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	12/29/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00394960 and IN00397076. Complaint IN00394960 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00397076 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: December 28 and 29, 2022. Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census Bed Type: SNF/NF: 104 Total: 104 Census Payor Type: Medicare: 4 Medicaid: 87 Other: 13 Total: 104 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 3, 2023.	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

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

Breque Norris | Executive Director | 01/12/2023

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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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided and individualized interventions were initiated to prevent falls for 1 of 3 residents reviewed for accidents (Resident D). Findings include: During an observation, on 12/29/22 at 11:00 a.m., Resident D was lying in bed in low position with a floor mat on the side of the bed. The resident's clinical record was reviewed on 12/28/22 at 1:52 p.m. Diagnoses included, but were not limited to, dementia, falls and abnormalities of gait and mobility. A 11/6/22, admission, MDS (Minimum Data Set) assessment indicated he had moderate cognitive impairment. He required extensive assistance with bed mobility and personal hygiene, and limited assistance with transfers, to walk in room and corridor, with locomotion on and off the unit, dressing, and toilet use. He was occasionally incontinent of bladder and frequently incontinent of bowel. He had fallen in the last 2-6 months prior to admission, without fractures. A current care plan, dated 11/2/22, indicated he was at risk for falls related to impaired mobility, potential for adverse side effects related to medications, history of falling and incontinence of bowel and bladder. The goal, with a revision date of 11/27/22 and a target date of 2/27/23, indicated	F 0689	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 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: 689 D Free of Accident Hazards/Supervision/Devices **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident D: No longer resides at the facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken**	01/12/2023

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	he would have no serious injuries related to falls through next review. Interventions included footwear to prevent slipping, orientation to new room and roommate, provide ADL (Activities of Daily Living) care as needed/requested and therapy as ordered, all dated 11/2/22. An intervention for call light or personal items available and in easy reach was initiated on 11/2/22 and revised on 11/14/22. An intervention for an emergency room transfer for evaluation was dated 11/9/22 and a low bed with a mat was initiated on 12/5/22 and revised on 12/11/22. A current care plan, dated 11/7/22, indicated he had an ADL self-care deficient related to dementia and required supervision/set-up to extensive assistance for bed mobility, transfers, eating and toileting. The goal, with a revision date of 11/27/22 and a target date of 2/27/22, indicated he would maintain current abilities through next review. The interventions included call light within reach, limited assistance of one staff member with mobility and a walker and therapy as ordered, all dated 11/7/22. The following interventions had been initiated on 11/7/22 and revised on 11/27/22: to show an increased need for assistance, extensive assistance of two staff members with bed mobility, extensive assistance of one staff member with toileting and extensive assistance of one staff member with transfers. Current physician orders included physical therapy three times a week for 30 days and hospice to evaluate and treat starting 12/28/22. The order dates for both was 12/28/22. A review of the resident's progress notes indicated the following: On 11/2/22 at 11:30 a.m., the resident admitted		Initial audit The facility completed a 30 day look back of all fall events to ensure that the resident's plan of care was updated and individualized interventions were initiated following a fall event. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Licensed Nurses were educated on the fall prevention guidelines to include but not limited to updating the residents plan of care following an event to ensure individualized interventions were initiated. On-going monitoring DNS or designee will review all fall events, during daily clinical review, to ensure there is appropriate updates to the plan of care to include individualized interventions. 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**	

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	from home and had brought his own walker. Neurological checks had been started upon admission due to a fall at home. He had a knot and bruise to the left side of his head, abrasions and bruises to his left and right arms, abrasions to left and right legs. A fall risk assessment, dated 11/2/22 at 1:29 p.m., indicated he was at risk for falls. A fall risk assessment, dated 11/9/22 at 7:10 p.m., indicated he was at risk for falls. On 11/9/22 at 9:59 p.m., the resident had been found lying on his left side against the closet in his room at 7:10 p.m. He had indicated he had tried to go to the restroom and his legs had felt weak, complained of left pain and was able to bear some weight with assistance. Order received to obtain a left hip X-ray. An 11/9/22 at 7:10 p.m., late entry, post-fall evaluation note indicated the resident had an unwitnessed fall in his room. He sustained a fracture to his left hip and skin tear to his left elbow. The clinical record did not include additional interventions to reduce the risk of falls. On 11/10/22 at 4:41 a.m., X-ray results had been received and an order obtained to send the resident to the emergency room for evaluation and treatment. On 11/10/22 at 11:53 a.m., an IDT (Interdisciplinary Team) note indicated the resident had been found on the floor in front of his closet with complaints of left hip pain. He had a history of falls. The root cause analysis determined he had been		**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.	

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	ambulating without assistance in his room. The immediate intervention put in place was for the emergency room transfer. The care plan had been updated and continued with new interventions implemented as charted. On 11/10/22 at 2:08 p.m., his wife called the facility to let them know he would have surgery to his left hip. On 11/18/22 at 6:00 p.m., the resident arrived back to the facility via ambulance transport. A fall risk assessment, dated 12/5/22 at 6:30 a.m., indicated he was at risk for falls. On 12/5/22 at 9:09 a.m., the resident was calling out for help and was observed lying on the floor beside his bed. He indicated he had tried to turn over, fell out of bed, and had hit his forehead on the floor. He was assisted to a standing position and then back to bed. A red area over his left eyebrow measured 3.8 centimeters (cm) long X 4.0 cm width. On 12/8/22 at 9:13 p.m., an IDT note indicated the resident had fallen out of bed trying to turn himself. He had a history of falls. The root cause analysis of the fall determined he rolled out of bed. The immediate intervention put in place was a low bed with a mat. The care plan had been updated and continued with new interventions implemented as charted. On 12/14/22 at 5:01 p.m., the resident's wife had taken his walker home since he now used a wheelchair. During an interview, on 12/29/22 at 1:53 p.m., the Director of Nursing indicated the resident's ADL			

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	care plan had been updated to reflect the additional assistance he now required with bed mobility, transfers and toileting after his fracture. "The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities," developed and supported by the Agency for Healthcare Research and Quality (AHRQ) #290-00-0011, Task Order No. 3 dated October 2005 and available at https://www.ahrq.gov/sites/default/files/publications/files/fallspxmanual.pdf indicated "...Chapter 4 Long Term Management...A. Interim Plan of Care for New Admissions. Most residents are at a higher risk of falling in the first 2-3 weeks following admission to a facility. However, it may take staff a significant portion of this period to develop a comprehensive care plan based on a multidisciplinary approach. Also, it may be difficult to determine the resident's risk this early in their stay. Other residents may have increased fall risk after admission that will decrease once adjustment to the facility is made. For these reasons, an interim plan of care should be implemented for all new admissions regardless of risk level. During this time, close observation to collect information about the resident's risk factors and individual behaviors can be used to develop a more comprehensive plan...Interim Plan of Care: *Close observation and increased supervision *Frequent orientation to room, bathroom and facility *Staff assistance to toilet or bedside commode ...." This Federal tag relates to complaint IN00397076. 3.1-45(a)			