| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/28/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Brickyard Healthcare - Knox Care Center | 300 E Culver Rd<br>Knox, IN 46534 |

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

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>32788<br><br>Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed and in place for pain for 1 of 16 resident care plans reviewed. (Residents 21 and 20)<br><br>Findings include:<br><br>1. The record for Resident 21 was reviewed on 6/25/24 at 11:55 a.m. Diagnoses included, but were not limited to, hypertension, Parkinson's disease, and unspecified pain.<br><br>The Quarterly MDS assessment, dated 4/9/24, indicated the resident was cognitively impaired, received opioid medication, and scheduled pain medication.<br><br>The Physician Order Summary, dated 6/2024, indicated the resident was to receive tramadol (an opioid pain medication) 50 mg (milligrams) twice a day.<br><br>The Medication Administration Record (MAR), dated 6/2024, indicated the resident had received the tramadol medication twice a day.<br><br>During an interview on 6/26/24 at 9:38 a.m., the Director of Nursing (DON) indicated the care plan should have been in place. They had recently completed a mock survey and identified some issues with care plans.<br><br>During an interview on 6/28/24 at 11:03 a.m., the [NAME] President of Regulatory Compliance (VPRC) indicated they had completed a mock survey a couple weeks ago and identified issues with care plans. They had completed an inservice and started audits. She provided the care plan audits, but the audits were for care plans related to anticoagulant medication and skin issues.<br><br>45666<br><br>2. Resident 20's record was reviewed on 6/25/24 at 1:59 p.m. Diagnoses included, but were not limited to, dementia and renal cancer.<br><br>(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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Quarterly Minimum Data Set (MDS) assessment, dated 4/18/24, indicated the resident was severely cognitively impaired for daily decision making. She required assistance with activities of daily living including, oral hygiene, toileting hygiene, showering, and personal hygiene. While a resident, she received insulin injections, antidepressants, opioids, and hypoglycemic medications.<br><br>The June 2024 Physician Order Summary indicated the resident received a scheduled Norco (opioid pain medication) 5-325 milligrams (mg) twice daily and Norco 5-325 mg every 12 hours as needed.<br><br>There was no care plan related to pain or opioid medication use.<br><br>During an interview on 6/26/24 at 10:33 a.m., the DON indicated the care plan should have been in place.<br><br>During an interview on 6/28/24 at 9:02 a.m., the VPRC indicated they had identified a problem with their care plans and had begun auditing to correct the issue.<br><br>A facility policy, titled Comprehensive Care Plans, received as current, indicated, .2. The comprehensive care plan will be developed within 7 days after completion of the comprehensive MDS assessment. All Care Assessment Areas triggered by the MDS will be considered in developing the plan of care .The facility's rationale for deciding wheter to proceed with care planning will be evicenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicalbe physical, mental, and psychosocial well-being .<br><br>3.1-35(a) |

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| | 155686 | A. Building<br>B. Wing | 06/28/2024 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582<br><br>Based on observation, record review and interview, the facility failed to ensure care plans were implemented and/ or updated with changes for 3 of 16 resident care plans reviewed. (Residents 44, 21, and 32)<br><br>Findings include:<br><br>1. On 6/25/24 at 9:47 a.m., Resident 44 was observed in her bed. She had a tubi grip (type of compression stocking) on her left leg and she had a wound vac attached to her right leg.<br><br>The resident's record was reviewed on 6/26/24 at 11:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, unspecified wound to right and left lower leg, cellulitis and Diabetes Mellitus.<br><br>The Admission Minimum Data Set assessment, dated 5/16/24, indicated the resident was cognitively intact and received care for a surgical wound.<br><br>A General Note, dated 6/10/24, indicated the resident had returned from the wound clinic with new orders for a wound vac to right lower leg at 125 mm/hg (millimeters of mercury).<br><br>A Physician's Order, dated 6/10/24, indicated to ensure wound vac properly functioning at 125 mm/hg every shift.<br><br>A Physician's Order, dated 6/19/24, indicated to change the wound vac three times and week. Cleanse the wound on right lower leg with wound cleanser, rinse wound with normal saline and pat dry. Apply barrier film to skin surrounding wound, apply black foam to base of wound and adhere with wound vac adhesive.<br><br>A Skin Care Plan initiated, 5/21/24, indicated the resident had a surgical wound to the right shin. Interventions included, but were not limited to, weekly skin assessment by licensed nurse, encourage good nutrition, monitor for signs of infection and keep incision site clean and dry. There was no intervention related to use of a wound vac.<br><br>During an interview on 6/27/24 at 10:00 a.m., the Director of Nursing indicated the care plan had not been updated.<br><br>32788<br><br>2. The record for Resident 21 was reviewed on 6/25/24 at 11:55 a.m. Diagnoses included, but were not limited to, hypertension, Parkinson's disease, and bipolar disorder with psychotic features.<br><br>The Quarterly MDS assessment, dated 4/9/24, indicated the resident was cognitively impaired and received antipsychotic medication.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A care plan, updated 3/1/24, indicated the resident was at risk for drug related complications associated with the use of the antipsychotic medication Nuplazid.<br><br>The Physician Order Summary, dated 6/2024, indicated the resident was to receive Seroquel (an antipsychotic medication) 25 mg (milligrams) twice a day. There were no current orders for the Nuplazid medication, it was discontinued on 2/12/24.<br><br>The Medication Administration Record (MAR), dated 6/2024, indicated the resident had received the Seroquel medication twice a day.<br><br>During an interview on 6/26/24 at 9:38 a.m., the Director of Nursing (DON) indicated the care plan should have been updated. They had recently completed a mock survey and identified some issues with care plans.<br><br>During an interview on 6/28/24 at 11:03 a.m., the [NAME] President of Regulatory Compliance (VPRC) indicated they had completed a mock survey a couple weeks ago and identified issues with care plans. They had completed an inservice and started audits. She provided the care plan audits, but the audits were for care plans related to anticoagulant medication and skin issues.<br><br>45666<br><br>3. Resident 32's record was reviewed on 6/26/24 at 10:15 a.m. Diagnoses included, but were not limited to, dementia and insomnia.<br><br>The Annual Minimum Data Set (MDS) assessment, dated 6/15/24, indicated the resident was moderately impaired for daily decision making. While a resident, she received antianxiety, antidepressant, diuretic, and opioid medications.<br><br>A Care Plan, dated 10/8/21, indicated the resident was at risk for sleep pattern disturbance and had an order for melatonin. Interventions included, but were not limited to, administer the sleep medications as ordered by the Physician, and observe, document, and report adverse side effects.<br><br>The April Medication Regimen Review (MRR), dated 4/18/24, indicated a recommendation to discontinue melatonin tablet 5 milligrams (mg), 1 tablet at bedtime.<br><br>The April 2024 Physician Order Summary indicated the melatonin 5 mg tablet at bedtime was discontinued on 4/26/24.<br><br>During an interview on 6/26/24 3:01 p.m., the Director of Nursing indicated the care plan should have been updated with the medication change.<br><br>During an interview on 6/28/24 at 9:02 a.m., the VPRC indicated they had identified a problem with their care plans and had begun auditing to correct the issues.<br><br>A facility policy, titled Comprehensive Care Plans, received as current, indicated, .5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment .<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3.1-35(b)(1) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>32788<br><br>Based on observation, record review, and interview, the facility failed to ensure activities were implemented for a cognitively impaired dependent resident for 1 of 1 residents reviewed for activities. (Resident 4)<br><br>Finding includes:<br><br>On 6/24/24 at 10:06 a.m., Resident 4 was lying in bed with her eyes closed. The room was dark, the television was off, and there was no music playing. There was a CD player/radio observed on her dresser, a doll and multiple stuffed animals on her shelf.<br><br>On 6/24/24 at 1:50 p.m., Resident 4 was lying in bed. The room was dark, the television was off, and there was no music playing.<br><br>On 6/25/24 at 1:56 p.m., Resident 4 was lying in bed. Her eyes were open, and she was yelling out. The room was dark, the television was off, and there was no music playing in her room. At this time, there was a singer performing in the main dining room.<br><br>On 6/26/24 at 11:07 a.m., Resident 4 was lying in bed. Her eyes were open, she was talking, and looking around the room. The room was dark, the television was off, and there was no music playing in her room.<br><br>On 6/26/24 at 2:02 p.m., Resident 4 was lying in bed. Her eyes were open, and she was looking at the ceiling. The room was dark, the television was off, and there was no music playing in her room.<br><br>The record for Resident 4 was reviewed on 6/26/24 at 9:24 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, delusional disorder, circadian rhythm sleep disorder, and anxiety disorder.<br><br>The Quarterly MDS assessment, dated 6/1/24, indicated the resident was cognitively impaired and required assistance with activities of daily living.<br><br>The Significant Change MDS assessment, dated 9/11/23, indicated the resident was cognitively impaired and required assistance with activities of daily living. It was important for her to listen to music, be around animals/pets, participate in her favorite activities and in religious activities.<br><br>A current care plan indicated the resident required one to one activity programming. Interventions included, offer 1:1 visits three or more per week as tolerated, offer activities and supplies for things she can do in her room such as Christian music, CD player, and Bible. Provide tactile stimulation such as hand massages and lotion, reading mail or reading the Bible.<br><br>A current care plan indicated the resident found strength and comfort in her religious beliefs. Interventions included, offer her gospel and Christian music, have her music playing for her daily, offer reading material such as the Bible, and read the Bible to her occasionally during her 1:1 visits.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The quarterly Activity Participation Review, dated 6/11/24, indicated the resident received 1:1 activities 3-4 days a week. The resident's favorite activities were marked as entertainment-television, music, movies, visiting groups. It was noted that she liked to listen to music and to her television and preferred a quiet environment.<br><br>The quarterly Activity Participation Review, dated 3/11/24, indicated the resident received 1:1 activities 3-4 days a week. The resident's favorite activities were marked as entertainment-television, music, movies, visiting groups. It was noted that staff played music for her and had TV on for her. She liked to have lotion put on her arms, hands, and legs.<br><br>The Activity Task documentation, dated 5/29/24 through 6/25/24, indicated 1:1 activities were completed 3 times per week and included conversation/reminiscing, sensory, music/singing, and TV. There were no other activities documented other than the 1:1 activities.<br><br>During an interview on 6/26/24 at 2:26 p.m., the Director of Nursing (DON) indicated the resident went through cycles where she would be awake for three days and then sleep for three days. On the days when she was sleeping, they would respect her quiet time and let her be. When she was awake, they would put on music for her. This had not been documented in the care plan.<br><br>During an interview on 6/28/24 at 9:17 a.m., the Activity Director indicated they completed 1:1 activities with the resident three times a week. They would make sure she had her music playing. If she was in a quiet time and content, then they would leave her alone and at times she would not want to be bothered. She had not documented the quiet time or any refusal in activity participation.<br><br>3.1-33(a) |