal disease and fluid overload she suspected dialysis was needed. She			

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	further indicated " ...HD ...MWF ...." meant dialysis on Monday, Wednesday and Friday, and the service would have needed to be scheduled. The dialysis schedule would have depended on whether the service was in-house or out and the admission person would normally have that information. The nurse would then contact the physician and the Director of Nursing and inquire where the dialysis service would be provided. In an interview on 08/16/22 at 3:46 p.m. the Director of Nursing reviewed the discharge information sent from the hospital. He indicated " ...HD ...MWF ...." Should have indicated where the dialysis service was to be performed and the facility would have set up transportation to the site, however any patients that required dialysis needed to be approved by the dialysis physician. The Admission Director did have paperwork, a referral, but it did not indicate hemodialysis was needed. When the nurse took report, she did find the resident had received dialysis in the hospital. He indicated he remembered asking if the resident would be receiving dialysis at the site, located in the skilled facility, and was told no. The nurse practitioner did order base line lab work and the results did not indicate dialysis was needed. He did speak with Resident C and the resident did not mention dialysis. After he noticed the dialysis access port the resident told him she did have dialysis in the hospital. He followed up with the dialysis site located in the facility and was told she was not on dialysis. The resident did have an appointment with her nephrologist and was told she did not require dialysis at that time. He indicated the nurse taking report was informed the resident was refusing dialysis at the hospital. The facility was not given information the resident required dialysis, the family did not give information the resident was going to dialysis and			

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	the resident said she was not getting dialysis. There was miscommunication with the hospital. During the interview with the Director of Nursing, the Admission Director indicated she did receive the referral from the hospital, it did not mention dialysis and she did not receive a call about sending information to the dialysis provider. The hospital should not send information about dialysis directly to the dialysis provider, that information needed to be sent through the facility's corporate admissions where if would have been scanned and then sent to MD 2 at the dialysis company. She did reach out to the case worker at the hospital and was told by the case worker dialysis information was not sent to the facility because the resident was refusing the service. In a telephone interview on 08/17/22 at 8:34 a.m., the Clinical Liaison indicated the hospital referral was accepted for admittance to the facility and at that time she was informed the resident was refusing dialysis. The case worker had called the family about refusing dialysis and the family was to find another treatment option. The resident was accepted by the skilled nursing facility, before she left the hospital, with the understanding she did not require dialysis. She indicated the facility should have followed up on the admission orders when the orders arrived at the facility. The record for Resident C was reviewed on 08/15/22 at 10:33 a.m. Diagnoses included but were not limited to end stage renal disease (kidney failure), dependence of renal dialysis and fluid overload (too much fluid volume in the body). Resident C admitted to the skilled nursing facility on July 16, 2022 and discharged on 07/28/22.			

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	A nurse's note, dated 07/16/22 at 12:50 p.m., indicated the resident arrived at the facility. The note did indicate Resident C had an access port for dialysis in her right upper chest. There was no note to indicate the hospital reported the resident was on dialysis or refusing dialysis. A physician's note, dated 07/20/22, indicated a Comprehensive Metabolic Panel result was reviewed there was a critical Cr (creatinine clearance-a measure of how well the kidneys filter creatinine form the blood stream via urination). The note indicated the resident was end stage renal disease and "...Elevated Cr is normal...." A nurse's note, dated 07/28/22 at 4:39 p.m., indicated the resident was transported by a family member to the hospital for dialysis. There were no notes to indicate resident had attended dialysis or refused dialysis during the facility stay from 07/16/22 to 07/28/22. A physician's order, initiated on 07/18/22 and discontinued on 07/26/22, indicated dialysis treatments on Monday through Friday at (name and address of dialysis facility) every day shift. A care plan, initiated on 07/16/22 and canceled on 08/01/22, indicated Resident C had an alteration in kidney function and was refusing dialysis. One intervention, initiated and revised on 07/18/22, indicated, " ...Resident specific dialysis schedule. Notify physician and dialysis center if unable to make appointments ...Location: willow springs ...Days: M-F ...." A facility referral form, printed from electronic mail (email) dated 07/12/22 at 11:00 a.m., was provided by the Director of Nursing on 08/16/22 at 4:09 p.m.			

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	The document did not include a need for dialysis services. A facility referral form, printed from electronic mail (email) dated 07/12/22 at 11:31 a.m., was provided by the Director of Nursing on 08/16/22 at 4:09 p.m. The document indicated the resident was accepted to the facility. The document did not mention dialysis services. A document provided by the Director of Nursing on 08/17/22 at 2:50 p.m., titled, "Name of Hospital" indicated, " ...Inpatient Discharge Instructions ...What to do next ...Instructions From Your Care Team ...HD-MWF...." An undated facility policy provided by the Director of Nursing, on 08/17/22 at 2:50 p.m., titled "Admission Orders" indicated, "...A physician must personally approve, in writing, a recommendation that an individual be admitted to a facility...A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide written and/or verbal orders for the resident's immediate care and needs..." This Federal tag relates to Complaint IN00386880. 3.1-37(a) 3.1-37(b)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the			

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	information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be			

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	retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to document medications or treatments after services were provided and failed to ensure documentation in the Medication Administration and Treatment Records (MAR/TAR) was accurate for 2 of 6 residents reviewed for nursing services related to documentation. (Resident C and Resident D) Findings include: In an interview on 08/17/222 at 1:18 p.m., the Director of Nursing indicated the nursing staff was expected to sign off on the MAR/TAR after administration of medications and treatments were provided to residents and the documentation in the MAR/TAR was to be correct/accurate. In an interview on 08/17/22 at 3:16 p.m. the	F 0842	Resident C and C no longer reside at the facility. All residents in the facility have the potential to be affected by the deficient practice. The facility completed an audit of the missed documentation. DCE/designee educated nursing staff on missing documentation along with completion of Medication/Treatment Administration Records. The policy utilized for education is medication administration. DNS/ designee will run administration audit report daily for	09/13/2022

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	Director of Nursing indicated the nurse did enter orders for dialysis, but Resident C did not go to dialysis. 1. The record for Resident C was reviewed on 08/15/22 at 10:33 a.m. Diagnoses included, but were not limited to, end stage renal disease (kidney failure), dependence of renal dialysis and fluid overload (too much fluid volume in the body). A physician's order, initiated on 07/16/22 and discontinued on 07/29/22 indicated to give clopidogrel 75 milligrams (mg) daily. The MAR/TAR for July 2022 had not been signed off for the clopidogrel 75 mg dose on July 18th. A physician's order, initiated on 07/18/22 and discontinued on 07/26/22, indicated dialysis treatments on Monday through Friday at (name and address of dialysis facility) every day shift. The MAR/TAR for July 2022 had been signed off on July 18, 19, 20, 21, 22, 25 and 26, indicating Resident C received dialysis treatments on those days. A physician's order, initiated on 07/16/22 and discontinued on 07/29/22 indicated to apply Nystatin Cream 1000000 unit/gram to affected areas every day and night shift. The MAR/TAR for July 2022 had not been signed off for the Nystatin cream administration on July 18th, night shift. 2. The record for Resident D was reviewed on 08/15/22 at 9:53 a.m. Diagnoses included, but were not limited to, acquired absence of the right foot, peripheral vascular disease and non-pressure		5 days a week to ensure compliance and is complete. This practice will continue for 8 weeks. Results of these audits will be brought to the QAPI meeting for six months to identify trends and to make recommendations. If issues/trends are identified, then audits will continue based on QAPI recommendation. I none noted, the will complete audits based on a prn basis. The date of compliance will be September 13, 2022.	

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	chronic ulcer of part of the left foot. Resident D admitted to the facility on 06/29/22 and left the facility on 07/20/22. A physician's order dated 06/29/22, indicated to administer aspirin enteric coated 81 mg once a day. The MAR/TAR for July 2022 had been signed off on July 21, 2022 indicating the medication was administered. A physician's order, initiated on 06/29/22, indicated to apply bacitracin ointment 500 units/gram to the left middle finger every day for 10 days. The MAR/TAR for July 03, 2022 was not signed off. A physician's order, initiated on 06/29/22, indicated to administer Vitamin D 25 mcg one time a day. The MAR/TAR for July 2022 had been signed off on July 21, 2022 indicating the medication was administered. A physician's order, initiated on 06/29/22, indicated to administer carvedilol (a medication for high blood pressure) 12.5 mg twice a day. The MAR/TAR for July 1 and July 3 had not been signed off for the 4:00 p.m. administration. The MAR/TAR for July 2022 had been signed off on July 21, 2022 for 8:00 a.m. indicating the medication was administered. A physician's order, initiated on 07/14/22,			

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	indicated to administer doxycycline (an antibiotic) 100 mg for 10 days until 07/22/22. The MAR/TAR for July 2022 had been signed off on July 21, 2022 for 8:00 p.m. indicating the medication was administered. A physician's order, initiated on 06/27/22, indicated to give Admelog Solostar 7 units of insulin three times a day. The MAR/TAR for July 1st was not signed off for the 5:00 p.m. dose, the July 3rd 12:00 or the 5:00 p.m. dose. The MAR/TAR for July 2022 had been signed off on July 21, 2022 for 8:00 a.m. indicating the medication was administered. A physician's order, initiated on 07/10/22, indicated to paint betadine to the left great toe, left second toe and left third toe, allow to dry, cover with an abdominal pad (a dressing), wrap with kerlix and secure, and every night shift. The Mar/TAR for July 18 had not been signed off to show the dressing change had been completed. A facility policy dated 2022, provided by the Director of Nursing on 08/17/22 at 2:50 p.m., titled, "Documentation in the Medical Record" indicated, "...Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation....Documentation shall be completed at the time of service, but no later than the shift in which the...care service occurred....False information shall not be documented...Documentation shall be accurate...and complete...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155834	A. BUILDING 00 B. WING	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	This Federal tag relates to Complaints IN00387597 and IN00386880. 3.1-50(a)(1) 3.1-50(a)(2)			