PRINTED: 09/13/2023
FORM APPROVED

| CENTERS FOR | MEDICARE & MEDIC | AID SERVICES | | | | <u>OM</u> | B NO. 0938-039 | |
|--|--|--|----------|-----------------------|--|--------------------|----------------|--|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MUL | TIPLE CO | NSTRUCTION | (X3) DATE SURVEY | | | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUIL | A. BUILDING <u>00</u> | | | COMPLETED | |
| | 155687 B. WING 08/0 | | 08/03/ | 03/2023 | | | | |
| NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL) | | |] | 2701 LY | ODDRESS, CITY, STATE, ZIP COD YN-MAR DR E, IN 47304 | | (X5) | |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | EFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | - | ΓAG | DEFICIENCY) | | DATE | |
| F 0000 | | | | | | | | |
| F 0607 SS=G Bldg. 00 | IN00414267 and IN Complaint IN00414 related to the allegal and F609. Complaint IN00413 the allegations are consumption of the allegation of the a | 1267 - Federal/state deficiencies tions are cited at F600, F607, 18854 - No deficiencies related to cited. 18854 - State Findings cited in 18856 of IAC 16.2-3.1. 1891eted August 9, 2023. | F 000 | 0 | Preparation, submission and implementation of this Plan of Correction does not constitute admission or agreement with t facts and conclusions set forth survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the qualicare and comply with all applicable federal and state requirements. The facility respectfully request desk review of our responses this survey. | he the ty of | | |
| I ARODATOD | V DIRECTOR'S OR PRO | VIDER/SUPPLIER REPRESENTATIVE'S SI | GNATIDE | | TITLE | | (X6) DATE | |
| LADUKATUK | I DINECTORS OR PRO | A TECHNOOL I FIEW MEEMESEN LATINE 2 21 | ONAIUKE | | HILE | | (AU) 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

Any defiency statement 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 disclodays 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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09/13/2023 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/03/2023 155687 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2701 LYN-MAR DR BRICKYARD HEALTHCARE - MUNCIE CARE CENTER MUNCIE. IN 47304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE §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 F 0607 What corrective actions will be 08/28/2023 failed to report to the Administrator or designee accomplished for those residents allegations of abuse for 1 of 3 allegations of abuse found to have been affected by the reviewed (CNA 6 to Resident D). This failure to deficient practice?; report the allegation immediately resulted in CNA Resident C: Clinical record was 6's abuse of a cognitively impaired resident later in reviewed and residents current the day. care and psychosocial needs. Resident B: Clinical record Findings include: was reviewed and residents

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Event ID:

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During an interview with LPN 19, on 8/2/23 at 4:39

p.m., she indicated CNA 7 had reported to her

Facility ID: 000097

current care and psychosocial

was reviewed and residents

needs. Resident D: Clinical record

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPI | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | NSTRUCTION | (X3) DATE SURVEY | |
|---|---|--|----------------------------|----------|--|------------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> | | | COMPLETED | |
| | | 155687 | B. WING 08/03/2023 | | | /2023 | |
| | | <u> </u> | <u> </u> | CTDEET A | ADDRESS CITY STATE 7ID COD | l | |
| NAME OF F | PROVIDER OR SUPPLIEF | 8 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| BDICKA | | MUNICIE CADE CENTED | | | /N-MAR DR | | |
| DRICKYA | ARD DEALTHOARE | E - MUNCIE CARE CENTER | | MONCI | E, IN 47304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | bbed roughly by CNA 6 | | | current care and psychosocial | | |
| | _ | on 7/29/23. LPN 19 was in the | | | needs. Resident E: Clinical re | cord | |
| | | other things and was passing | | | was reviewed and residents | | |
| | medication at the time CNA 7 reported this to her | | | | current care and psychosocial | | |
| | (between 8:00 a.m. and 9:00 a.m.). She did not | | | | needs. C.N.A. no longer an | | |
| | report the allegation to the Administrator or their | | | | employee of the facility LPN 1 | 19: | |
| | designee. | | | | received one on one education | | |
| | | | | | the Guidelines for Resident Al | ouse | |
| | An Incident Submission email confirmed an | | | | Prevention and Reporting of | | |
| | incident report was submitted to the Indiana | | | | Abuse. ¿¿ How be identified | and | |
| | Department of Health on 8/3/23 at 2:51 p.m. The | | | | what corrective action will be | | |
| | actual or identified date and time of the incident | | | | taken?¿ All residents that res | | |
| | was 7/31/23 at 1:39 p.m. The report indicated the | | | | in the facility have the potentia | | |
| | following: | | | | be affected by the same allege | | |
| | | | | | action. The facility completed | | |
| | _ | led, on 8/3/23, indicated during | | | interviews with employees and | t | |
| | _ | on, CNA 7 reported that | | | residents to ensure that any | | |
| | 1 | CNA 6 was rough during her | | | allegations of abuse are | | |
| | | zed CNA 6 held her wrist and | | | investigated and reported time | - | |
| | _ | shower chair. Resident D was | | | the appropriate agency. No fu | | |
| | moderately cognitive | vely impaired. | | | events were identified. What | | |
| | | 11 1 701 0/2/22 | | | measures will be put into place | | |
| | _ | w with the DON, on 8/3/23 at | | | and what systemic changes w | ıll | |
| | | eated she thought they had 24 | | | be made to ensure that the | | |
| | | se and had always reported | | | deficient practice does not | | |
| | | ars to the State Agency. The | | | recur?; Facility staff were | | |
| | | eportable related to staff to | | | in-serviced on the guidelines f | | |
| | | what she was told during | | | Abuse Prevention and Reporti | - | |
| | | were still completing | | | include but not limited to the ty | /pes | |
| | | sekeeper was not interviewed | | | of abuse and reporting time | d on | |
| | 1 | 31/23. The allegation of abuse | | | frame. ED and DNS educate | | |
| | · | y were not aware of until hey had investigated the | | | guideline for timely initiation of | | |
| | | ident D along with the | | | investigation and reporting an | | |
| | _ | for Resident B and was | | | allegation of abuse to the | | |
| | ~ | tigation in the binder, it was | | | appropriate agency. ED or Designee will conduct a rando | m | |
| | | State Agency. LPN 19 was | | | interview/audit of 5 residents a | | |
| | | eporting the allegation of | | | | - | |
| | _ | | | | Employees weekly x 4 weeks, | | |
| | | O, she knew about the orning but she was busy with | | | then 3 Residents and 3 | | |
| I | i anegation in the mo | nning out she was ousy with | 1 | | Employees weekly x 5 months | ó. | I |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155687 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 08/03/2023 | | | | |
|--|--|---|---------------------|--|---|--|--|--|
| | NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER (Y4) ID. SUMMARY STATEMENT OF DEFICIENCIE | | | STREET ADDRESS, CITY, STATE, ZIP COD 2701 LYN-MAR DR MUNCIE, IN 47304 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | DATE | | | |
| | Abuse and Incident 12/8/22 and retrieve https://www.in.gov/-and-Incident-Reported indicated the foll a situation or occurreported by staff, re other health care proyet been investigate noncompliance with related to mistreatm abuse, including inj misappropriation of propertyImmediate in the absence of a serequirement, but no allegation is made, allegation involve a to resident abuse must be reported. See from any source, including members, or Also, each occurrent are aware of or with it must be reported. | thealth/files/IDOH-LTC-Abuse rting-policy_policy-SIGNED.p owing: "Alleged violation is rence that is observed or sident, relative, visitor, or ovider, or others but has not d and, if verified, could be a the federal requirements ent, exploitation, neglect, or uries of unknown source, and resident ely means as soon as possible, shorter state time frame t later than two hours after the fif the events that cause the buseAll allegations of staff reaff may receive allegations cluding other staff, residents, other health care providers. ce must be reported. If staff ressed any abuse that occurs," | | Interviews will be done to ensithat any alleged violations are identified, properly investigate and according to the guidelines. ED or Designee review all allegations of abuse ensure that incident was repoper facility guidelines.; This rimit will occur with every allegation abuse x 6 months.; How be monitored to ensure the deficing practice will not recur, i.e., who quality assurance program with put into place?; Results of the audits will be brought to QAP monthly x 6 months to identify trends and to make recommendations.; If issues/trends are identified, the audits will continue based on QAPI recommendation.; If noted, then will complete audits abased on a prn basis.; | e ed to e to orted eview n of ient at II be nese I / | | | |
| F 0609 SS=D Bldg. 00 | , , . | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OLT311

Facility ID: 000097

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| | T OF HEALTH AND HU R MEDICARE & MEDIO | | | | FORM APPROVED OMB NO. 0938-039 |
|---|--|--|--|--|-----------------------------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155687 NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER | | (X2) MULTIPLE (A. BUILDING B. WING | CONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 08/03/2023 | |
| | | 2701 | T ADDRESS, CITY, STATE, ZIP COD LYN-MAR DR CIE, IN 47304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | violations involvir exploitation or mi injuries of unknown misappropriation reported immedia hours after the all events that cause or result in serious than 24 hours if the allegation do not result in serious administrator of the officials (including Agency and adult state law provides care facilities) in a through establish | of resident property, are stely, but not later than 2 legation is made, if the se the allegation involve abuse is bodily injury, or not later the events that cause the involve abuse and do not bodily injury, to the the facility and to other to the State Survey is protective services where is for jurisdiction in long-term accordance with State law end procedures. | | | |
| | investigations to the designated resolution officials in accordinct including to the S 5 working days of alleged violation is corrective action. Based on interview failed to report timallegations of abus (CNA 6 and Reside | ys and record review, the facility ely to the State Agency e for 3 of 3 allegations of abuse ent B, CNA 6 and Resident D, | F 0609 | What corrective actions will to accomplished for those resident found to have been affected to the contract of | ents by the |
| | report accurate info | Resident C) and failed to brmation regarding allegations allegations of abuse (CNA 6 | | deficient practice?¿ Residen Clinical record was reviewed residents current care and psychosocial needs. Residen | and |

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Findings include:

1. Review of a handwritten statement signed by

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Clinical record was reviewed and

Clinical record was reviewed and

residents current care and psychosocial needs. Resident D:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|--|-----------------------|---------------|---|-----------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> | | COMPLETED | | |
| | | 155687 | B. WING 08/03/2023 | | | /2023 | |
| | | <u> </u> | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIER | 8 | | | YN-MAR DR | | |
| BRICKYA | ARD HEALTHCARE | - MUNCIE CARE CENTER | | | E, IN 47304 | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIE | | | | | · | | (V.E.) |
| (X4) ID PREFIX | | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| TAG | · | CY MUST BE PRECEDED BY FULL | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| TAG | | 2 LSC IDENTIFYING INFORMATION /29/23 and provided in the | | IAG | residents current care and | | DATE |
| | | on binder, indicated she and | | | | | |
| | | a male resident's room to put | | | psychosocial needs. Resident Clinical record was reviewed a | | |
| | | - | | | residents current care and | anu | |
| | him in bed and when they walked in, Resident B was laying in his bed. CNA 6 proceeded to shake | | | | psychosocial needs. C.N.A. I | 20 | |
| | Resident B pretty hard and Resident B was yelling | | | | longer an employee of the | 10 | |
| | to stop. CNA 6 grabbed Resident B by one leg | | | | facility LPN 19: received one | on | |
| | and one arm and Resident B started kicking to be | | | | one education on the Guidelin | | |
| | put down and CNA 6 dropped Resident B on the | | | | for Resident Abuse Prevention | | |
| | floor. Resident B hit her head on a bed frame. | | | | Reporting of Abuse. ¿¿ How | | |
| | noof. Resident B lift her flead off a bed frame. | | | | identified and what corrective | De | |
| | A change of condition note, dated 7/29/23 at 1:09 | | | | action will be taken?¿ All | | |
| | p.m., indicated Resident B hit her head during a | | | | residents that reside in the fac | sility | |
| | possible fall incident. She had a small bump on | | | | have the potential to be affect | • | |
| | the top of the right side of her head and she | | | | by the same alleged action. | | |
| | | ck pain with range of motion. | | | facility completed interviews w | | |
| | _ | ER (Emergency Room). | | | employees and residents to | ,,,,,, | |
| | one was sent to the | ER (Emergency Room). | | | ensure that any allegations of | | |
| | Review of a facility | r-reported incident document, | | | abuse are investigated and | | |
| | - | te of 7/29/23 at 2:03 p.m., | | | reported timely to the appropri | iate | |
| | indicated the follow | - | | | agency. No further events wer | | |
| | indicated the folion | | | | identified. What measures w | | |
| | A description of the | e incident, added on 7/30/23, | | | put into place and what syster | | |
| | _ | ported she and CNA 6 went to | | | changes will be made to ensu | | |
| | | esident. Resident B was | | | that the deficient practice does | | |
| | - | resident's bed and CNA 6 | | | recur?¿ Facility staff were | | |
| | | Resident B to assist her to her | | | in-serviced on the guidelines f | or | |
| | _ | B became agitated during | | | Abuse Prevention and Report | | |
| | | ed and she struck CNA 6 in the | | | include but not limited to the ty | - | |
| | | attempted transfer, Resident B | | | of abuse and reporting time | , i · = = | |
| | | that time, CNA 7 alerted staff in | | | frame. ED and DNS educate | d on | |
| | | he nurse for assistance. CNA | | | guideline for timely initiation of | | |
| | | the room and CNA 7 remained | | | investigation and reporting an | | |
| | | til the nurse arrived. | | | allegation of abuse to the | | |
| | | | | | appropriate agency. ED or | | |
| | The action taken, ac | dded on 7/30/23, was CNA 6 | | | Designee will conduct a rando | m | |
| | | corted out of the building and | | | interview/audit of 5 residents a | | |
| | | investigation. The physician | | | Employees weekly x 4 weeks, | | |
| | | esident B was transferred to a | | | then 3 Residents and 3 | | |
| | | valuation and treatment. | | | Employees weekly x 5 months | S. | |
| | · • | | | | ' ' | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155687 NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER IDENTIFICATION SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER IDENTIFICATION SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 2701 LYN-MAR DR MUNCIE, IN 47304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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 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 nountioned to be monitored following event for any signs and symptoms of discomfort and psychosocial distress. Plan of care was being |
|--|
| NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG Was transferred to a local hospital for further evening with no injuries noted. 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 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 |
| NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL RAGIORECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DATE 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 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 STREET ADDRESS, CITY, STATE, ZIP COD 2701 LYN-MAR DR MUNCIE, IN 47304 ID PREFIX GRAGIONECTIVE ACTION SHOULD BE (X5) COMPLETION GRASH-RECEION (EACH CORRECTIVE ACTION SHOULD BE (ACTION SHOULD BE |
| AMME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER 2701 LYN-MAR DR MUNCIE, IN 47304 |
| PREFIX TAG Resident B's family, Administrator and DON were notified. 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. 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 Resident B's family, Administrator and DON were notified. Tag PREFIX TAG 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 |
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| |
| i nevenosocial distress. Plan of care was nether. I I recommendations: It |
| psychosocial distress. Plan of care was being recommendations.¿ If reviewed and interventions were updated. reviewed and interventions were updated. |
| audits will continue based on |
| |
| |
| |
| and leg, nor the CNA dropping the resident to the based on a prn basis.¿ |
| 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.). |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|---|-------|---------|--|-------|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | | | | COMPL | | |
| 155687 | | | B. WI | NG | | 08/03 | /2023 |
| NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER | | | | 2701 LY | ADDRESS, CITY, STATE, ZIP COD YN-MAR DR E, IN 47304 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE. | COMPLETION |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | incident report was Department of Heal actual or identified was 7/31/23 at 1:39 following: The description add another investigation Resident D alleged shower and verbaliz pushed her into the moderately cognitive This report was not being reported to the designee. 3. A facility reporter Administrator, with 2:45 p.m. and report indicated the followed The description add Resident E was seen Resident E was seen Resident C while he hands around his ne redirect Resident E responded by swing Resident E. Resider started swinging he they were leaving the resided in AACU. An Incident Submiss incident was submit of Health on 8/1/23 | submitted within two hours of e facility Administrator or di incident reported by the the incident date of 7/31/23 at ted on 8/1/23 at 1:12 p.m. ving: led, on 8/1/23, indicated in by the nurse standing over e was lying in bed with her eck. The nurse was able to and separate her. Resident C ging his hand towards in E became agitated and in the hands towards the nurse as the room. Both residents sesion email confirmed the ted to the Indiana Department at 1:12 p.m. The actual or time of the incident was | | | | | |

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Facility ID: 000097

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | X1) PROVIDER/SUPPLIER/CLIA | r í | | NSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--------------------|--------|---|-----------------------------|------------|
| | | IDENTIFICATION NUMBER | A. BUII | | 00 | | |
| 155687 | | | B. WING 08/03/2023 | | | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP COD | | |
| | | | | | N-MAR DR | | |
| BRICKYA | ARD HEALTHCARE | E - MUNCIE CARE CENTER | | MUNCIE | E, IN 47304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE (| COMPLETION |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | During an interview | with the DON, on 8/3/23 at | | | | | |
| | - | rated 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 | | | | | | |
| | | what she was told during | | | | | |
| | - | were still completing | | | | | |
| | | sekeeper was not interviewed | | | | | |
| | - | 31/23. The allegation of abuse y were not aware of until | | | | | |
| | - | hey had investigated the | | | | | |
| | | ident D along with the | | | | | |
| | _ | for Resident B and was | | | | | |
| | located in the invest | tigation in the binder, it was | | | | | |
| | - | State Agency. LPN 19 was | | | | | |
| | - | eporting the allegation of | | | | | |
| | |), she knew about the | | | | | |
| | - | orning but she was busy with | | | | | |
| | other things. | | | | | | |
| | Review of the curre | ent IDOH "Long-Term Care | | | | | |
| | | Reporting Policy," effective | | | | | |
| | 12/8/22 and retrieve | ed from | | | | | |
| | | /health/files/IDOH-LTC-Abuse | | | | | |
| | • | rting-policy_policy-SIGNED.p | | | | | |
| | | owing: "Alleged violation is | | | | | |
| | | rence that is observed or sident, relative, visitor, or | | | | | |
| | | ovider, or others but has not | | | | | |
| | - | ed and, if verified, could be | | | | | |
| | | n the federal requirements | | | | | |
| | - | nent, exploitation, neglect, or | | | | | |
| | abuse, including inj | uries of unknown source, and | | | | | |
| | misappropriation of | | | | | | |
| | | tely means as soon as possible, | | | | | |
| | | shorter state time frame | | | | | |
| | | t later than two hours after the | | | | | |
| | allegation is made, allegation involve a | if the events that cause the | | | | | |
| | anegation involve a | ouse | | | | | |

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Facility ID: 000097

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2023 FORM APPROVED OMB NO. 0938-039

| | ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING | | | | (X3) DATE SURVEY COMPLETED 08/03/2023 | |
|---|---|---------------------------------------|---|--|---------------------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | Cross reference F60 | 00. lates to complaint IN00414267. | | | | |
| | 3.1-28(c) | • | | | | |

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