STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155367	A. BUILDING _____ B. WING _____	C 10/25/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00418925 and IN00420133. Complaint IN00420133 - No deficiencies related to the allegations are cited. Complaint IN00418925 - Federal/state deficiencies related to the allegations are cited at F689. Survey dates: October 24 and 25, 2023 Facility number: 000258 Provider number: 155367 AIM number: 100289160 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicare: 6 Medicaid: 71 Other: 12 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 31, 2023.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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

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F 689	Continued From page 1 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff were being supervised when a staff member physically kicked a resident in his back for 1 of 3 residents reviewed for abuse. (Resident B) The deficient practice was corrected on 10/15/2023, prior to the start of the survey, and was therefore past noncompliance. Finding includes: An incident report to the Indiana Department of Health indicated a staff member struck Resident B in the back while he was standing next to the medication cart in the facility. The resident complained of back pain, on 10/3/2023, after the kick to his back. The resident was sent to the hospital for evaluation per physician's order, on 10/3/2023. The staff member was suspended when the hospital staff indicated the resident alleged abuse by the staff member. Family was notified and the investigation continued. The resident returned to the facility with no new orders from the hospital and was not admitted to the hospital. The local police department was notified of the abuse allegation. The record for Resident B was reviewed on 10/25/2023 at 10:31 a.m. Diagnoses included, but were not limited to, discitis (an infection of the intervertebral disc space) of the lumbosacral region, osteomyelitis (inflammation of the bone) of the vertebra and lumbar region, electrocution,	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

chronic pain, and acquired absence of the left and right upper limbs.

An Emergency Room (ER) report from the hospital, dated 10/3/2023, indicated no acute fracture or traumatic subluxation was identified. Vertebral body heights were preserved. Sacral joints were congruent. The impression was no evidence of acute fracture or traumatic subluxation of the lumbar. The police were notified and spoke with the resident. The resident spoke with the facility, and he returned to the facility with no new orders.

In a facility investigation note, dated 10/3/2023, Staff Member 3 indicated the resident came to her around 8:00 p.m., and indicated Staff Member 2 ran up to him jokingly and kicked him in the back while he was at the medication cart earlier in the day. He did not report it until now because Staff Member 2 asked him not to report the incident. The resident said he had called his lawyer and his lawyer wanted him to have an x-ray. Staff Member 3 notified the Director of Nursing (DON) and began an investigation.

In a facility investigation note, dated 10/3/2023, Staff Member 2 indicated she did jokingly kick the resident in his back, on 10/3/2023 at 5:00 p.m., while he was standing near the nurses medication cart on the south hall. She meant to kick the medication cart but missed and kicked the resident instead. She indicated the resident was in some pain but was not eligible for pain medication for another hour. The resident was okay with the incident and knew it was not intentional and she was just playing around. She did not report the incident.

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F 689	Continued From page 3	F 689		

In a facility investigation note, dated 10/4/2023, Staff Member 4 indicated she was at the nursing medication cart with the resident at 5:00 p.m., on 10/3/2023, when Staff Member 2 came walking by and playfully kicked her foot up and her foot made contact with the residents lower back area. The resident was not upset nor in pain. The resident signed himself out of the facility to go and play with his dog outside. Later in the evening, around 7:30 p.m., the resident complained of pain in the lower back area. The area was red, no bleeding was noted, and medication was given to the resident for pain. The staff member did not report the incident.

A facility investigation note, dated 10/3/2023 at 11:25 p.m., indicated during an interview with the Executive Director (ED) and the resident, the resident indicated he did feel the staff member intended to kick him but not to cause him any harm. It was a lack of professionalism from Staff Member 2. She was just playing around and made a "bone head move". He was not afraid of Staff Member 2 and was not afraid to be at the facility.

A facility investigation note, dated 10/3/2023 at 11:30 p.m., indicated during an interview with the DON and the resident while the resident was in the hospital ER, the resident indicated he felt a jolt on his back while he was standing at the medication cart. The resident indicated he was kicked by Staff Member 2 with her boot to his back. The resident indicated it could have been unintentional. The resident indicated he was not afraid of Staff Member 2. She meant him no harm. The x-rays of his back were okay, and the police had been notified. He felt safe to return to the facility.

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F 689	Continued From page 4	F 689		

A facility investigation note, dated 10/4/2023 at 8:30 a.m., indicated during an interview with the ED and the resident, the resident indicated he did not want to talk without his lawyer present. The resident did indicate he and Staff Member 2 were friends and he felt bad he got her into trouble. He indicated he felt safe at the facility and wanted to stay until he was discharged.

A staff member notification, dated 10/3/2023, indicated Staff Member 2 was suspended pending investigation of an alleged abuse allegation. Staff member 2 made contact with a resident's back potentially causing injury and did not report the unusual occurrence immediately.

A staff member notification, dated 10/5/2023, indicated Staff Member 2 was terminated. Staff Member 2 made contact with a resident's back potentially causing injury and did not report the unusual occurrence immediately.

A staff member notification, dated 10/4/2023, indicated Staff Member 4 was given disciplinary action for not reporting an unusual occurrence which involved a violation of safety rules.

During an interview, on 10/25/2023 at 1:19 p.m., the ED indicated Staff Member 2 kicked Resident B in his back. Resident B was sent to the ER for evaluation after complaining of pain 3 hours after the incident occurred. His x-rays were negative for trauma or a fracture. Staff Member 2 was suspended immediately and then terminated after the investigation. Staff Member 4 received disciplinary action for not immediately starting an investigation when the incident occurred.

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F 689	Continued From page 5 During an interview, on 10/25/2023 at 2:47 p.m., the DON indicated she was not notified of the abuse allegation until 3 hours after the incident occurred. The staff thought Staff Member 2 was horseplaying with the resident and he had no pain nor was upset about the incident. The resident complained of pain and requested an x-ray of his back which was when they notified her of the incident. The deficient practice was corrected, by 10/15/23, after the facility implemented a systemic plan that included the following actions: The facility investigated the incident involving Resident B and the abuse allegation, terminated Staff Member 2, educated the staff on abuse, residents rights and professionalism and the facility began audits on residents which included skin assessments and interviews. This Federal tag relates to Complaint IN00418925. 3.1-45(a)(2)	F 689		