STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Richmond Care Center	1042 Oak Dr Richmond, IN 47374

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 28309 Based on interview and record review, the facility failed to ensure a care plan was developed and implemented for seizure-like activities for 1 of 3 residents reviewed for falls. (Resident C) Findings include: The clinical record for Resident C was reviewed on 5-3-24 at 2:35 p.m. His diagnoses included, but were not limited to, unspecified tremor and unspecified convulsions. A nursing note, dated 4-12-24, indicated he had a history of seizure activity. At least three seizure-like activities were documented for Resident C on 4-18-24, and least two more seizure-like activities were documented on 4-20-24. At least one seizure-like activity was associated with a fall. A review of Resident C's clinical record failed to demonstrate any care plan development for care and/or services related to seizure-like activities. This was brought to the attention of the Director of Nursing (DON) on 5-3-24. The DON was informed of the lack of care plans for Resident C related to this resident's seizures or seizure-like activity on 5-3-24 at 4:30 p.m. In an interview with the DON on 5-6-24 at 9:05 a.m., she indicated she had reviewed this resident's clinical record and was unable to locate any care plans for seizures or seizure-like activity. On 5-6-24 at 1:55 p.m. the DON provided a copy of a policy dated, 2023, and entitled, Comprehensive Care Plans. This policy indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . This Federal tag relates to Complaint IN00433180. 3.1-35(a) 3.1-35(b(1)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28309 Based on interview and record review, the facility failed to ensure a staff member followed policies for the safe use of a mechanical lift, requiring the operation of the mechanical lift to be conducted by 2 staff members, resulting in a fall from the mechanical lift and a fracture for 1 of 3 residents reviewed for falls and the use of mechanical lifts. (Resident B and CNA 3) The deficient practice was corrected on 4-25-24, prior to the start of the survey, and was therefore past noncompliance. The facility had completed an assessment of the resident who had experienced a fall from a mechanical lift and was sent to an area emergency room , began an immediate investigation into the circumstances of the fall, conducted education and skills checkoffs with staff for safe transfers and use of mechanical lifts, inspected all mechanical lifts in the facility, conducted audits of the clinical records of residents who utilize mechanical lifts and began random care observations for safe mechanical lift operations with staff, and updated her care plans upon return to the facility on [DATE]. Findings include: The clinical record of Resident B was reviewed on 5-3-24 at 10:33 a.m. Her diagnoses included, but were not limited to, cerebral infarction with left non-dominant side affected, diabetes with neuropathy, morbid obesity, cognitive communication disorder, hypertensive with heart disease and chronic kidney disease and general muscle weakness. Her most recent Minimum Data Set (MDS) assessment, dated 2-21-24, indicated she is cognitively intact, is non-ambulatory, uses a wheelchair for mobility and is dependent for all transfers from one surface to another. A review of her care plans indicated she requires a mechanical lift for transfers, with two assist transfers at all times. The facility sent a report of a fall with fracture to the Indiana Department of Health's Long-Term Care Division on 4-19-24 and a follow-up report on 4-26-24. It indicated Resident B while transferring from her chair to bed, encountered a fall. It indicated she complained of pain and upon notification to the physician, orders were obtained to send her to a local hospital's emergency room for further evaluation. An immediate investigation was begun. The follow-up detailed a new fracture was identified, which was an area of a previous fracture of the left tibial plateau (around the area of the patella/knee cap). It indicated the orthopedic consultant found the fracture to be inoperable and placed a knee immobilizer for resident comfort. It indicated staff education was conducted on safe transfers and mechanical lift procedures immediately. The resident returned to the facility on [DATE], with staff monitoring and treating the resident for pain, with no concerns observed. A psychosocial follow-up for 3 days post return for 3 days with no concerns noted. The interdisciplinary team (IDT) met and reviewed the resident for fall interventions and updating of her care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Corporate Executive Director (ED) on 5-3-24 at 10:40 a.m., she shared Resident B is a long-term resident. She explained on the date of the fall, 4-18-24, around 8:00 p.m., Resident B being transferred with a mechanical lift by CNA 3. The aide thought she had the 4 straps secured well and as she went to reach for the resident's cell phone that had fallen, something happened and she (Resident B) fell from the lift. She ended up fracturing her knee and was sent out to the hospital. She did not have surgery for the knee fracture. In a second interview with the Corporate ED on 5-3-24 at 11:45 a.m., she indicated the type of mechanical lift used for this resident requires two (2) persons to operate. She shared CNA 3 was hired in January, 2024, had her normal skills checkoff, as well as participated in the building's annual skills checkoff on 1-10-24, which included mechanical lifts and was successful. The Corporate ED indicated the facility obtained a written statement from CNA 3 and she was placed on suspension, pending investigation and was terminated related to not following the facility's policies regarding mechanical lifts require two (2) persons to operate and this resulted or contributed to a fall with a fracture for Resident B. A signed statement from CNA 3, dated 4-18-24, indicated Resident B had requested to be put to bed and CNA 3 took her from the dining room to her room to do so, via a Broda chair. CNA 3 indicated the mechanical lift sling was already in place under the resident, hooked resident on the sling on yellow on the top and the bottom was on green .raised her up and removed the chair. Legs were spread on the [brandname of mechanical lift]. When turning the [brandname of mechanical lift] to the bed .realized the bed was too high .walked away from [brandname of mechanical lift] to lower the bed .heard phone fall to the floor that was on the resident's chest. As .turned .saw resident doing roll out of the [brandname of mechanical lift] to the floor .immediately yelled to nurse on the floor for assistance. Resident was laying on back on the floor . sat with resident on the floor to provide comfort while nurse was completing assessment. A review of CNA 3's employment record was conducted. It indicated she began employment on 12-7-23, has possessed a CNA certification since 10-11-18, completed her general orientation to the facility on [DATE], participated in an inservice on Safe Transfer on 1-10-24 and completed her job specific orientation, including Transfer using [brandname of mechanical lift] on 1-23-24. A facility document, dated 4-18-24, indicated her suspension began on 4-18-24, related to Staff person was not using proper techniques when using [brandname of mechanical lift]. Resident fell . It indicated this infraction was deemed, gross misconduct and are subject to immediate suspension, pending investigation for termination if the violation is substantiated. An IDT [interdisciplinary team] note, dated 4-25-24, reviewed the details of Resident B's fall which occurred on 4-18-24. It indicated the root cause of the fall was, Staff attempting to transfer resident with 1 assist [staff member]. It identified the immediate interventions were to transfer the resident to a local emergency room for further evaluation and treatment. It added other interventions initiated included, Clinical education and evaluation of the function and operation of [brand name of mechanical lift] life [sic]. It indicated Resident B's care plans were reviewed and updated. On 5-3-24 at 11:55 a.m., the Corporate ED provided a binder, entitled, Ad Hoc QAPI binder related to a fall from a mechanical lift of 4-18-24, dated 4-19-24. This binder included the following information: -An audit was completed for all residents who use a mechanical lift to ensure plans of care were up to date. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Education was completed with all staff on safe use of mechanical lifts for transfers with ongoing monitoring to be completed for safe transfers with ongoing monitoring of 3 staff members to be observed weekly for 4 weeks, then monthly for 4 months to complete 6 months. Observations to be completed on alternating shifts and alternating staff. Results will be be brought to QAPI for 6 months to identify trends and to make recommendations. If no trends/issues are identified, then the review will be completed on a prn (as needed basis. This process to be monitored by the ED/designee. A mechanical lift validation checklist for staff was conducted, beginning 4-18-24 and 4-19-24, with ongoing audits 4-25-24 and 5-1-24. - A Care Plan audit of residents who require the use of mechanical lift was conducted with 4 of 22 residents's care plans requiring updating. -An education inservice/training entitled, Safe Resident/Handling Transfer related to mechanical lifts was conducted with 35 staff members, dated 4-19-24. -A mechanical lift inspection was conducted on 4-19-24, and all other mechanical lift with no concerns noted by the maintenance department. Monthly routine mechanical lift inspections are conducted on all mechanical lifts. Records reflect no mechanical lift concerns for over four months. On 5-3-24 at 12:30 p.m., the Corporate Nurse provided a copy of a policy entitled, Safe Resident Handling/Transfers, dated 2023. This policy indicated It is the policy of this facility to ensure that residents are handled in and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines .Two staff members must be utilized when transferring residents with a mechanical lift . This Federal tag relates to Complaint IN00432977. 3.1-45(a)(1) 3.1-45(a)(2)