STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155367	A. BUILDING 00 B. WING	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE– SYCAMORE VILLAGE CARE CEN	2905 W SYCAMORE ST KOKOMO, IN 46901

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00372844. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00372844 - Substantiated. Federal/State deficiencies related to the allegations are cited at F695. Survey dates: February 23 and 24, 2022 Facility number: 000258 Provider number: 155367 AIM number: 100289160 Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 8 Medicaid: 61 Other: 23 Total: 92 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 7, 2022.	F 0000	Preparation, submission and implementation of this POC does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our POC is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal Regulatory requirements. The facility respectfully request desk review for this citation .	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning,			

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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	is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on interview and record review, the facility failed to recognize a change in respiratory condition and to timely implement interventions for a change in condition for 1 of 3 residents reviewed for oxygen (Resident B). Finding includes: During an interview, on 2/24/21 at 12:31 p.m., a family member indicated the resident had been in isolation due to Covid and when she called to check on the resident's condition, the staff had told her he had been out of his room and had biscuits and gravy. The information did not make sense for the resident to be out of his room since he was on isolation. The resident's condition worsened and he was sent to the hospital. At the hospital, his blood sugar was 655, he was septic and he was not in those conditions when he went to the facility. The record for Resident B was reviewed on 2/23/2022 at 1:44 p.m. Diagnoses included, but were not limited to, Covid-19, type 2 diabetes mellitus, chronic obstructive pulmonary disease, unspecified dementia and atrial fibrillation. A baseline care plan, dated 1/13/22, indicated the resident did not use oxygen therapy and was in droplet isolation. The medical conditions indicated the resident did not need terminal care. A physician's order, dated 1/14/22, indicated oxygen at 2-3 L (liters) per minute by nasal cannula to keep oxygen saturations above 92%	F 0695	F 695 Respiratory/Tracheostomy Care and Suctioning to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents that reside at the facility have the potential to be affected by the same alleged deficient practice. Initial audit An initial medical record audit was completed with a look back of 7 days to identify any residents that experienced a change in condition to ensure it was recognized and they received timely intervention for the change in condition. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education Licensed Nurses were educated on change of condition guidelines to include but not limited to, recognize a change in respiratory condition and to timely implement interventions for a change in condition. QMA/Nurse Aides were educated on change of condition guidelines to promote their situational understanding and facilitate timely communication/notification with licensed nurses. On-going monitoring The DNS or Designee	03/19/2022

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	and to call the physician if an increase was needed. A Weights and Vitals Summary form indicated the resident had the following oxygen (02) saturations: a. On 1/13/22 at 10:14 p.m., was 97% on room air. b. On 1/14/22 at 4:05 a.m., was 96% on room air. c. On 1/14/22 at 10:58 a.m., was 96% on room air. d. On 1/14/22 at 7:50 p.m., was 96% on room air. e. On 1/15/22 at 9:50 a.m., was 96% on room air. f. On 1/15/22 at 1:04 p.m., was 93% on room air. g. On 1/15/22 at 7:26 p.m., was 94% on room air. h. On 1/16/22 at 1:38 a.m., was 95% on room air. i. On 1/16/22 at 2:15 p.m., was 96% on room air. j. On 1/16/22 at 7:59 p.m., was 95% on room air. k. On 1/17/22 at 6:32 a.m., was 96% on room air. l. On 1/17/22 at 12:28 p.m., was 97% on room air. m. On 1/17/22 at 10:25 p.m., was 97% on room air. n. On 1/18/22 at 6:37 a.m., was 88% on room air. A Weights and Vital summary form indicated the next oxygen saturation was documented on 01/18/22 at 11:47 a.m., and was 91% via oxygen mask. The documentation did not include an assessment or interventions for the resident due to the dropped oxygen saturation at 6:37 a.m., until 11:45 a.m., which was 5 hours and 8 minutes later. A change of condition progress note, dated 1/18/22 at 11:45 a.m., indicated Resident B was having increased shortness of breath and a decreased level of consciousness. The resident's 02 saturation was 88% on room air and oxygen at 4L per nasal cannula was applied. There were crackles noted to all lung fields and the resident had jerking movements to his bilateral upper extremities.		will review residents daily during morning clinical review and/or rounding to ensure changes in condition were identified and interventions implemented timely. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance Alleges the facility failed to recognize a change in respiratory condition and to timely implement interventions for a change in condition. 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 po 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 based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	

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	This progress note was not marked as a late entry. A progress note, dated 1/18/22 at 11:50 a.m., indicated 911 was dispatched. A progress note, dated 1/18/22 at 12:00 p.m., indicated the EMTs' were on the scene. The resident was being taken to the hospital and departed the parking lot at 12:10 p.m. An emergency room note, dated 1/18/22, indicated the resident was noted to have a fever, altered mental status, shortness of breath and a rapid heart rate. His temperature was 100.2 and he also had markedly elevated sodium, severe hyperglycemia and severe urinary retention. The resident was writhing around on the bed and looked uncomfortable. The resident had 1600 ml (milliliters) of urine output immediately with the Foley catheter placement. A Hospital report, titled "Death Note," dated 1/19/22 at 8:40 p.m., indicated Resident B was presented by EMS (emergency medical services) from the nursing home. The resident was Covid positive on 1/14/2022. Upon presentation to the emergency room, the resident had altered mental status, had a heart rate in the 170's, an elevated white blood cell count, fever, acute kidney injury, severe hyperglycemia, severe hypernatremia (elevated blood sodium) and urinary outlet obstruction. The resident was started on IV antibiotics to treat for possible sepsis and given fluid resuscitation. The resident's daughter was informed this would most likely be a terminal event. The diagnoses at the time of death were sepsis, severe hypernatremia, altered mental status, acute kidney injury, atrial fibrillation with rapid ventricular response, hyperglycemia, Covid			

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	positive and a history of hypothyroidism. During an interview, on 2/24/22 at 2:14 p.m., QMA 2 indicated he was working the Covid unit on 1/18/22 and Resident B had only been at the facility for a few days. The resident did pretty well except the last day. He did wear oxygen and would take the oxygen off himself at times. The morning of 1/18/22, the resident was worse and his oxygen was real low. QMA 2 put the resident's oxygen on him. At about 11:45 a.m., on 1/18/22, QMA 2 got the ADON (Assistant Director of Nursing) and asked her to check the resident. The resident was sent to the ER. During an interview, on 2/2422 at 2:48 p.m., the ADON indicated she could not remember what time she went to check on Resident B on 1/18/22. She indicated she charted at 11:45 a.m., and it was the time the resident was sent to the ER. She usually arrived at the facility at 9:00 a.m. A current policy, titled "Oxygen Administration," not dated and received from the clinical support staff on 2/24/22 at 2:17 p.m., indicated "...Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences...Oxygen is administered under orders of a physician, except in the case of an emergency. In such case oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control...Personnel authorized to initiate oxygen therapy include physicians, RN's, LPN's and respiratory therapists...Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentration, or evidence of			

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	complications associated with the use of oxygen...." A current policy, titled "Documentation in Medical Record," not dated and received from the DON (Director of Nursing) on 2/24/2022 at 4:50 p.m., 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...When documentation occurs after the fact, outside acceptable time limits, the entry shall be clearly indicated as 'late entry'...." This Federal Tag relates to Complaint IN00372844 3.1-47(a)(6)			