STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00414267 and IN00413854. Complaint IN00414267 - Federal/state deficiencies related to the allegations are cited at F600, F607, and F609. Complaint IN00413854 - No deficiencies related to the allegations are cited. Survey dates: August 2 and 3, 2023. Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 3 Medicaid: 85 Other: 14 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 9, 2023.	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 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.	
F 0607 SS=G Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaushik Patel	HFA	09/08/2023

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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	§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.			
	Based on interviews and record review, the facility failed to report to the Administrator or designee allegations of abuse for 1 of 3 allegations of abuse reviewed (CNA 6 to Resident D). This failure to report the allegation immediately resulted in CNA 6's abuse of a cognitively impaired resident later in the day. Findings include: During an interview with LPN 19, on 8/2/23 at 4:39 p.m., she indicated CNA 7 had reported to her	F 0607	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident C: Clinical record was reviewed and residents current care and psychosocial needs. Resident B: Clinical record was reviewed and residents current care and psychosocial needs. Resident D: Clinical record was reviewed and residents	08/28/2023

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	Resident D was grabbed roughly by CNA 6 during her shower on 7/29/23. LPN 19 was in the process of handling other things and was passing medication at the time CNA 7 reported this to her (between 8:00 a.m. and 9:00 a.m.). She did not report the allegation to the Administrator or their designee. An Incident Submission email confirmed an incident report was submitted to the Indiana Department of Health on 8/3/23 at 2:51 p.m. The actual or identified date and time of the incident was 7/31/23 at 1:39 p.m. The report indicated the following: The description added, on 8/3/23, indicated during another investigation, CNA 7 reported that Resident D alleged CNA 6 was rough during her shower and verbalized CNA 6 held her wrist and pushed her into the shower chair. Resident D was moderately cognitively impaired. During an interview with the DON, on 8/3/23 at 2:10 p.m., she indicated she thought they had 24 hours to report abuse and had always reported abuse within 24 hours to the State Agency. The information in the reportable related to staff to resident abuse was what she was told during interviews and they were still completing interviews. The housekeeper was not interviewed until on Monday 7/31/23. The allegation of abuse for Resident D, they were not aware of until Monday 7/31/23. They had investigated the allegation with Resident D along with the allegation of abuse for Resident B and was located in the investigation in the binder, it was not reported to the State Agency. LPN 19 was suspended for not reporting the allegation of abuse to Resident D, she knew about the allegation in the morning but she was busy with		current care and psychosocial needs. Resident E: Clinical record was reviewed and residents current care and psychosocial needs. C.N.A. no longer an employee of the facility LPN 19: received one on one education on the Guidelines for Resident Abuse Prevention and Reporting of Abuse. ¿¿ How be identified and what corrective action will be taken?¿ All residents that reside in the facility have the potential to be affected by the same alleged action. The facility completed interviews with employees and residents to ensure that any allegations of abuse are investigated and reported timely to the appropriate agency. No further events were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?¿ Facility staff were in-serviced on the guidelines for Abuse Prevention and Reporting to include but not limited to the types of abuse and reporting time frame. ED and DNS educated on guideline for timely initiation of an investigation and reporting an allegation of abuse to the appropriate agency. ED or Designee will conduct a random interview/audit of 5 residents and 5 Employees weekly x 4 weeks, then 3 Residents and 3 Employees weekly x 5 months.	

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	other things. Review of the current IDOH "Long-Term Care Abuse and Incident Reporting Policy," effective 12/8/22 and retrieved from https://www.in.gov/health/files/IDOH-LTC-Abuse-and-Incident-Reporting-policy_policy-SIGNED.pdf indicated the following: "...Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, or other health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property...Immediately means as soon as possible, in the absence of a shorter state time frame requirement, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse...All allegations of staff to resident abuse must be reported. Staff may receive allegations from any source, including other staff, residents, family members, or other health care providers. Also, each occurrence must be reported. If staff are aware of or witnessed any abuse that occurs, it must be reported...." Cross reference F600 and F609. This Federal tag relates to complaint IN00414267. 3.1-28(c)		Interviews will be done to ensure that any alleged violations are identified, properly investigated and according to the guidelines. ED or Designee to review all allegations of abuse to ensure that incident was reported per facility guidelines.¿ This review will occur with every allegation of abuse x 6 months.¿ How 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 audits will continue based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			

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	§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interviews and record review, the facility failed to report timely to the State Agency allegations of abuse for 3 of 3 allegations of abuse (CNA 6 and Resident B, CNA 6 and Resident D, and Resident E and Resident C) and failed to report accurate information regarding allegations of abuse for 1 of 3 allegations of abuse (CNA 6 and Resident B). Findings include: 1. Review of a handwritten statement signed by	F 0609	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident C: Clinical record was reviewed and residents current care and psychosocial needs. Resident B: Clinical record was reviewed and residents current care and psychosocial needs. Resident D: Clinical record was reviewed and	08/28/2023

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	CNA 7 and dated 7/29/23 and provided in the facility's investigation binder, indicated she and CNA 6 walked into a male resident's room to put him in bed and when they walked in, Resident B was laying in his bed. CNA 6 proceeded to shake Resident B pretty hard and Resident B was yelling to stop. CNA 6 grabbed Resident B by one leg and one arm and Resident B started kicking to be put down and CNA 6 dropped Resident B on the floor. Resident B hit her head on a bed frame. A change of condition note, dated 7/29/23 at 1:09 p.m., indicated Resident B hit her head during a possible fall incident. She had a small bump on the top of the right side of her head and she reported she had neck pain with range of motion. She was sent to the ER (Emergency Room). Review of a facility-reported incident document, with an incident date of 7/29/23 at 2:03 p.m., indicated the following: A description of the incident, added on 7/30/23, indicated CNA 7 reported she and CNA 6 went to provide care on a resident. Resident B was sleeping in another resident's bed and CNA 6 attempted to wake Resident B to assist her to her own bed. Resident B became agitated during transfer from the bed and she struck CNA 6 in the face and during an attempted transfer, Resident B fell to the floor. At that time, CNA 7 alerted staff in the hallway to get the nurse for assistance. CNA 7 had CNA 6 leave the room and CNA 7 remained with Resident B until the nurse arrived. The action taken, added on 7/30/23, was CNA 6 was immediately escorted out of the building and suspended pending investigation. The physician was notified and Resident B was transferred to a local hospital for evaluation and treatment.		residents current care and psychosocial needs. Resident E: Clinical record was reviewed and residents current care and psychosocial needs. C.N.A. no longer an employee of the facility LPN 19: received one on one education on the Guidelines for Resident Abuse Prevention and Reporting of Abuse. ¿¿ How be identified and what corrective action will be taken?¿ All residents that reside in the facility have the potential to be affected by the same alleged action. The facility completed interviews with employees and residents to ensure that any allegations of abuse are investigated and reported timely to the appropriate agency. No further events were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?¿ Facility staff were in-serviced on the guidelines for Abuse Prevention and Reporting to include but not limited to the types of abuse and reporting time frame. ED and DNS educated on guideline for timely initiation of an investigation and reporting an allegation of abuse to the appropriate agency. ED or Designee will conduct a random interview/audit of 5 residents and 5 Employees weekly x 4 weeks, then 3 Residents and 3 Employees weekly x 5 months.	

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	Resident B's family, Administrator and DON were notified. The type of injury added, on 7/30/23, indicated Resident B was noted with complaints of pain and was transferred to a local hospital for further evaluation and treatment, she returned later in the evening with no injuries noted. The preventative measures added, on 7/30/23, indicated an investigation was initiated. CNA 6 was suspended pending outcome of investigation. Staff education was initiated for safe transfers, abuse prevention, and approach with dementia patients. At this time, Resident B continued to be monitored following event for any signs and symptoms of discomfort and psychosocial distress. Plan of care was being reviewed and interventions were updated. The report lacked the allegations of CNA 6's actions of shaking the resident, grabbing her arm and leg, nor the CNA dropping the resident to the ground. An Incident Submission email confirmed the report was submitted to the Indiana Department of Health on 7/30/23 at 1:46 p.m. and the actual or identified date and time of the incident was 7/29/23 at 2:03 p.m. 2. During an interview with LPN 19, on 8/2/23 at 4:39 p.m., she indicated CNA 7 had reported to her Resident D was grabbed by CNA 6 during her shower on 7/29/23. This had been reported to her prior to CNA 6 pulling Resident B from the bed. LPN 19 was in the process of handling other things and was passing medication at the time CNA 7 reported this to her (between 8:00 a.m. and 9:00 a.m.).		Interviews will be done to ensure that any alleged violations are identified, properly investigated and according to the guidelines. ED or Designee to review all allegations of abuse to ensure that incident was reported per facility guidelines.¿ This review will occur with every allegation of abuse x 6 months.¿ How 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 audits will continue based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	

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	An Incident Submission email confirmed an incident report was submitted to the Indiana Department of Health on 8/3/23 at 2:51 p.m. The actual or identified date and time of the incident was 7/31/23 at 1:39 p.m. The report indicated the following: The description added, on 8/3/23, indicated during another investigation, CNA 7 reported that Resident D alleged CNA 6 was rough during her shower and verbalized CNA 6 held her wrist and pushed her into the shower chair. Resident D was moderately cognitively impaired. This report was not submitted within two hours of being reported to the facility Administrator or designee. 3. A facility reported incident reported by the Administrator, with the incident date of 7/31/23 at 2:45 p.m. and reported on 8/1/23 at 1:12 p.m. indicated the following: The description added, on 8/1/23, indicated Resident E was seen by the nurse standing over Resident C while he was lying in bed with her hands around his neck. The nurse was able to redirect Resident E and separate her. Resident C responded by swinging his hand towards Resident E. Resident E became agitated and started swinging her hands towards the nurse as they were leaving the room. Both residents resided in AACU. An Incident Submission email confirmed the incident was submitted to the Indiana Department of Health on 8/1/23 at 1:12 p.m. The actual or identified date and time of the incident was 7/31/23 at 2:45 p.m.			

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	During an interview with the DON, on 8/3/23 at 2:10 p.m., she indicated she thought they had 24 hours to report abuse and had always reported abuse within 24 hours to the State Agency. The information in the reportable related to staff to resident abuse was what she was told during interviews and they were still completing interviews. The housekeeper was not interviewed until on Monday 7/31/23. The allegation of abuse for Resident D, they were not aware of until Monday 7/31/23. They had investigated the allegation with Resident D along with the allegation of abuse for Resident B and was located in the investigation in the binder, it was not reported to the State Agency. LPN 19 was suspended for not reporting the allegation of abuse to Resident D, she knew about the allegation in the morning but she was busy with other things. Review of the current IDOH "Long-Term Care Abuse and Incident Reporting Policy," effective 12/8/22 and retrieved from https://www.in.gov/health/files/IDOH-LTC-Abuse-and-Incident-Reporting-policy_policy-SIGNED.pdf indicated the following: "...Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, or other health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property...Immediately means as soon as possible, in the absence of a shorter state time frame requirement, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse...."			

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	Cross reference F600. This Federal tag relates to complaint IN00414267. 3.1-28(c)			