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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare -Sycamore Village Care Center	2905 W Sycamore St Kokomo, IN 46901

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident was kept safe during care and transfers for 1 of 4 residents reviewed for accidents. (Resident C)Findings include:During an interview, on 1/7/26 at 10:39 a.m., Resident C's daughter indicated the resident had fallen twice. The first was from her bed. The resident's bed was smaller than her current bed, she rolled out and fell on the floor during incontinence care. There was only one CNA in the room, and the CNA pushed the resident too hard, and she fell out of her bed. The second was from the mechanical lift. The facility did not call her when the resident's lift strap on the pad broke. The resident called from the ambulance. When the resident was in the emergency room, the Executive Director called but it was at least 30 minutes after the resident was in the emergency room. The Executive Director had asked if she wanted to see the broken pad and then when she asked to see the pad the Executive Director indicated it was no longer available. The clinical record for Resident C was reviewed on 1/6/26 at 10:34 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, congestive heart failure, hypertension, morbid obesity, and osteoarthritis of the right and left knee.An annual Minimal Data Set (MDS) assessment, dated 10/23/25, indicated Resident C was dependent on staff with transfers.A care plan, dated 12/18/24, indicated Resident C had a self-care performance deficit. Interventions included, but were not limited to, 1/28/25, trapeze bar above the bed to assist with repositioning. 12/18/24, Resident C required substantial assistance to complete bed mobility, was dependent on toileting, and totally dependent on transfers. Encourage Resident C to participate, when possible, with each interaction.A care plan, dated 12/18/24, indicated Resident C was at risk of falls. Interventions included, but were not limited to, 12/18/24, assistance with transfers, ensure resident wore appropriate non-skid footwear, and the environment remained safe.1. A facility's change of condition note, dated 11/26/25 at 11:50 a.m., indicated Resident C was receiving incontinence care. While the resident turned towards the window on her left side, the resident fell out of the bed. The resident held herself with the trapeze, her hand slipped off, and she fell out. The resident received a small scratch on the back of her right lower leg. The new intervention was for two (2) people to assist with care. A fall risk evaluation, dated 11/26/25, indicated Resident C had a low risk for falls.A physician's progress note, dated 11/28/25 at 8:00 a.m., indicated Resident C was seen for follow-up of right ankle pain experienced post fall. Her x-ray did not show acute fracture. She had right ankle pain with no acute fracture or dislocation seen.An interdisciplinary team note, dated 12/4/25 at 11:11 a.m., indicated Resident C had a fall and slid off the edge of the bed during care, on 11/26/25. The new intervention was two (2) caregivers when providing peri care.During an interview, on 1/4/26 at 2:51p.m., Resident C indicated she had fallen when she was too close to the edge of the bed while staff were providing incontinence care, and she rolled off the bed. The bed was too small. During an interview, on 1/7/25 at 1:00 p.m., the Executive Director indicated Resident C did fall out of bed during incontinence care. Resident C did not (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get hurt.During an interview, on 1/7/26 at 5:04 p.m., CNA 17 indicated she was completing peri care on the resident. Resident C helped with turning from her back towards the window. She grabbed the overhead trapeze and rolled to the left. The bed was close to the window, Resident C slid off the bed, and her left foot went to the floor, and her right leg went up in the air. She landed on the floor and was in a split position between the bed and the window. CNA 17 yelled for the nurse, and they used the mechanical lift to help Resident C off the floor.2. An interdisciplinary team note, dated 12/4/25 at 12:45 p.m., indicated Resident C returned from the emergency room after a recent fall. Resident C had complaints of pain related to the fall.A facility's change of condition note, dated 12/4/25 at 3:00 p.m., indicated Resident C was being transferred with the Hoyer lift. Resident C was approximately an inch off the bed when the Hoyer sling snapped and the resident fell to floor. Three (3) staff members were present at the transfer. Resident C had significant pain in her lumbar area and was sent to the emergency room for evaluation.A fall risk evaluation, dated 12/4/25 at 3:30 p.m., indicated Resident C had 1-2 falls in the past 3 months. Resident C was chairbound and incontinent.An interdisciplinary team note, dated 12/5/25 at 10:01 a.m., indicated Resident C fell from Hoyer sling. The Hoyer sling broke and the resident was sent to the emergency room for evaluation.A nursing progress note, dated 12/5/25 at 12:40 p.m., indicated Resident C returned from the hospital. She reported new back pain. New physician's orders were received for as needed Norco (a pain medication), Robaxin (a muscle relaxing medication), and routine Lidoderm patches (a topical patch used for pain) to her back.A nursing progress note, dated 12/5/25 at 2:53 p.m., indicated Resident C was assessed for side rails and passed the assessment.A post fall evaluation, dated 12/8/25 at 4:24 p.m., indicated Resident C was being transferred with the Hoyer lift when the Hoyer sling strap broke. The resident had a bruise on her hand and lower back pain.A hospital document, dated 12/26/25, indicated an x-ray of the spine was completed with no fractures detected. The hospital was unable to obtain a CT (computed tomography) scan due to patient's weight. The resident had a fall from a height of less than 3 feet and reported experiencing pain localized to the thoracic (middle section of the spine), right shoulder, and noted discomfort associated with positional changes in bed.A fall risk evaluation, dated 1/2/25, indicated Resident C was at moderate risk for falls. During an observation, on 1/6/26 at 11:11 a.m., Certified Nursing Assistant (CNA) 13 and CNA 14 were transferring Resident C into her recliner. Resident C was lying flat in her bariatric bed. Resident C grabbed the trapeze handle and assisted in rolling herself over onto her left side. CNA 13 placed the large blue Hoyer pad underneath the resident and instructed the resident to roll onto her right side. Once the pad was under the resident; CNA 14 pushed the mechanical lift to the right side of the bed. The CNAs attached the straps of the pad onto the hooks and began to lift Resident C off the bed. Resident C asked the CNAs to stop and to cross the straps at her feet. CNA 13 informed Resident C they could not cross the straps. CNA 13 indicated the pad was the correct pad for Resident C and the nurse had told her which pad to use. During an interview, on 1/6/26 at 11:19 a.m., Unit Manager 16 indicated the mechanical lift pads were based on the resident's weight and were normally stored in each resident's room. During an observation and interview, on 1/6/26 at 11:25 a.m., Unit Manager 16 indicated the lift pads were normally kept in the clean storage room or the resident's room. Unit Manager 16 pulled a lift pad out from a large blue barrel to look at the tag with the weight. The pad did not have a weight limit on tag and Unit Manager 16 indicated she was not sure why. The Patient Lift Safety Guide indicated assess the patient's size, weight, and hip measurement and choose the size of the sling based on the manufacturer's recommendation for the patient's measurements. Choosing the correct sling size was critical for safe patient transfer. If the sling was too large, the patient could slip out. If the sling (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was too small, the patient could fall out. If the sling was between sizes, the smaller size could keep the patient more secure. Using the wrong sling or attaching the sling incorrectly could cause an accident which could result in serious injury or death.During an interview, on 1/6/26 at 11:30 a.m., Resident C indicated the staff had crossed the straps down by her feet on more than one occasion. When staff used the large pad, she felt like she would slide out. The CNAs not normally assigned to her would use the incorrect pad. Resident C indicated the pad the staff used the day of the incident felt smaller. She told the CNAs and they said it would be okay then shortly after was when the strap broke and she fell. She hit her right shoulder and back on the mechanical lift legs. She felt like she broke her back. During an interview, on 1/7/25 at 4:22 p.m., CNA 10 indicated on the day of the incident, CNA 11, CNA 12, and herself hooked the straps to the lift. She could not remember how they attached the straps. CNA 12 raised the resident up about 2 inches off the bed and pulled the lift out. CNA 11 was guiding the resident when the stitching on the strap came loose, the resident fell and landed on the mechanical lift legs. Resident C hit her left lower back on the mechanical lift. CNA 10 was not sure which pad they used or if the pad was the correct weight limit for Resident C. During an interview, on 1/9/26 at 10:30 a.m., the Ombudsman indicated Resident C's family member had called him with concern. Resident C had fallen from a mechanical lift and had also fallen from the bed during peri care. During an interview, on 1/9/26 at 10:39 a.m., LPN 2 indicated Resident C required a mechanical lift. During an interview, on 1/9/26 at 10:42 a.m., RN 3 indicated to use the mechanical lift, you should know the weight of the resident. The pads were labeled with the weights. She believed the resident used a pad for 500 pounds. The CNAs should know which pad Resident C used. During an interview, on 1/9/26 at 12:50 p.m., CNA 11 indicated on the day of the incident, she helped CNA 10 and 12 with Resident C. They used the bigger pad which crossed under the resident at the legs. CNA 12 began to raise the resident up while she guided the resident off the bed. Resident C had just cleared the bed when the right strap unraveled and broke. The resident fell to the ground and hit her back on the mechanical lift legs. 3. During an interview, on 1/9/25 at 1:22 p.m., Resident C indicated earlier this morning two (2) guys, and a girl (unable to recall their names) came in with the mechanical lift to transfer her back to bed. The resident had an overhead trapeze at the head of bed. During the transfer, the mechanical lift hit her overhead trapeze bar and knocked the trapeze bar down. The trapeze bar bumped the back of her head. The resident indicated her head was a little sore but did not bleed. During an interview, on 1/9/25 at 9:45 a.m., the Executive Director (ED) indicated Resident C did have an incident with the mechanical lift today. The trapeze bar dropped and hit the back of her head. She had a small bump on her head, but it was not open. She spoke to the resident who stated she was fine.At the exit conference, the ED indicated she had no additional information provided related to the incidents. The facility did not have a policy on the use of mechanical lifts.A current facility policy, titled Accidents and Supervision, dated 12/4/25 and received from the ED on 1/9/25 at 11:30 a.m., indicated .The residents' environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents.All staff.are to be involved in observing and identifying potential hazards in the environment.This citation relates to Intake 2680656.3.1-45(a)(1)3.1-45(a)(2)