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	10/03/2023

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

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00418241 and IN00417492. Complaint IN00418241 - Federal/State deficiencies related to the allegations are cited at F567 and F602. Complaint IN00417492 - No deficiencies related to the allegations are cited. Survey dates: September 26, 27, 28, 29 and October 2 and 3, 2023. Facility number: 000258 Provider number: 155367 AIM number: 100289160 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 2 Medicaid: 74 Other: 11 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 12, 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 0550 SS=D	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights			

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

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	10/03/2023

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

(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
Bldg. 00	§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as			

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	10/03/2023

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

(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
	required under this subpart. Based on observation, interview and record review, the facility failed to ensure residents were dressed in regular clothing like other residents unless their preferences were identified for alternative clothing for 1 of 1 resident reviewed for dignity. (Resident 75) Finding includes: During an observation, on 9/28/23 at 1:15 p.m., Resident 75 was in her room, sitting in her wheelchair. She was wearing a hospital gown and had a blanket covering her legs. During an observation, on 9/28/23 at 3:44 p.m., the resident was in a wheelchair propelling herself in the hallway and common area wearing a hospital gown. The other residents in the facility were observed wearing regular clothing. The record for Resident 75 was reviewed on 9/27/23 at 4:39 p.m. Diagnoses included, but were not limited to, fracture of the right femur (thigh bone), chronic obstructive pulmonary disease, and post-traumatic stress disorder. A resident personal belongings inventory sheet, dated 9/13/23 and signed by the resident, indicated one black sleeveless top, one brownish colored pair of slippers, one white Columbia sweater, one pair of black biker shorts, two brushes, one black cell phone, one charger and extra black box, two (2) word search books, and one coloring book. A care plan for wearing a hospital gown in the hallway and common areas was not located. During an interview, on 9/29/23 at 3:11 p.m., the	F 0550	F 550 Resident Rights/Exercise of Rights What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 75: (Likens) Residents clinical record was reviewed and reflects preference for clothing was identified and plan of care updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial audit: All residents were audited for preference and plan of care reflects preference to include but not limited to clothing. 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 guideline for Resident Rights to include but not limited to identifying resident preference with dressing/grooming and plan of care updated to include preferences. On-going DNS or will interview and observe at least 3 per day to ensure residents are dressed per their preference and plan of care. 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	11/03/2023

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	10/03/2023

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

(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
	resident indicated she preferred to wear her clothes and did not like to wear a gown in the halls. The resident was admitted with one pair of yellow pants, one red shirt, and a pair of white socks. There were no clothes in her room and the staff told her they were down in the laundry being washed. She indicated they had not washed her clothes since she had been there. During an interview, on 9/29/23 at 3:13 p.m., the Executive Director (ED) and the Director of Nursing (DNS) indicated last Friday they had a conversation with the resident about calling her loved one to bring clothes in. They both indicated her family brought clothes into her. On 9/28/23, there was a late note put in, for 9/27/23, indicating the resident's clothes were being labeled and in the laundry. During an interview, on 9/29/23 at 3:20 p.m., the ED and DNS asked the resident if she remembered talking to them. The ED and DNS asked if they could get clothes for her. The DNS and ED asked the resident if she called her loved one to bring her clothes as was mentioned in their conversation. During an interview, on 9/29/23 at 3:21 p.m., the resident indicated she remembered talking to them. The resident did not call her loved one to bring in the clothes and her boyfriend never brought her clothes. The resident indicated she wanted to wear something other than a hospital gown. During an interview, on 9/29/23 at 3:35 p.m., the resident indicated she only had the outfit she was admitted to the facility. She came with one pair of yellow pants, one red shirt, and one pair of white socks. Her boyfriend did not bring her clothes.		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 based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿ Request for IDR reasoning: The community is IDR due to completed with . Resident admitted to the state surveyor during an interview that community had offered to call family on 9/22/2023 to request clothing and resident declined offer. stated that her family would be in over the and she would ask at this time for them to bring in clothing. did not have any concerns at this time related to wearing hospital . had brought in clothing on 9/27/2023 which was taken down to be laundered and tagged.	

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	10/03/2023

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

(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
	She was wearing a Colts short sleeved shirt, a white pair of pants, and a pair of short white socks given to her by staff. During an interview, 9/29/23 at 3:09 p.m., the Clinical Support Nurse indicated there was no care plan or documentation to indicate the resident's preference was to wear a hospital gown. A current policy, titled "Resident Rights," not dated and received from the ED at the entrance conference, indicated "...The facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility...." 3.1-3(t)			
F 0567 SS=E Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in			

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	10/03/2023

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

(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
	excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.			
	Based on interview and record review, the facility failed to notify residents' family representatives prior to staff spending the residents' personal funds for 4 of 4 residents reviewed for protection of resident funds. (Residents B, E, F and D) Findings include: A facility incident report, dated 9/12/23, indicated Unit Manager 10 was utilizing Kohl's cash which was rewarded when purchasing resident items to assist them in spending down their resident accounts. During the investigation, it was discovered Unit Manager 10 had purchased items for 4 residents between 2022-2023 and had received Kohl's cash during the purchases and it was not returned to the residents.	F 0567	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident Residents clinical record was reviewed and updated to include accurate inventory Family/responsible party was notified of purchasing that was completed by facility staff. Resident E: Residents clinical record was reviewed and updated to include accurate inventory Family/responsible party was notified of purchasing that was completed by facility staff.	11/03/2023

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	10/03/2023

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

(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
	1. The record for Resident B was reviewed on 9/27/23 at 5:02 p.m. Diagnoses included, but were not limited to, anxiety disorder, bipolar disorder, cognitive communication disorder, and depressive disorder. During an interview, on 9/28/23 at 11:49 a.m., the Business Office Manager (BOM) indicated the Social Service Director (SSD) and Unit Manager 10 were able to shop for the residents. They would go to the BOM and request money. They would ask for $1,000.00 or more to shop for the residents' personal items. The families were not notified of the funds being removed from the personal accounts. 2. The record for Resident E was reviewed on 9/27/23 at 3:59 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and depressive disorder. During an interview, on 10/02/23 at 9:09 a.m., the Executive Director (ED) indicated the families were not notified of the money taken out of the resident's funds. 3. The record for Resident F was reviewed on 9/27/23 at 4:0 p.m. Diagnoses included, but were not limited to, dementia with agitation, anxiety disorder, and delusional disorders. An email, dated 8/2/22 at 2:52 p.m., indicated the family representative asked to be informed of all purchases made on the resident's behalf. During an interview, on 9/28/23 at 11:49 a.m., the BOM indicated the former Activity Director was the one mainly shopping for the resident. Unit Manager 10 would shop for the residents on the		Resident F: Residents clinical record was reviewed and updated to include accurate inventory Family/responsible party was notified of purchasing that was completed by facility staff. Resident Residents clinical record was reviewed and updated to include accurate inventory Family/responsible party was notified of purchasing that was completed by facility staff. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial audit: Facility completed a 14 day look back of residents that had funds pulled for shopping had documentation that family was notified and gave permission for facility staff to shop for the resident. Director has designated Social Services, Activity Director and Memory Care Director to purchase for residents. Prior to other individuals purchasing for	

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	10/03/2023

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

(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
	dementia unit. The staff would request money for the residents. They would provide receipts and bring in the purchased item. 4. During an interview, on 9/27/23 at 4:07 p.m., Resident D's family member indicated the BOM gave permission to Unit Manager 10 to use the resident's money to buy clothes for the resident. The facility did not get her consent to spend the money. Unit Manager 10 had spent some of the money for herself. The record for Resident D was reviewed on 9/27/23 at 4:07 p.m. Diagnoses included, but were not limited to, dementia, generalized anxiety disorder, down syndrome, and a communication deficit. During an interview, on 10/2/23 at 9:09 a.m., the ED indicated Unit Manager 10 only admitted to using 360 dollars of Kohls cash and she was aware there was a lot more than Unit Manager 10 admitted to. The Power of Attorney (POA) was not notified prior to shopping. A current policy, titled "Resident Personal Funds," dated 2023 and received from the ED on 9/28/23 at 10:56 a.m., indicated "...The resident has a right to manage his or her financial affairs to include the right to know, in advance, what charges a facility may impose against a resident's personal funds...The facility will establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's person funds entrusted to the facility on the resident's behalf...The individual financial record must be available to the resident through quarterly statements and upon request...."		residents, it must be approved by the ED. Family or representative must be contacted for consent to do purchasing and documented. Shopping for resident items will be done during business hours to ensure timely reconciliation of funds and items purchased are placed on inventory sheet promptly upon return to facility. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education: Business office staff educated in for handling and distribution of resident funds. Managers on the process for handling funds and making purchases for residents. Purchases for residents being by facility staff that are greater than $300.00 must be reviewed/approved by Executive director.	

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	10/03/2023

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

(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
	This Federal Tag relates to Complaint IN00418241. 3.1-6(e)		On-going ED will review RFMS with BOM to ensure handling and distribution of funds are accurate with no discrepancies. Weekly x 8 weeks then monthly 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 based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿ Request for IDR reasoning: The community is requesting IDR as this breakdown was previously identified prior to the annual survey with systems put in place to correct the breakdown. The community asked the state board of health why they were not being considered to be back in compliance with no explanation.	

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	10/03/2023

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

(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 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.			

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	10/03/2023

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

(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
	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on interview and record review, the facility failed to notify the physician of a blood glucose level greater than the physician's call orders for 1 of 1 resident reviewed for notification. (Resident B) Finding includes: The record for Resident B was reviewed on 9/27/23 at 5:02 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and dependence on renal dialysis. A care plan, dated 11/27/20, indicated the resident was at risk for alteration in blood glucose due to diabetes mellitus. The interventions included, but were not limited to, give insulin per order, report abnormal results per parameters/guidelines. A physician's order, dated 9/17/22, indicated to give Lispro (insulin for blood glucose levels) solution 100 unit/ml(milliliter). Inject the insulin as per sliding scale if the blood glucose levels were as follows: a. 150-200 = 1 units.	F 0580	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident B: Clinical record was reviewed to include physician orders regarding blood glucose monitoring. MD/NP was notified of blood glucose outside of parameters with any follow up noted in the progress note. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial audit: The facility completed	11/03/2023

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	10/03/2023

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

(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
	b. 201-250 = 2 units. c. 251-300 = 3 units. d. 301-350 = 4 units. e. 351-400 = 5 units. Call the physician if the blood glucose levels were less than 70 or more than 400. A facility vital sign document indicated the following blood glucose levels: a. The blood glucose level, on 4/10/23, was 446. The physician was not notified. b. The blood glucose level, on 4/14/23, was 475. The physician was not notified. c. The blood glucose level, on 4/21/23, was 423. The physician was not notified. d. The blood glucose level, on 9/24/23, was 447. The physician was notified 3 days later, on 9/29/23. There was no documentation to indicate the physician was notified of the blood glucose levels out of the call parameter. During an interview, on 10/3/23 at 11:16 a.m., the Nurse Manager indicated if a blood glucose level was out of range, they would call their endocrinologist. The nurses would sometimes take a second blood glucose level when they received a high reading. It was preferred, the nurses not chart a high blood glucose level until they have tested it twice. The facility policy indicated when a resident had a blood glucose level out of the physician's call orders, the nurse should call the physician if it was out of the range. During an interview, on 10/3/23 at 4:14 p.m., the Director Nursing Services (DNS) indicated the facility did not contact the physician with the blood glucose levels above 400. A current policy, titled "Blood Glucose		a 5 day look back of all residents that have blood glucose monitoring orders to ensure MD/NP was notified of any obtained outside of ordered parameters and documented in the clinical record. 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 (RN/LPN/QMA) were educated on the guideline for Blood Glucose monitoring to include but not limited to notifying the MD/NP of a blood glucose level outside of the ordered parameters. On-going monitoring: DNS or will review alerted blood glucose levels during morning clinical review to ensure the clinical record includes documentation that the MD/NP was notified of levels outside of the ordered parameters. 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	

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	10/03/2023

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

(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
	Monitoring," revised 2022 and received from the Director of Nursing on 10/3/23 at 9:00 a.m., indicated "...The facility will perform blood glucose monitoring as per physician's orders...Verify the physician's orders...Report critical test results to physician timely...Document the procedure...." 3.1-5(a)(2) 3.1-5(a)(3)		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 based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect the residents' right to be free from verbal abuse for 1 of 1 resident reviewed for abuse. (Resident C)	F 0600	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿	11/03/2023

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	10/03/2023

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

(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
	Finding includes: During an interview, on 9/26/23 at 10:07 a.m., Resident C indicated someone had sworn at her and was unsure of who or when. The record for Resident C was reviewed on 9/28/23 at 11:53 a.m. Diagnoses included, but were not limited to, major depressive disorder, heart failure, and vascular dementia. The facility did an investigation on 7/12/23. The investigation included: a. During an interview, on 7/12/23, CNA 4 indicated he was asked for help by 2 other CNAs to assist with care for Resident C. b. During an interview, on 7/12/23, CNA 5 indicated she and CNA 6 got the help of CNA 4 to help provide care for Resident C. She indicated the resident was resistant to care and she heard CNA 4 say "shut your old a** up." The roommate was not in the room. c. During an interview, on 7/12/23, CNA 6 indicated she asked CNA 4 to help provide care to Resident C. She indicated while providing care she heard CNA 4 say "yeah you know what time it is, come on, get your old a** up." The facility investigation indicated they did not substantiate the allegation. During the investigation, the facility identified customer service issues with CNA 4 and made the decision to no longer employ him. During an interview, on 9/29/23 at 3:44 p.m., CNA 5 indicated CNA 4 said "shut your old a** up" to the resident. During an interview, on 9/29/23 at 3:44 p.m., CNA		Resident C: (Wilkins) Clinical record was reviewed to ensure the plan of care reflects resident current care and psychosocial needs. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial audit: Residents and staff were interviewed utilizing abuse questions to ensure any concerns have been reported timely and with follow up. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;¿ Education: Facility staff were educated on the guidelines for Abuse Prevention/Reporting to include but not limited to protecting the resident from verbal abuse.	

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	10/03/2023

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

(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
	6 indicated CNA 4 said "yeah you know what time it is, come on, get your old a** up" to the resident. During an interview, on 10/2/23 at 11:35 a.m., the Clinical Support Nurse indicated she did not deny the incident happened, but the facility did abuse training and an investigation so "what else could the facility have done." During an interview, on 10/03/23 at 12:45 p.m., the DNS (Director of Nursing Services) indicated the resident used to work in a factory and was a truck driver, so she was used to foul language. What seemed like inappropriate language to one person might not be inappropriate language to the resident. She was not sure if the resident was care planned for being ok with inappropriate language. A current care plan, dated 3/13/23, indicated to allow for a calm and unhurried environment and to encourage communication. The resident did not have a care plan for being ok with the use of inappropriate language. A current policy, titled "Abuse, Neglect and Exploitation," dated 2023 and received upon entrance from the Executive Director indicated "..."Verbal Abuse" means the use of oral, written or gestured communication or sounds that willfully includes disparaging or derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability...." 3.1-27(b)		On-going monitoring: ED or will complete abuse question interviews with staff and residents and ensure any concerns are followed up on 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 audits will continue based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿ Request for IDR reasoning: The community is requesting to IDR this deficiency as this had	

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	10/03/2023

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

(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
			been previously investigated with no deficiencies. This was investigated on August 7-August 8, 2023, complaint #IN00413528. The community is asking what new information came forward to reopen this reportable. The surveyor states that he asked the resident if “anyone” had every cussed around her giving him reasoning to reinvestigate. This resident has a fluctuating BIMs on 6-16-2023 was a 4 and on 9-15-2023 her BIMs was an 8. The community asked the surveyor if they asked if the question was proposed to resident if “anyone” had cussed around her or if “employees” had cussed around her as these were two very different proposals. The survey team was unable to answer the community at this time. states on 9-26-2023, that resident indicated that “someone” had sworn at her and was unsure of who or when. The community requested for the state to re-interview the resident and was declined. The community interviewed on 10-2-2023. At this time the resident believed that she was at a hospital in Indianapolis. The community asked if anyone had ever used inappropriate language around her and she specifically “not any employees, some of the other people who live	

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	10/03/2023

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

(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
			here sometimes say things." Community asked resident if she was affected in any way and she said, "No, Lord no, I worked in a factory for 40 years." The statements from the two employees who were also interviewed are not consistent.	
F 0602 SS=E Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to ensure residents' personal property was not used by staff for 4 of 4 residents reviewed for misappropriation of property. (Residents B, E, F and D) Findings include: A facility incident report, dated 9/12/23, indicated Unit Manager 10 was utilizing Kohl's cash which was rewarded when purchasing resident items to assist them in spending down their resident accounts. During the investigation, it was discovered Unit Manager 10 had purchased items for 4 residents between 2022-2023 and had received Kohl's cash during the purchases and it was not returned to the residents.	F 0602	F 602 E Exploitation/Misappropriation What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident Residents clinical record was reviewed and updated to include accurate inventory Family/responsible party was notified of purchasing that was completed by facility staff. Resident E: Residents clinical record was reviewed and updated to include accurate inventory Family/responsible party was notified of purchasing that	11/03/2023

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	10/03/2023

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

(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
	1. The record for Resident B was reviewed on 9/27/23 at 5:02 p.m. Diagnoses included, but were not limited to, anxiety disorder, bipolar disorder, cognitive communication disorder, and depressive disorder. A Withdrawal Transaction Report for a Kohl's receipt, dated 10/8/22, indicated Unit Manager 10 was using her personal account and receiving Kohl's cash and Kohl's rewards. The amount Unit Manager 10 received was Kohl's cash of $400.00 and Kohl's rewards of $106.73. During an interview, on 9/29/23 at 3:32 p.m., the Executive Director (ED) indicated she took the Kohl's receipts and verified the receipts with the items in the resident's room. The item on the receipt indicated a bottle of Juicy Couture cologne was purchased for $119.00. The items purchased did not get put on the resident's inventory sheet, however the ED indicated the facility took the receipts and matched the items on the receipt with what was in the residents room. The Juicy Couture cologne was not verified. During an interview, on 9/28/23 at 11:49 a.m., the Business Office Manager indicated the former Activity Director was the one mainly shopping for the resident. Unit Manager 10 would shop for the residents on the dementia unit. The staff would come to her and request money. The residents had to spend down their money so nothing was really said. They would provide receipts and bring in the purchased items. They would ask for 1000's of dollars before and now anything over $300 must be approved by the ED. The families were not called to notify them of the funds being removed from the resident's account.		was completed by facility staff. Resident F: Residents clinical record was reviewed and updated to include accurate inventory Family/responsible party was notified of purchasing that was completed by facility staff. Resident Residents clinical record was reviewed and updated to include accurate inventory Family/responsible party was notified of purchasing that was completed by facility staff. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial audit: Facility completed a 14 day look back of residents that had funds pulled for shopping had documentation that family was notified and gave permission for facility staff to shop for the resident. Director has designated Social Services, Activity Director and Memory Care Director to purchase for residents. Prior to other individuals purchasing for residents, it must be approved by the ED. Family or representative must be contacted for consent to do purchasing and documented. Shopping for resident items will be done during business hours to ensure timely reconciliation of funds and items purchased are placed on resident's inventory sheet promptly upon return to	

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	10/03/2023

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

(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
	2. The record for Resident E was reviewed on 9/27/23 at 3:59 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and depressive disorder. A Withdrawal Transaction Report for a Kohl's receipt, dated 8/26/23, indicated Unit Manager 10 was using her personal account and receiving Kohl's cash and Kohl's rewards. The amount Unit Manager 10 received was Kohl's cash of $360.00 and Kohl's rewards of $91.88. 3. The record for Resident F was reviewed on 9/27/23 at 4:0 p.m. Diagnoses included, but were not limited to, dementia with agitation, anxiety disorder, and delusional disorders. A Withdrawal Transaction Report for a Kohl's receipt, dated 8/26/23, indicated Unit Manager 10 was using her personal account and receiving Kohl's cash and Kohl's rewards. The amount Unit Manager 10 received was Kohl's cash of $400.00 and Kohl's rewards of $11.68.4. During an interview, on 9/27/23 at 4:07 p.m., Resident D's family member indicated the BOM gave permission for Unit Manager 10 to use the resident's money to buy clothes for the resident. The facility did not get her consent to spend the money. Unit Manager 10 had spent some of the money for herself. The record for Resident D was reviewed on 9/27/23 at 4:07 p.m. Diagnoses included, but were not limited to, dementia, generalized anxiety disorder, down syndrome, and a communication deficit. An investigation report, dated 9/25/23, indicated Unit Manager 10 made the following purchase, on 8/8/22 at 7:12 p.m.:		facility. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education: Business office staff educated in the process for handling and distribution of resident funds. Managers on the process for handling funds and making purchases for residents. Purchases for residents being by facility staff that are greater than $300.00 must be reviewed/approved by Executive director. On-going ED will review RFMS with BOM to ensure handling and distribution of funds are accurate with no discrepancies. Weekly x 8 weeks then monthly 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 based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿ Request for IDR reasoning: The community is requesting IDR as this breakdown was previously identified prior to the annual survey with systems put in place to correct the breakdown. The community asked the state board	

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	10/03/2023

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

(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
	a. The receipt total was $1,122.32. b. Unit Manager 10's charge card ending in 4201 was charged $300. c. The rest of the bill was paid with the resident's funds totaling $900 in cash. $77.68 was issued in change. d. A total of $200 in Kohl's cash was issued. The $200 Kohls cash was not returned to the resident. An investigation report, dated 9/25/23, indicated Unit Manager 10 made a purchase which used $900 from the resident's funds. $160 in Kohl's cash was issued. The $160 in Kohl's cash was not returned to the resident. During an interview, on 10/2/23 at 9:09 a.m., the ED indicated Unit Manager 10 only admitted to using $360 of Kohls cash and she was aware there was a lot more than Unit Manager 10 admitted to. The Power of Attorney (POA) was not notified prior to shopping. During an interview, on 9/28/23 at 11:49 a.m., the Business Office Manager indicated the former Activity Director was the one mainly shopping for the residents. Unit Manager 10 would shop for the residents on the dementia unit. The staff would request money for the residents. They would provide receipts and bring in the purchased items. They would ask for 1000's of dollars before. The families were not called to notify them of the funds being removed from the resident's account. A current policy, titled "Abuse, Neglect and Exploitation," dated 2023 and received from the ED on 9/29/23 at 4:46 p.m., indicated "...by		of health why they were not being considered to be back in compliance with no explanation.	

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	10/03/2023

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

(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
	developing and implementing written policies and procedures that prohibit an prevent abuse, neglect, exploitation and misappropriation of resident property...Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent...." This Federal Tag relates to Complaint IN00418241. 3.1-28(a)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will			

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	10/03/2023

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

(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
	provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on observation, interview and record review, the facility failed to ensure a comprehensive care plan was implemented to address a resident's preferences for 1 of 1 resident reviewed for dignity. (Resident 75) Finding includes: During an observation, on 9/28/23 at 3:44 p.m., Resident 75 was in a wheelchair in the common area wearing a hospital gown. The record for Resident 75 was reviewed on 9/27/23 at 4:39 p.m. Diagnoses included, but were not limited to, fracture of the right femur (thigh bone), chronic obstructive pulmonary disease, and post-traumatic stress disorder.	F 0656	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 75: Residents clinical record was reviewed and reflects preference for clothing was identified and plan of care updated. How other residents having the potential to be affected by the same deficient practice will be	11/03/2023

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	10/03/2023

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

(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
	A care plan for wearing a hospital gown in the common areas was not located. During an interview, on 9/29/23 at 3:11 p.m., the resident indicated she preferred to wear her own clothes and did not like to wear a gown in the halls. The resident was admitted with one pair of yellow pants, one red shirt, and a pair of white socks. There were no clothes in her room and the staff told her they were down in the laundry being washed. She indicated they had not washed her clothes since she had been there. During an interview, on 9/29/23 at 3:09 p.m., the Clinical Support Nurse indicated there was no care plan or documentation to indicate the resident's preference was to wear a hospital gown. A current policy, titled "Care Plan Revisions Upon Status Change," dated 2/2023 and received from the Director of Nursing Services on 10/13/22 at 1:20 p.m., indicated "...The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change...Upon identification of a change in status, the nurse will notify the Minimum Data Set (MDS) Coordinator, the physician, and the resident representative...The care plan will be updated with the new or modified interventions...." 3.1-31(a)		identified and what corrective action will be taken¿ Initial audit: All residents were audited for preference and plan of care reflects residents' preference to include but not limited to clothing. 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 guideline for Resident Rights to include but not limited to identifying resident preference with dressing/grooming and plan of care updated to include preferences. On-going monitoring : DNS or designee will interview and observe at least 3 resident per day to ensure residents are dressed per their preference and plan of care. 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	10/03/2023

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

(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
			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 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record review, the facility failed to ensure activities were offered daily for 5 of 5 residents reviewed for activities. (Resident 18, 23, 29, 43 and 85) Findings include:	F 0679	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿	11/03/2023

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	10/03/2023

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

(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
	1. During an interview, on 9/28/23 at 1:34 p.m., Resident 18 indicated there had been a volunteer coming in twice a week for bingo. They had not had an Activity Director for months. The record for Resident 18 was reviewed on 9/29/23 at 4:16 p.m. Diagnoses included, but were not limited to, depressive disorder, anxiety disorder, hypertension, and heart failure. A care plan, dated 12/24/19, indicated the resident made their activity interests known. Interventions included, but were not limited to, enjoyed attending group functions such as bingo, trivia, and parties/socials at her discretion. A documentation survey report, for 9/1/23 to 9/28/23, indicated the resident participated in 8 activities marked for dayshift and 3 activities marked for evening shift. 2. During an interview, on 9/28/23 at 1:35 p.m., Resident 23 indicated she was so bored and depressed because she had nothing to do. The record for Resident 23 was reviewed on 9/2/23 at 4:16 p.m. Diagnoses included, but were not limited to, anxiety disorder, bipolar disorder, and hypertension. A care plan, dated 11/17/21, indicated the resident made their activity interests known. Interventions included, but were not limited to, enjoyed attending group functions such as socials, spiritual programs, resident council, bingo/other games, and exercise at her discretion and parties/socials at her discretion. A documentation survey report, for 9/1/23 to		Activity preferences were obtained for the 5 residents (resident's 18, 23, 29, 43 and 85) who were identified, and their individual plan of care was updated to reflect these preferences. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Activity preferences were obtained for all other residents and those preferences were placed in their care plan. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Activity director and activity assistant have been hired, oriented and working at the facility. The activity calendar has been reviewed and revised to ensure daily activities will be provided to those residents per their preferences.	

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	10/03/2023

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

(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
	9/28/23, indicated the resident participated in 8 activities marked for dayshift and 1activity marked for evening shift. 3. During an interview, on 9/28/23 at 1:37 p.m., Resident 29 indicated all the facility had to do was bingo twice a week. The record for Resident 29 was reviewed on 10/2/23 at 4:16 p.m. Diagnoses included, but were not limited to, depressive disorder, anxiety disorder, bipolar disorder, and schizophrenia. A care plan, dated 3/27/23, indicated the resident had personal preferences and activities of interest. Interventions included, but were not limited to, it was important for the resident to make her own decisions related to group activities and her level of participation. A documentation survey report, for 9/1/23 to 9/28/23, indicated the resident participated in 8 activities marked for dayshift and 2 activities marked for evening shift. 4. During an observation, on 9/29/23 at 9:23 a.m., the resident was lying in her bed. She indicated no activities were offered to her yesterday or today and she was bored. During an interview, on 9/26/23 at 12:10 p.m., Resident 43 indicated she enjoyed doing activities and had not participated in them for a while. The Activity staff quit and had been gone for a few months. The only activity they had was bingo once or twice a week and a volunteer came in for bingo. The record for Resident 43 was reviewed on 9/2/23 at 4:16 p.m. Diagnoses included, but were not		Daily monitoring logs for activities will be completed by the activity director/ and reviewed during daily start up to ensure residents are being provided with activities per their preferences. 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 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	10/03/2023

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

(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
	limited to, depressive disorder, anxiety disorder, hypertension, and heart failure. A care plan, dated 12/24/19, indicated the resident made their activities of interest known. Interventions included, but were not limited to, enjoyed attending group functions such as bingo, trivia, and parties/socials at her discretion. A documentation survey report, for 8/24/23 to 9/14/23, indicated the resident participated in 3 activities marked for dayshift. During an interview, on 9/28/23 at 11:49 a.m., the Business Office Manager indicated the previous Activity Director was no longer employed and it had been several months since there had been an Activity Director for the skilled side of the building. During an interview, on 9/29/23 at 8:40 a.m., the Director of Nursing Services (DNS) indicated they hired two different people for activities and they both quit. The old Activities Director quit without notice a few months ago. The facility had a volunteer coming in twice a week for bingo and a lady once a month played a harp during meals. The skilled side did not have activities and the dementia unit did. She could not pull activities from the dementia unit. The dementia unit went to Indiana beach on an outing and the skilled side had not been on any outings. During an interview, on 9/29/23 at 9:12 a.m., the DNS indicated they offered the residents coloring pages and bingo twice a week. During an interview, on 10/02/23 at 10:00 a.m., the Executive Director (ED) indicated she was aware activities was an issue.5. During an observation,			

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	10/03/2023

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

(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
	on 9/27/23 at 10:52 a.m., Resident 85 was lying in bed in his room. During an observation, on 9/28/23 at 1:41 p.m., the resident was lying in bed in his room with his eyes closed. The television was on. During an observation, on 9/29/23 at 12:32 p.m., the resident was lying in bed in his room with his eyes closed. The television was on. During an observation, on 10/3/23 at 9:59 a.m., the resident was lying in bed with his eyes closed. The room was darkened, the television was not on and there was no reading material on his bedside table, nightstand, or dresser. The record for Resident 85 was reviewed on 9/29/23 at 3:52 p.m. Diagnoses included, but were not limited to, bipolar disorder with current episode depressed, type 2 diabetes mellitus with diabetic neuropathy, generalized anxiety disorder, weakness, and mild cognitive impairment of an unknown cause. A care plan, dated 6/26/23, indicated the resident had impaired cognitive function as evidenced by a diagnosis of mild cognitive impairment of an unknown cause. The interventions included, but were not limited to, involve in activities not dependent on the resident's ability to communicate, music, parties, games and involve in enjoyable activities which orient to reality. An activity assessment, dated 6/17/23, indicated the resident's leisure preferences included reading, television, music, and visiting with family. An activity report, dated August 2023, indicated the resident had activities on 8/5, 8/6, 8/12, 8/13,			

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	10/03/2023

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

(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
	8/19, 8/26 and 8/27/23. This was a total of 7 days out of 31. An activity report, dated September 2023, indicated the resident had activities on 9/1, 9/2, 9/3, 9/9, 9/10, 9/11, 9/16, 9/17, 9/24 and 9/25. This was 10 days out of 30 days. During an observation and interview, on 10/3/23 at 10:50 a.m., an anonymous staff indicated the resident did not have any reading material in his room currently. He did like the daily handout provided by the facility although for some reason he did not have one in his room. There was no reading material on his dresser, nightstand or on his bedside table. He would play bingo sometimes. During an interview, on 10/3/23 at 11:27 a.m., the Director of Nursing Services (DNS) indicated the resident's son was very active and would bring stuff in and out of the resident's room. The resident would go to bingo sometimes. During an interview, on 10/3/23 at 11:39 a.m., the DNS indicated the facility had not had a full-time staff for activities since June 2023. The Executive Director (ED) indicated they had volunteers twice a week for bingo. There was music entertainment once monthly and therapy animals every 2 weeks. A current policy, titled "Activities," dated 2023 and received from the Medical Record staff on 10/2/23 at 10:00 a.m., indicated "...It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as			

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	10/03/2023

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

(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
	well as support their physical, mental and psychosocial well-being. Activities will encourage both independence and interaction with the community...'Activities' refer to any endeavor, other than routine ADLs [activities of daily living], in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical cognitive, and emotional health. These include, but are not limited to activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence...Each resident's interest and needs will be assessed on a routine basis...Activities will be designed with the intent to...Enhance the resident's sense of well-being, belonging, and usefulness...Create opportunities for each resident to have a meaningful life...Promote or enhance physical activity...Promote or enhance cognition...promote or enhance emotional health...Reflect resident's interests and age...Reflect choices of the resident...Activities will include individual, small and large group activities as well as...Indoor and Outdoor Activities...Activities away from the facility...Religious Programs...Exercise Programs...Community Activities...Social Activities...In-Room Activities...Individualized Activities...Educational Programs...." 3.1-33(a) 3.1-33(b)(1) 3.1-33(b)(2) 3.1-33(b)(3) 3.1-33(b)(4) 3.1-33(b)(5) 3.1-33(c)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

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	10/03/2023

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

(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
	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 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 there was communication between the hospice company and the facility for care provided by the hospice staff for 1 of 1 resident reviewed for hospice. (Resident 73) Findings include: The record for Resident 73 was reviewed on 9/28/23 at 1:23 p.m. Diagnoses included, but were not limited to, traumatic subdural (between the skull and the brain) hemorrhage, dementia with other behavioral disturbance, aphasia (difficulty speaking), senile degeneration of the brain, anxiety disorder, major depressive disorder, and repeated falls. A care plan, dated 12/18/22, indicated the resident was on hospice care related to end of life care. The interventions included, but were not limited to, coordinate care with hospice, keep the family informed of changes in condition, and to notify hospice of any changes in condition or medication changes. A physician's order, dated 3/8/23, indicated hospice. The hospice binder had a CNA visit listed, on 9/22/23.	F 0684	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 73: (Waggoner) Residents clinical record was reviewed and updated to include communication with hospice regarding care and services provided by hospice staff. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; Initial Facility completed an audit of all residents receiving hospice service to ensure their records included communication regarding care and services provided by Hospice.	11/03/2023

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	10/03/2023

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

(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
	The hospice Certified Nursing Assistant (CNA) care plan, dated 7/27/23, indicated the CNA was to complete a shower at each visit, assist to get dressed, comb hair, shampoo hair, complete oral hygiene, and provide nail care. The hospice care plan did not include the frequency of hospice CNA visits. During an interview, on 9/28/23 at 3:21 p.m., the Dementia Unit Manager (UM) did not know if the hospice CNA had been at the facility this week for the resident. During an interview, on 9/29/23 at 3:20 p.m., LPN 12 indicated she would call hospice to find out why the hospice CNA had not been to the facility this week or why there was no documentation of the CNA visit. The hospice supervisor was not sure if the hospice CNA had been to see the resident this week and would find out and call the facility back. The hospice CNA was to visit the resident at the facility twice weekly. During an interview, on 10/2/23 at 2:13 p.m., the Director of Nursing Services (DNS) indicated the resident admitted to the facility on hospice. During an interview, on 10/3/23 at 10:05 a.m., CNA 7 indicated the hospice CNA was supposed to be at the facility twice weekly for the resident although the CNA only came once weekly. A current policy, titled, "Hospice Services Facility Agreement", dated 2023 and received from the DNS on 10/3/23 at 1:20 p.m., indicated, "...It is the policy of this facility to provide and/or arrange for hospice services in order to protect a resident's right to a dignified existence, self-determination, and communication with, and access to, persons		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 guideline for Hospice services to include but not limited to documenting communication with hospice regarding services or changes to scheduled services by hospice provider. On-going monitoring: DNS or designee will review clinical records of at least 2 residents that receive hospice services to ensure there is documentation and communication regarding services received or changes to services provided by hospice. 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	

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	10/03/2023

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

(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
	and services inside and outside the facility...The Administrator maintains agreements with one or more Medicare-certified hospices...If hospice care is furnished in the facility through an agreement, the facility will...Ensure the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services...Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC [long term care] facility before hospice care is furnished to any resident...The written agreement[s] will set out at least the following...The services hospice will provide...the hospice's responsibilities for determining the appropriate hospice plan of care...The services the facility will continue to provide based on each resident's plan of care...A communication process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day...The facility has a designated [the Assistant Director of Nursing, or specify the member from the interdisciplinary team] to be responsible for working with hospice representatives to coordinate care to the resident provided by the facility and hospice staff...The designated member of the facility working with the hospice representative is responsible for...Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family...." 3.1-37(a)		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 0688 SS=D	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility			

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	10/03/2023

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

(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
Bldg. 00	§483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to ensure a resident's contracted fingers/hands were assessed and to provide services for the contractures for 1 of 2 residents reviewed for limited range of motion. (Resident 73) Finding includes: During an observation, on 9/29/23 at 12:18 p.m., Resident 73 was sitting up in bed, with a food tray in front of her and was eating using her hands. The resident's fingers were all pointed to the palms of her hands. The record for Resident 73 was reviewed on 9/28/23 at 1:23 p.m. Diagnoses included, but were not limited to, traumatic subdural (between the skull and the brain) hemorrhage, dementia with other behavioral disturbance, aphasia (difficulty	F 0688	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident: 73: (Waggoner) Residents clinical record was reviewed and updated to include assessment and plan of care for contracture. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿	11/04/2023

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	10/03/2023

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

(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
	speaking), senile degeneration of the brain, anxiety disorder, major depressive disorder, and repeated falls. A care plan, dated 12/20/22, indicated the resident had difficulty chewing related to her diagnosis of dementia. The resident used assistive devices to aid in feeding herself and still needed staff assistance. The interventions included, but were not limited to, use a divided plate as ordered, monitor meal consumption, and to provide assistance at meals. The care plan did not include anything about finger/hand contractures. A wound care progress note, dated 4/11/23, indicated the resident had moisture and odor noted on the palmar surface of her bilateral hands related to contractures. The resident had generalized dry, thin, and fragile skin. The plan included, the resident's fingernails needed trimmed and to ensure the hands were dried completely to prevent yeast and skin breakdown. The wound note did not include if the contractures were new or had been there previously. A Minimum Data Set (MDS) assessment, dated 7/6/23, indicated the resident had no impairment in functional limitation with her hands. During an observation, on 10/2/23 at 12:21 p.m., with the Clinical Support Nurse, the resident was sitting up in a Broda chair (chair for positioning). The resident's fingers were contracted towards the palms of her hand. During an interview, on 10/2/23 at 12:22 p.m., the		Initial audit: The facility completed an audit/observation of all residents to ensure residents with contractures have been identified, assessed and plan of care updated. 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 guideline for Prevention of Decline of Range of Motion to include but not limited to completing a thorough assessment, notification to MD/NP and collaboration with therapy services if ordered. On-going monitoring: DNS or designee will review 2 residents daily to include new admissions to ensure a thorough assessment was completed of range of motion and that identified contractures have been addressed per the guideline. These reviews to be conducted 5 times weekly x 4 weeks, then 3	

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	10/03/2023

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

(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
	Dementia Unit Manager indicated the resident could only barely open her hands and could grasp some items. During an interview, on 10/2/23 at 12:23 p.m., CNA 7 indicated the resident could only partially open her fingers and most of the time her fingers were closed towards the palms of her hands. During an interview, on 10/2/23 at 2:13 p.m., the Director of Nursing Services (DNS) indicated the resident did not have a previous therapy evaluation of her hands since she was on hospice. During an interview, on 10/2/23 at 2:28 p.m., Occupational Therapist (OT) 11 indicated today was the first therapy screening for the resident. She was asked to look at the resident's hands. The resident had trouble opening her hands. Both hands had contractures. All the resident's fingers except her thumbs had contractures. She was not able to determine the cause of the contractures. The resident's wrists had limited range of motion although no contracture. During an interview, on 10/2/23 at 2:42 p.m., the Executive Director (ED) indicated she did not know the resident's condition of her fingers/hands at admission and did not know if the contractures were the same, better, or worse. During an interview, on 10/3/23 at 10:05 a.m., CNA 7 indicated the resident's Kardex on the computer kiosk did not have anything listed about the resident's hand contractures or range of motion (ROM) for the fingers/hands. During an interview, on 10/3/23 at 11:47 a.m., the DNS indicated there was no documentation to show if the resident's contractures were present		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 audits will continue 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	10/03/2023

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

(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
	upon admission or if they had improved or worsened. The documentation she could provide was the wound note, dated 4/11/23. During an interview, on 10/3/23 at 3:54 p.m., the DNS indicated the resident did not have a care plan for the finger/hand contractures. A current policy, titled "Skin Assessment," dated 2022 and received from the DNS on 10/3/23 at 1:20 p.m., indicated "...It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment...A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury...." The facility did not provide a policy on contractures by time of exit. 3.1-42(a)(1) 3.1-42(a)(2)			
F 0725 SS=D Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and			

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	10/03/2023

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

(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
	considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based on interview and record review, the facility failed to provide enough staff to prevent low weekend staffing reported in the third quarter to the Pay-Roll Based Journal (PBJ) staffing report and to provide staff to have activities for the residents on the 100 and 200 halls. Findings include: 1. A PBJ staffing report, for the third quarter of 2023, indicated the facility had reported low weekend staffing for the months of April, May, and June. During a resident council meeting, on 9/28/23 at 1:34 p.m., the resident council reported the staff were slow to answer call lights or they would come into the room, turn off the call light, and not come back. The day shift and the evening shift were the worst for getting call lights answered.	F 0725	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Activity preferences were obtained for the 5 residents (resident's 18, 23, 29, 43 and 85) who were identified, and their individual plan of care was updated to reflect these preferences. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿	11/03/2023

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	10/03/2023

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

(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
	During an interview, on 10/3/23 at 12:35 p.m., the Executive Director (ED) indicated she did not start working until July 2023 and was not able to address the low weekend staffing as reported on the PBJ report. During an interview, on 10/03/23 at 12:57 p.m., the Director of Nursing Services (DNS) indicated the third quarter staffing was excessively low on the weekend. They had several staff quit and leave. The month of April had lots of staff off for spring break. They were working short, one Unit Manager and 10 CNAs (Certified Nursing Assistants) over all the shifts. The facility management staff had worked to cover the CNA shortages. She was not able to show the schedules for the third quarter when management covered the shortages for the CNAs and would provide the schedules on 10/4/23 by email. The facility had not provided schedules to show how the management staff covered the shortages for the CNAs during the third quarter. 2. During a resident council meeting, on 9/28/23 at 1:34 p.m., the resident council representative indicated the facility had not had activities for months now. There was a volunteer who came in twice a week for bingo. The facility would only allow the volunteer to work two days a week. They indicated it was boring and depressing since there was nothing to do. During an interview, on 10/3/23 at 11:39 a.m., the DNS indicated the facility had not had full time staff for activities since June 2023. The Executive Director (ED) indicated contracted services were being used and providing activity staff as needed. They also had volunteers twice a week for bingo. There was music entertainment once monthly and		Activity preferences were obtained for all other residents on the 100 and 200 halls: those preferences were placed in their care plan. Activity director and activity assistant have been hired and started. The activity calendar has been reviewed and revised to ensure daily activities will be provided to those residents per their preferences. All open positions for Nursing staff have been posted on Indeed and the facility is working with a recruiter to fill those positions. A new referral bonus was implemented to recruit new employees. A Pickup bonus is being offered for staff to pick up shifts the weekends. Weekly recruitment calls are scheduled to review all open positions and applicant flow to ensure the building staffing needs are being filled.	

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	10/03/2023

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

(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
	therapy animals every 2 weeks. A current policy, titled "Activities," dated 2023 and received from the Medical Record staff on 10/2/23 at 10:00 a.m., indicated "...It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction with the community...." 3.1-17(a)		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Daily monitoring logs for activities will be completed by the activity director/ and reviewed during daily start up to ensure residents are being provided with activities per their preferences. On-going monitoring: Weekend staffing will be reviewed prior to the weekend to ensure sufficient staffing is scheduled. A weekends nurse manager will be present in the facility 8 hours each day. A nurse manager and the staffing coordinator will be on call to help fill staffing call offs. 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	

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	10/03/2023

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

(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
			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 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;			

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	10/03/2023

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

(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
	§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview and record review, the facility failed to ensure residents and resident's representatives were informed of the risks of antipsychotic medications and a gradual dose reduction was considered for 2 of 5 residents reviewed for unnecessary medications. (Resident 73 and J) Findings include: 1. During an observation, on 9/27/23 at 12:00 p.m., Resident 73 was in her room with staff assisting	F 0758	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 73: (Waggoner) Resident's clinical record was reviewed and updated to include communication with the resident/representative regarding risks of antipsychotic medications	11/03/2023

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	10/03/2023

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

(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
	her to eat lunch and the resident was making some grunting sounds. During an observation, on 9/28/23 at 3:07 p.m., the resident responded "yes" to the knock on her door. During an observation, on 9/29/23 at 3:25 p.m., the resident was in the shower room with staff and making repetitive sounds. The record for Resident 73 was reviewed on 9/28/23 at 1:23 p.m. Diagnoses included, but were not limited to, traumatic subdural (between the skull and the brain) hemorrhage, dementia with other behavioral disturbance, aphasia (difficulty speaking), senile degeneration of the brain, anxiety disorder, major depressive disorder, and repeated falls. a. A care plan, dated 12/19/22, indicated the resident was at a risk for adverse effects related to psychotropic drug use. The interventions included, but were not limited to, observe for side effects and report to the physician, a pharmacist review of the medications as needed, provide medication as ordered by the physician, and evaluate for effectiveness and to refer to mental health services for medication and behavior intervention recommendations. A care plan, dated 4/11/23, indicated the resident occasionally had disruptive behaviors during activities such as yelling out which was related to the diagnosis of dementia. The interventions included, but were not limited to, the resident didn't like to sit still for long so please bring to activities just before the program begins, provide shorter duration activities, call the resident's name or gently touch her arm to help maintain		and a gradual dose reduction review. Resident J: (Ridgeway) Resident's clinical record was reviewed and updated to include communication with the resident/representative regarding risks of antipsychotic medications and a gradual dose reduction review. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial The facility completed an audit of residents that receive antipsychotic medication to ensure residents and resident's representatives were informed of the risks of antipsychotic medications and a gradual dose reduction was considered. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿	

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	10/03/2023

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

(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
	awareness of the activity, offer soothing activities and understand if the resident wants to stay in her room. A physician's order, dated 12/9/22, indicated to give aripiprazole (an antipsychotic medication) 2 milligram (mg) one time a day related to severe dementia with behavioral disturbance. A care plan meeting minutes, dated 12/9/22, indicated the team members in attendance included nursing and the resident's family member. The areas discussed included, discharge plans, advanced directives, acute medical conditions, chronic medical conditions, skin/wound conditions, nutrition/hydration, cognition, bowel/bladder, rehabilitation services, physical function, and behavior health activities. The care plan meeting minutes did not include anything about medications, medications side effects, or medication risks and benefits. During an interview, on 10/2/23 at 2:13 p.m., the Director of Nursing Services (DNS) indicated the facility talked about the resident's medications during the care plan meeting although they did not have any specifics about what was discussed listed in the care plan meeting minutes. The facility did not have any documentation of a review of the medication risks and benefits. b. A Treatment Administration Record (TAR), for the month of March 2023, with behavior monitoring for psychosis/delusions, agitation and repetitive calling out, indicated the resident had none of those behaviors for the month. A TAR, for the month of April 2023, with behavior monitoring for psychosis/delusions, agitation and		Education: Clinical staff (RN/LPN) were educated on the guideline for Use of Psychotropic Medication to include but not limited to ensuring residents and resident's representatives were informed of the risks of antipsychotic medications and a gradual dose reduction was considered. On-going monitoring DNS or designee will review all new orders for antipsychotic medications and GDR recommendations to ensure residents and resident's representatives were informed of the risks of antipsychotic medications and a gradual dose reduction was considered. 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¿	

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	10/03/2023

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

(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
	repetitive calling out, indicated the resident had one behavior on April 7 for the day shift. The resident remained the same after the interventions of fluids, food, redirection, and one to one. The TAR did not indicate which one of the listed behaviors occurred. A pharmacy physician recommendation, dated 4/3/23, indicated the resident had a current order for aripiprazole 2 mg daily for dementia with behaviors since 12/22. Please consider discontinuing. The physician/prescriber response, dated 4/14/23, indicated the gradual dose reduction (GDR) was contraindicated due to the resident continued to exhibit behaviors and the behaviors were expected to worsen with a change of medication. The physician/prescribed response did not include the type of behaviors exhibited by the resident. A progress note, dated 6/2/23 at 12:23 p.m., indicated the resident was being assisted with lunch. The resident often had behaviors of yelling out related to the diagnosis of dementia and difficulty making herself understood. The resident's behavior was not distressing to herself or to others. The resident was generally easily redirected. The resident's care plan reflected she would yell at at times. During an interview, on 10/3/23 at 10:05 a.m., CNA 3 indicated the resident would repeat words, really didn't have any behaviors, and did not try to hurt herself or anyone else. Sometimes she would try to get out of bed by herself.		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.¿	

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	10/03/2023

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

(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
	During an interview, on 10/3/23 at 11:29 a.m., the DNS indicated the resident's behaviors included some calling out and some refusals of care. The resident's daughter in law had indicated the resident was rude and blunt. The DNS was not able to report any psychosis, delusions, or distressing resident behaviors.2. The record for Resident J was reviewed on 9/27/23 at 4:19 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, cognitive communication deficit, insomnia, anxiety, dementia in other diseases, and psychosis related to dementia and depression. A physician's order, dated 8/23/23, indicated Risperdal (a medication for schizophrenia) 0.5 mg daily for psychosis with dementia. An IDT (interdisciplinary team) note, dated 3/1/23 at 5:55p.m., indicated a new order for Risperdal 0.25 mg (milligrams) was given by the psychiatric nurse practitioner. The resident's husband and hospice were made aware of the new order. The resident would be observed routinely for signs and symptoms of side effects to the medication. AIMs (Abnormal Involuntary Movement scale) assessment completed and would be completed routinely while taking antipsychotic medication. An IDT note, dated 3/29/23 at 2:44 p.m., indicated a new order was given by the psychiatric nurse practitioner to increase the dosage of Risperdal to 0.5 mg at bedtime. Hospice and the resident's husband made aware of the new order. The IDT notes did not include documentation on education provided to the husband regarding the antipsychotic medications, risks/benefits, or medication side effects.			

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	10/03/2023

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

(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
	A care plan, dated 2/11/22, indicated a potential for drug related complications associated with the use of psychotropic medications related to anti-anxiety, anti-depressant, and anti-psychotic medications. Interventions included, but were not limited to, observe for side effects of antipsychotic medication, and report them to the physician: sedation (sleepiness), drowsiness, dry mouth, constipation, blurred vision, extra pyramidal symptoms (muscle dysfunction), weight gain, edema (swelling), postural hypotension (low blood pressure), sweating, loss of appetite, and urinary retention. During an interview, on 10/3/23 at 11:00 a.m., the DNS indicated she did not have documentation of education for the husband regarding the use of the Risperdal, side effects, or the risks and benefits of the medication. A current publication, titled "Mobile PDR (physician's desk reference)," indicated "...Abilify [aripiprazole] is an antipsychotic...used in adults for schizophrenia, bipolar 1 disorder and as an adjunct for major depression... antipsychotics are not a recommended treatment of dementia-related psychosis in geriatric adults and the use of Abilify should be avoided if possible due to an increase in morbidity and mortality in elderly adults with dementia receiving antipsychotics...deaths have typically resulted from heart failure, sudden death or infections (primarily pneumonia)...an increased incidence of cerebrovascular adverse events, including fatal events, has been reported...." A current publication, titled "Mobile PDR (physician's desk reference)," indicated "...Risperdal (risperidone) is an antipsychotic...used for schizophrenia and bipolar			

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	10/03/2023

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

(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
	disorder in adults...antipsychotics are not a recommended treatment of dementia-related psychosis in geriatric adults and the use of risperidone should be avoided if possible due to an increase in morbidity and mortality in elderly adults with dementia receiving antipsychotics...deaths have typically resulted from heart failure, sudden death or infections (primarily pneumonia)...an increased incidence of cerebrovascular adverse events, including fatal events, has been reported...." A current policy, titled "Use of Psychotropic Medication," not dated and received from the DNS on 10/3/23 at 1:00 p.m., indicated "...the indications for initiating, withdrawing or withholding medications as well as the use of non-pharmacological approaches will be determined by: assessing the residents underlying condition, current signs, symptoms expressions, and preferences and goals for treatment ...identification of underlying causes (when possible)...the attending physician will assume leadership in medication management by developing, monitoring, and modifying medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team...the indications for use of any psychotropic drug will be documented in the medical record...residents who use psychotropic drugs shall receive a gradual dose reduction, unless clinically contraindicated, in an effort to discontinue these drugs...the effects of psychotropic medications on a resident's physical, mental and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation (routine and as needed), during the pharmacist's monthly medication regimen review, during MDS (minimum data set) review (quarterly, annually, significant			

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	10/03/2023

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

(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
	change), and in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturers specifications, and the resident's comprehensive plan of care...the residents response to the medication(s), including progress towards goals and presence/ absence of adverse consequences, shall be documented in the resident's medical record ...the facility shall identify the medication for use, as possible, using pre-admission screening and other pre-admission data ...the physician in collaboration with the consultant pharmacist shall re-evaluate the use of the medication and consider whether or not the medication can be reduced or discontinued upon admission or soon after admission...." 3.1-48(a)(6) 3.1-48(b)(2)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and			

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	10/03/2023

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

(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
	(ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview and record review, the facility failed to ensure a resident who requested dental services had the paperwork completed and was scheduled for the dentist for 1 of 2 residents reviewed for dental. (Resident H) Finding includes: During an observation, on 9/26/23 at 2:23 p.m., Resident H was watching television in her room. She had some missing bottom teeth and no top teeth. Her front bottom teeth were noted to have some yellowish substance from the gums extending up to the teeth.	F 0791	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident H: (Stewart) Residents clinical record was reviewed and updated to reflect residents' consent for dental services, communication with provider for services and scheduling of appointment.	11/03/2023

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	10/03/2023

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

(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
	The record for Resident H was reviewed on 9/27/23 at 4:07 p.m. Diagnoses included, but were not limited to, unspecified dementia, chronic obstructive pulmonary disease, cerebral infarction, hemiplegia (paralysis of one side of the body) affecting the right dominant side, dysphagia (difficulty swallowing), and osteoarthritis. A physician's order, dated 4/27/23, indicated the resident may see the podiatrist, dentist, audiologist, ophthalmologist, and optometrist. An application for limited benefit in-facility dental policy was signed by the resident's responsible party on 4/27/23 to consent to the facility dental services. A care plan, dated 4/27/23, indicated the resident was at a risk for dental problems related to full upper dentures, partial bottom dentures, and being dependent for oral care. The resident did not want to wear the dentures. The interventions included, but were not limited to, assist with oral care as needed and to observe and notify the physician of any changes in dental status. A care plan, dated 6/30/23, indicated the resident would have the following ancillary services made available to her including dental, optical, podiatry, and audiology. The goal included the resident would have the desired ancillary services through the next review on 8/4/23. The interventions included, but were not limited to, the resident had elected to have dental, optical, audiology, and behavioral health services. During an interview, on 10/2/23 at 2:19 p.m., the Director of Nursing Services (DNS) indicated she		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; ¿ Initial audit: The facility audited residents that consented for dental services to ensure timely scheduling of with dental provider. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;¿ Clinical staff were educated on the guideline for Dental Services to include but not limited to residents that consent for dental services have timely schedule of visits and communication is reflected in the clinical record. On-going DNS or will review new admissions or residents with changes in dental needs for consent for dental services and	

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	10/03/2023

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

(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
	did not take care of scheduling and putting residents on the dental list. She did not know the reason Resident H had not been seen by the dentist yet. A dental schedule, for 10/18/23, did not include Resident H as being scheduled for dental services. A progress note, dated 10/2/23 at 3:11 p.m., indicated the resident's Designated Power of Attorney (DPOA) was called and informed of paperwork which needed signed for the resident to be seen for dental care. During an interview, on 10/3/23 at 10:56 a.m., the Social Services Director indicated it would take 3 to 4 days for a dental referral to be sent and then it would take one (1) month to three (3) months before the resident would be seen for dental services. The SSD did not know the reason Resident H's dental visit had been delayed. During an interview, on 10/3/23 at 11:06 a.m., the Alzheimer's Unit Director indicated the resident needed additional paperwork signed before she could be put on the dentist's list and she was not aware of the needed paperwork. The SSD just gave her the paperwork yesterday. A current policy, titled "Dental Services," dated 2023 and received from the DNS on 10/3/23 at 1:20 p.m., indicated "...It is the policy of this facility to assist in obtaining routine [to the extent covered under the State plan] and emergency dental care...'Routine dental services' means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings [new and repairs] minor partial or full denture adjustments,		ensure services are scheduled and provided. 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 audits will continue 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	10/03/2023

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

(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
	smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures...The dental needs of each resident are identified through the physical assessment...and are addressed in each resident's plan of care...Residents and /or resident representatives, during the admission process, are notified of dental services available under the State plan...The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location...All actions and information regarding dental services, including any delays related to obtaining dental services will be documented in the resident's medical record...." 3.1-24(a)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable			

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	10/03/2023

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

(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
	diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP			

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	10/03/2023

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

(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
	and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure staff sanitized their hands during dining service, staff used gloves to touch medications and a resident's Foley (indwelling urinary) catheter was off the floor for 1 of 2 dining rooms observed, 1 of 7 residents observed for medication administration and 1 of 1 resident reviewed for urinary catheters. (Activity Staff 2, Resident M, and Resident 35) Findings include: 1. During a dining observation of the memory care unit, on 9/27/23 at 11: 48 a.m., Activity Staff 2 was observed to assist a resident to cut up the food on her plate and spread her napkin out. Activity Staff 2 then took a clean tray from the food cart and walked into another resident room to assist her to set up her tray. Then Activity Staff 2 picked up the dirty tray from outside the memory care isolation room and put the dirty tray on the dining table which had drinks with some type of red liquid. The drinks had not been used yet. There were also unused condiment packets and a coffee carafe for serving on the same table. Activity Staff 2 did not sanitize her hands after touching any of the trays including the dirty tray from the isolation room.	F 0880	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ One on one education was provided to Activity staff #2 regarding hand hygiene. One on one education was provided to LPN # 8 regarding medication administration. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Education: all staff have been educated on Hand hygiene. All nursing staff have been	11/03/2023

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	10/03/2023

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

(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
	During an interview, on 9/27/23 at 12:10 p.m., the Executive Director (ED) indicated she would do an in-service on the use of hand sanitizer with the staff.2. During an observation, on 9/26/23 at 2:38 p.m., Resident M was lying in bed with the catheter bag on the floor. The Social Service Director (SSD) went into the resident's room, hooked the catheter bag on the wheelchair, and indicated the catheter bag should not be on the floor. The record for Resident M was reviewed on 9/27/23 at 4:57 p.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder (the nerves and muscles do not work well together in the bladder), presence of urogenital implants (way to help treat stress incontinence caused by a weak sphincter) and urinary tract infection. A care plan, dated 11/3/22, indicated the resident had alterations in elimination of bowel and bladder, indwelling urinary catheter. Interventions included, but were not limited to, keep the drainage bag of the catheter below the level of the bladder and off the floor. During an interview, on 9/26/23 at 2:38 p.m., the Social Service Director indicated the catheter bag should not be on the floor. During an interview, on 10/2/23 at 9:23 a.m., the Executive Director (ED) was aware the catheter bag on the floor. 3. During an ongoing observation of medication administration, on 9/27/23 starting at 9:57 a.m., LPN 8 did not sanitize her hands. The nurse took a pill out of the package using her bare hands and		educated on catheter care regarding ensuring catheter bags are not on the floor. All licensed nursing staff have been educated medication administration. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ On-going monitoring: during walking rounds, DNS/ED will complete audits of hand hygiene during meals, hand hygiene during medication administration and catheter care to ensure catheter bags are not on the floor. 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¿	

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	10/03/2023

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

(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
	placed the pill in a medication cup for Resident 35. The record for Resident 35 was reviewed on 9/27/23 at 2:57 p.m. Diagnoses included, but were not limited to, congestive heart failure, hypertension, and diabetes mellitus. During an interview, on 9/27/23 at 10:07 a.m., LPN 8 indicated she should have sanitized her hands and not touched the pill with her bare hands. During an interview, on 9/27/23 at 11:17 a.m., the Director of Nursing Services (DNS) indicated pills should not be touched with bare hands. A current policy, titled "Hand Hygiene," dated 2023 and received from the DNS on 10/3/23 at 1:20 p.m., indicated "...Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR)...Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of proactive...." A current policy, titled "Medication Administration," dated 2023 and received from the DNS on 10/2/23 at 1:20 p.m., indicated "...Wash hands prior to administering medication per facility protocol and products...." 3.1-18(b)(1) 3.1-18(l)		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.¿	