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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 IN00375666 Complaint IN00375666 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F690 and F695. Survey dates: March 28 and 29, 2022 Facility number: 000258 Provider number: 155367 AIM number: 100289160 Census bed type: SNF/NF: 96 Total: 96 Census payor type: Medicare: 3 Medicaid: 65 Other: 28 Total: 96 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 5, 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 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.¿	
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			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident was scheduled for Physician prescribed procedures in a timely manner for 1 of 3 residents reviewed for quality of care. (Resident B) Finding includes: A Confidential Interview was conducted during the course of the survey with two different Confidential Interviewees at the same time (Confidential Interviewee 1 and 2). Confidential Interviewee 1 indicated they both had concerns regarding the care their loved one was receiving at the facility. Confidential Interviewee 1 indicated the staff did not follow through with requests made by Confidential Interviewee 2 and herself, regarding the resident's medical care. Resident B had a discharge from her breast for over three months and they had "begged" the facility staff to get a Mammogram completed. RN 5 had forgotten to call and schedule the Mammogram appointment for at least one and a half months after the Physician wrote the order. When the staff "finally" had the Mammogram scheduled for 3/16/22, the appointment was canceled because the original Physician's order was "misplaced" and the Mammogram center would not take her without it. It was found later that day, on RN 4's office desk. RN 4 indicated she would call and get the appointment rescheduled by the end of the day, but she did not because by the time she called the Mammogram Center had closed. The Mammogram appointment was rescheduled for 3/30/22, but the resident was not able to attend that appointment because she was admitted to the	F 0684	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident B: Medical Record was reviewed for orders for testing. Resident continues to decline colonoscopy, documented that MD and family are aware. Mammogram was completed on 4/5/22 and results reviewed with provider, benign and follow up in a year noted in results. RN 4: received education on timely follow up on physician orders regarding scheduling appointments and documentation 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 orders for a physician prescribed procedure have the potential to be affected by the alleged deficient practice.	04/22/2022

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	hospital on 3/26/22. The staff was also supposed to schedule a Colonoscopy for Resident B because she had been having loose stools, not wanting to eat and her family had a history of colon cancer. That was not scheduled by the nursing staff to be completed, so the Physician was going to try to do it while she was in the hospital due to the concern of colon cancer and she continued to have loose stools. Resident B's record was reviewed on 3/29/22 at 2:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease with acute exacerbation, schizophrenia, anxiety disorder, dependence on supplemental oxygenation, respiratory failure with hypoxia and encephalopathy. A progress note, dated 1/10/22 at 12:41 p.m., indicated the Nurse Practitioner (NP) spoke to Resident B regarding having a Mammogram and a Colonoscopy completed and she was agreeable to both procedures. The NP called and spoke to the resident's number one emergency contact, who was also in agreement with both tests being completed. The NP documented both tests would be scheduled and the daughters would be notified of the dates and times. The resident's progress notes following 1/10/22, lacked any further information indicating when the resident received her Mammogram and the Colonoscopy. A hospital record, titled "Consultation," dated 3/27/22, indicated the daughter reported to the hospital Physician Resident B had a breast discharge ongoing for at least one year from the right breast. She was scheduled for a mammography, but she was not happy with the		A 15 day look back was completed of all orders to ensure any prescribed procedures have been scheduled as ordered or with documentation if declined by resident or representative. 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 staff were educated on the guideline for following physician orders with focus on scheduling prescribed procedures On-going monitoring DNS or Designee will review physician orders daily during clinical review for timely scheduling and pertinent documentation. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿	

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	facility due to there was a delay in the diagnosis. The Physician did observe a large amount of breast tenderness and a mass on palpation. During an interview, on 3/29/22 at 5:25 p.m., RN 6 indicated the resident's Mammogram was scheduled on 3/16/22, but she was unable to go due to transportation issues. It was rescheduled for 3/30/22, but she did not know if she would get it or not because she was in the hospital. As far as she knew, there had not been a Colonoscopy scheduled. The last she knew Resident B had refused to get it completed. This visit was for the Investigation of Complaint IN00375666 3.1-37(b)		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.¿	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;			

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on interview and record review, the facility failed to provide Activities of Daily Living (ADL's) assistance to a resident related to incontinence care for 1 of 3 residents reviewed for bowel incontinence (Resident B). Finding includes: A Confidential Interview was conducted during the course of the survey with two different Confidential Interviewees at the same time (Confidential Interviewee 1 and 2). Confidential Interviewee 1 indicated they both had concerns regarding the care their loved one was receiving at the facility. They had concerns Resident B was incontinent of her bowels and she had been found multiple times, by the Confidential Interviewees during visits, in bed with dried feces on her, on her clothes and on her bed linens even with a brief in place. Confidential Interviewee 2 indicated feces was	F 0690	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident B: Clinical record was and care plan updated to reflect residents current care needs regarding Bowel/Bladder incontinence. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿	04/22/2022

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	left in the resident's pants from where the facility staff did not rinse her pants out prior to placing the clothes in the laundry basket. She had posted notes in the resident's room asking the staff to wash the feces out, prior to placing the clothes in the laundry basket. The facility staff was supposed to be doing every two hour checks on Resident B because they had left her with dried feces multiple times. Confidential Interviewee 2 indicated Confidential Interviewee 1 had cleaned dried feces off the toilet seat many times because the staff did not change the resident's brief after she had a bowel movement, so the resident took herself to the bathroom and tried to change her own brief while smearing feces all over the toilet, which did not get cleaned off the toilet seat. Resident B's record was reviewed on 3/29/22 at 2:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease with acute exacerbation, schizophrenia, anxiety disorder, dependence on supplemental oxygenation, respiratory failure with hypoxia and encephalopathy. The resident's annual MDS (Minimum Data Set) assessment, dated 12/15/21, indicated the resident required extensive assist with a two person assist for bed mobility. The resident was a limited assist with a one person assist for toileting and total dependence with a two person assist for bathing. She was not steady, but was able to stabilize without human assistance while moving on and off the toilet. A document, titled "Grievance Form," dated 3/8/22 and provided by the Executive Director on 3/28/22 at 4:30 p.m., indicated Resident B's daughter filed a grievance related to when she		All residents that require assistance with toileting or incontinence have the potential to be affected by the same alleged deficient practice. The facility completed a review of all residents that require assistance with toileting or incontinence needs to ensure their plan of care accurately reflects care needs. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education Clinical Staff were educated on the guidelines for toileting and incontinence care. On-going monitoring DNS or designee will interview each review day that require assistance with toileting or incontinent care to determine if needs are being met timely. DNS or designee will complete	

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	entered the resident's room, she observed the resident covered in stool, which happened frequently. The CNA "acted" as if Resident B did not require any assistance with toileting. RN 6 completed the Grievance form. The incident occurred 3 days prior to the date on the grievance form on the day shift. The Grievance form follow-up indicated the resident was placed on a two hour toileting schedule. Her care plan was update to indicate she required extensive assist for toileting. The CNAs Kardex was updated for the two hour toileting plan and extensive assistance. An in-service with the staff was completed. A verbal conversation occurred with the CNA who was on the hallway at that time. The grievance form indicated it was resolved on 3/14/22. A current policy, titled "Incontinence," undated and provided by the Executive Director on 3/29/22 at 5:00 p.m., indicated "Policy: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Policy Explanation and Compliance Guidelines...4. Residents that are incontinent of bladder or bowel will receive appropriate treatment...." This visit was for the Investigation of Complaint IN00375666 3.1-41(a)(2)		random observations of 5 residents each review day that require assistance with toileting or incontinent needs to ensure needs are being met 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 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.¿	

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0695 SS=E 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, 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 observation, interview and record review, the facility failed to change the oxygen therapy, nebulizer treatment and tracheostomy equipment as ordered, failed to properly store necessary respiratory equipment at the residents' bedside when it was not in use and failed to provide a nebulizer breathing treatment while following the facility protocol for 5 of 17 residents reviewed for respiratory care (Resident B, F, H, J and E). Findings include: A Confidential Interview was conducted during the course of the survey with two different Confidential Interviewees at the same time (Confidential Interviewee 1 and 2). Confidential Interviewee 1 indicated they both had concerns regarding the care their loved one was receiving at the facility. The concern Confidential Interviewee 1 voiced was when she and Confidential Interviewee 2 visited Resident B, on several occasions, they would find her oxygen disconnected from the concentrator unit. The oxygen tubing would be rolled up and sitting on the concentrator unit. The staff indicated the resident removed the oxygen herself.	F 0695	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident B's Oxygen tubing was replaced, dated and placed in a bag. Oxygen concentrator was moved right next to her bed. Resident F 's nebulizer tubing, tracheostomy tubing and trach mask were replaced, dated and Nebulizer was placed in a bag. Resident H 's Oxygen tubing was replaced, dated and placed in a bag. Resident J's nebulizer tubing was replaced, dated and placed in a bag. Resident longer resides at facility	04/22/2022

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Confidential Interviewee 1 indicated if Resident B removed her oxygen tubing herself it should be laying on the floor, not rolled up and sitting on the concentrator unit, since it was hard for the resident to reach while lying in the bed. On 3/28/22 at 12:22 p.m., the facility tour was started with RN 3 in attendance and the following observations were made: 1. Residents' oxygen therapy (the administration of oxygen at concentrations greater than that in ambient air 20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia (decreased perfusion of oxygen to the body's tissues), nebulizer treatment (a treatment, which was used to treat respiratory conditions. The nebulizer machine used to administer the treatment converts a liquid medication into a mist, which can easily and painlessly inhaled into the lungs by breathing in the mist.) A Tracheostomy (an opening surgically created through the neck into the windpipe to allow direct access to the trachea was observed to not be labeled with a date indicating when the tubing was changed last and/or there were no signatures on the residents' electronic treatment administration record (ETAR) to indicate the respiratory equipment had been changed for that particular resident as ordered by his or her Physician. a. On 3/28/22 at 1:07 p.m., Resident B's oxygen tubing was not attached to her oxygen concentrator. Her Nebulizer tubing was observed to have a brown piece of tape on it with a handwritten date 3/7/22. RN 3 indicated at that time, the resident's oxygen was taken with her when she went to the hospital by ambulance and the Nebulizer tubing used for the Nebulizer		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 that receive oxygen therapy and/or nebulizer therapy have the potential to be affected by the same alleged deficient practice. An audit was completed of all residents that receive oxygen therapy and/or nebulizer therapy to ensure they have equipment and tubing changed and stored per facility guidelines, orders for administration and treatment followed and any required assessment documented appropriately What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education	

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	breathing treatments were to be changed weekly, on Sundays by the midnight shift. She indicated when the staff changed any respiratory equipment they were to place a piece of tape with the date and the staff member's initials who changed it on the equipment. There was a handwritten note on the resident's oxygen concentrator attached with a rubber band to the oxygen flowmeter dial indicating "Don't Turn off. She will not check to see if it's on. Thanks Family" RN 3 indicated the resident's family posted notes frequently. Resident B's record was reviewed on 3/29/22 at 2:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease with acute exacerbation, schizophrenia, anxiety disorder, dependence on supplemental oxygenation, respiratory failure with hypoxia and encephalopathy. A physician's order, dated 2/17/22, indicated to change the oxygen and nebulizer tubing every night shift every Sunday night. The ETAR (Electronic Treatment Administration Record), dated March 2022, indicated there was no nursing staff members initials documented in the signature box for the date of 3/20/22. During an interview, on 3/29/22 at 5:00 p.m., RN 6 indicated if there was a blank signature box on the EMAR (Electronic Medication Administration Record) or ETAR, then the particular medication was not administered or the treatment was not completed as ordered by the resident's physician. b. On 3/28/22 from 1:30 p.m., to 1:52 p.m., during a continuous observation in Resident F's room the nebulizer tubing, tracheostomy tubing and trach mask were observed to be without a		Licensed staff educated on the guidelines for Oxygen Administration and Nebulizer therapy to include following physician orders, tubing changes and equipment storage. On-going monitoring DNS or Designee will complete an audit and rounding observation of residents that receive oxygen therapy and/or nebulizer therapy to ensure guidelines and orders are followed. 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 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	

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	date on them to indicate what date the nebulizer and trach equipment had been changed. Resident F's record was reviewed on 3/29/22 at 3:15 p.m. Diagnoses included, but were not limited to, dependence on supplemental oxygen, diastolic (congestive) heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic neuropathy, shortness of breath and chronic respiratory failure. A physician's order, dated 3/1/22, indicated to change the oxygen and nebulizer tubing and clean the concentrator filter every night shift every Sunday night. The ETAR, dated March 2022, indicated there was no nursing staff member's initials documented in the signature box for the date of 3/20/22. c. On 3/28/22 at 2:00 p.m., Resident H's oxygen tubing was observed to have a brown piece of tape with a handwritten date of 3/14/22, with an illegible set of initials on it. The resident indicated he used his oxygen at night only. RN 3 indicated his oxygen tubing was to be changed weekly on Sundays on the midnight shift with a piece of tape to indicate when the tubing was changed. Resident H's record review was completed on 3/29/22 at 3:45 p.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, obstructive sleep apnea, chronic obstructive pulmonary disease and personal history of malignant neoplasm of bladder. A physician's order, dated 3/7/22, indicated to give oxygen at 1-2 liters per minute by nasal cannula as needed and to call the physician if the		noted, then will complete audits based on a prn basis.¿	

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

resident's oxygen saturations were below 90% every shift.

A physician's order, dated 3/722 and start on 3/13/22, indicated to change the oxygen and humidification and clean the concentrator filter every night shift every Sunday night.

d. On 3/28/22 at 2:10 p.m., Resident J's nebulizer machine tubing was observed to have a brown piece of tape with a handwritten date of 3/7/22 on it with an illegible set of initials. There was no plastic bag on the oxygen concentrator to store the oxygen tubing while the resident was using her portable tank.

Resident J's record was reviewed on 3/29/22 at 4:00 p.m. Diagnoses included, but were not limited to, dependence on supplemental oxygen, pulmonary hypertension, schizoaffective disorder, bipolar type, acute and chronic respiratory with hypoxia, chronic obstructive pulmonary disease with acute exacerbation and protein-calorie malnutrition.

A physician's order, dated 3/2/22 with a start date of 3/6/22, indicated to change out the resident's oxygen and nebulizer supplies, clean concentrator filter every night shift every Sunday.

2. The following respiratory equipment was not properly stored when not in use at these residents' bedside.

a. On 3/28/22 at 2:00 p.m., Resident H's oxygen tubing could not be found upon entering the room. The resident indicated as he pulled it out, by the tubing attached to the concentrator machine, he only used his oxygen at night and the

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	staff stored his oxygen tubing on the floor under his concentrator. The oxygen was observed wound up in its original package under the oxygen concentrator. RN 3 indicated the resident's oxygen should be stored in a bag on the concentrator and not on the floor under the concentrator. She was going to have a staff member get him a new oxygen set up. Resident H's record review was completed on 3/29/22 at 3:45 p.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, obstructive sleep apnea, chronic obstructive pulmonary disease and personal history of malignant neoplasm of bladder. b. On 3/28/22 at 2:21 p.m., Resident E's nebulizer machine was observed sitting on top of a white towel, on the floor, next to the wall at the head of the bed. The nebulizer mask was not covered and was sitting on the bare floor in front of the nebulizer machine. RN 3 indicated the resident's nebulizer equipment should not be stored on the floor and she was going to have the maintenance department get another night stand in his room to put his equipment on. Resident E's record was reviewed on 3/29/22 at 3:05 p.m. Diagnoses included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, chronic respiratory failure and type 2 diabetes mellitus. 3. On 3/28/22 from 1:30 p.m., to 1:52 p.m., during a continuous observation in Resident F's room the following events were observed. Upon entering Resident F's room at 1:30 p.m., a nebulizer breathing treatment was heard to be running. RN 3 was observed to go to his bedside			

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	and check the empty nebulizer cup, which was screwed into his tracheostomy tubing connector. Then she shut off the nebulizer machine. RN 3 indicated a nurse should be in the room with Resident F during his nebulizer treatment monitoring him for complications during the treatment. She also indicated a post nebulizer assessment needed to be completed following the nebulizer treatment. There was no respiratory assessment completed during the continuous timeframe this surveyor and RN 3 was in the residents room or after the resident's nurse answered his call light, which had been turned on by RN 3. Resident F's record was reviewed on 3/29/22 at 3:15 p.m. Diagnoses included, but were not limited to, dependence on supplemental oxygen, diastolic (congestive) heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic neuropathy, shortness of breath and chronic respiratory failure. A physician's order, dated 2/11/22, indicated Ipratropium-Albuterol solution (a medication inhaled into the lungs through an aerosol treatment using a nebulizer machine to open the bronchial tubes, so the resident can breathe easier) 0.5-2.5 (3) mg (milligrams)/3 ml (milliliters) 3 ml inhalation by mouth by way of the nebulizer machine every 6 hours related to chronic obstructive pulmonary disease with acute exacerbation. Resident F had a care plan, which addressed the problem he had an alteration in respiratory status due to his tracheostomy related to his ineffective breathing pattern, repeated signs and symptoms of pneumonia and a diagnosis of respiratory failure. Interventions included, but were not			

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	limited to, "5/11/16 with revision on 3/11/21-Administer oxygen per orders...3/16/20 with revision on 4/29/20-Ipratropium Albuterol solution per order...." A progress note, dated as a late entry on 3/29/22 at 11:18 a.m., indicated on 3/28/22 at 2:15 p.m., the resident's breathing treatment was administered and the pre and post respiratory assessments were completed. During an interview, on 3/28/22 at 1:54 p.m., LPN 7 indicated she started Resident F's nebulizer breathing treatment at 1:15 p.m., then she got called out of his room. After that, RN 3 and the surveyor went into the resident's room and she "never" made it back into his room. She indicated she had not completed a post respiratory assessment on Resident F following his nebulizer treatment. A current policy, titled "Nebulizer Therapy," undated and provided by the Executive Director on 3/29/22 at 5:00 p.m., indicated "Policy: It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique...Care of the Resident...14. Observe resident during the procedure for any change in condition. 15. When medication delivery is complete, turn the machine off. Treatment may be considered complete with the onset of nebulizer sputtering. 16. Disassemble and rinse the nebulizer with sterile or distilled water and allow to air dry. Care of the Equipment: 1. Clean after each use...3. Disassemble parts after every treatment. 4. Rinse the nebulizer cup and mouthpiece with sterile or distilled water...7. Once completely dry, store the neb Pulitzer cup and the mouthpiece in a zip lock bag. 8. Change			

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	the nebulizer tubing per facility policy...Documentation: Record the following information in the resident's medical record...5. Resident's response to treatment...." A current policy, titled "Oxygen Administration," undated and provided by the Executive Director on 3/28/22 at 4:00 p.m., indicated "Policy: 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. Definitions: 'oxygen therapy' is the administration of oxygen of concentrations greater than that in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia. 'Hypoxia' means decreased perfusion of oxygen to the tissues. Policy Explanation and Compliance Guidelines: 1. 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...5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: a. Follow manufacturer recommendations for the frequency of cleaning equipment filters. b Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. c. Change humidifier bottle when empty. d. If applicable, change nebulizer tubing and delivery devices per facility policy and as needed if they become soiled or contaminated. e. Keep delivery devices covered in plastic bag when not in use...7. Cleaning and care of equipment shall be in accordance with facility policies for such equipment...."			

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	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	This visit was for the Investigation of Complaint IN00375666. 3.1-47(a)(4) 3.1-47(a)(6)			