STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR VILLAGE	8800 SPOON DR, INDIANAPOLIS, , 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00376771 and IN00377559. Complaint IN00376771 - Unsubstantiated due to lack of evidence Complaint IN00377559- Substantiated. State deficiencies related to the allegations are cited at R216 and R241. Survey date: April 26, 2022 Facility number: 011799 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 2, 2022	R 0000	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Greenbriar Village as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil**	

			procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.	

R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure the resident needs assessment included an evaluation of the resident's ability to self-administer medications and/or a physician's order for the residents to self-administer medications for 3 of 3 residents reviewed for self-administration of medications. (Resident B, C, and D) Findings include: 1. The clinical record for	R 0216	**This plan of correction is submitted as required under State and Federal law.** **The submission of this Plan of Correction does not constitute an admission on the part of Greenbriar Village as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or**	06/06/2022

	Resident B was reviewed on 4/26/22 at 9:14 a.m. Resident B's diagnoses included, but not limited to, asthma, tardive dyskinesia (a conditions affecting the nervous system, often caused by long-term use of some psychiatric medications), major depressive disorder, anxiety, fibromyalgia, migraine, scoliosis, and lumbar degenerative disc disease. A SLUMS (St. Louis University Mental Status Exam) conducted on 2/21/22 indicated, Resident B had mild neurocognitive disorder. A Physician's order placed on 2/18/22 indicated, Resident B may self-administer medications with or without reminders and may go out on a leave of absence with medications. Resident B's clinical record did not contain a self-administration of medication assessment. 2. The clinical record for Resident C was reviewed on 4/26/22 at 2:26 p.m. Resident C's diagnoses included, but not limited to, chronic obstructive pulmonary disease, diabetes mellitus, atrial fibrillation, and congestive heart failure. A SLUMS conducted on 1/7/21 indicated, Resident C had normal cognition. A Physician's order dated		**shareholder of the Community or affiliated companies.** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; . How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?; and	

	12/22/20 indicated, Resident C may self-administer medications with or without reminders and may go out on a leave of absence with medications. Resident C's clinical record did not contain a self-administration of medication assessment. 3. The clinical record for Resident D was reviewed on 4/26/22 at 2:20 p.m. Resident D's diagnoses included, but not limited to, hypertension, congestive heart failure and coronary artery disease. A SLUMS conducted on 4/22/20 indicated, Resident D had mild neurocognitive disorder. Resident D's clinical record did not contain a physician's order for Resident D to self-administer medications. The last self-administration assessment was completed on 10/25/21. An interview with ED (Executive Director) was conducted on 4/26/22 at 1:37 p.m. ED indicated, residents who wish to self-administer their own medications should have had a self-administration assessment done on admission to the facility. An interview with DON (Director of Nursing) was conducted on 4/26/22 at 2:56 p.m. DON indicated, she was unable to locate a physician's order for		. By the date, the systemic changes will be completed. R 216 1. Residents B, C and D's evaluations are completed and physician's orders for self administration obtained. The Community will ensure a complete and documented Self Administration evaluation of a new resident's needs for Self Administration are completed on admission, if applicable. 2. The Community reviewed each resident's record to determine which residents if any, could be affected by the alleged deficient practice.	

	Resident D to self-administer medications nor could she locate Resident B's nor Resident C's completed self-administration assessments. DON indicated self-administration assessments were to to occur bi-annually to coincide with the bi-annual evaluations. A Resident Self-Management of Medications policy was received on 4/26/22 at 9:52 a.m. from ED. The policy indicated, "1. Some Residents may prefer to manage all or part of their medications without our assistance. If this is the case, first verify that the Resident's physician has indicated that the Resident is capable of self-administering medications or is capable of self-administering medications with assistance by checking 'yes' on the Physician Move-In Report...2. If the physician has checked 'yes' to indicate the Resident is capable of self-administration, the Wellness Director should conduct a Medication Self Administration Assessment...If the Wellness Director and/or ED do not feel that the Resident has this capability, discuss the results with the physician...3. Self Medication assessments should be done as indicated by state regulations but if no regulation, quarterly at minimum...If the physician will not approve a		3. The Executive Director will in-service the leadership staff staff on resident needs assessment including an evaluation of the resident's ability to self-administer medications and/or a physician's order for the residents to self-administer medications. 4. The Wellness Director or designee will audit all new admission resident’s charts weekly for one month then monthly for five months, to ensure the assessments are completed and orders for Self administration obtained by the physician. The Welness Director or designee will audit all Self Administration Assessments on Yardi system weekly to ensure they are completed bi-annually as per new policy 5. Systemic changes will be completed: June 6, 2022	

	self-administration plan, inform the Resident of the physician's decision and that State regulations will not allow self-medication without a physician's order...If the Resident does not choose to obtain a physician's order, self-medication cannot occur." This state finding relates to Complaint IN00377559 Based on interview and record review, the facility failed to ensure the resident needs assessment included an evaluation of the resident's ability to self-administer medications and/or a physician's order for the residents to self-administer medications for 3 of 3 residents reviewed for self-administration of medications. (Resident B, C, and D) Findings include: 1. The clinical record for Resident B was reviewed on 4/26/22 at 9:14 a.m. Resident B's diagnoses included, but not limited to, asthma, tardive dyskinesia (a conditions affecting the nervous system, often caused by long-term use of some psychiatric medications), major depressive disorder, anxiety, fibromyalgia, migraine, scoliosis, and lumbar degenerative disc disease. A SLUMS (St. Louis University			

	Mental Status Exam) conducted on 2/21/22 indicated, Resident B had mild neurocognitive disorder. A Physician's order placed on 2/18/22 indicated, Resident B may self-administer medications with or without reminders and may go out on a leave of absence with medications. Resident B's clinical record did not contain a self-administration of medication assessment. 2. The clinical record for Resident C was reviewed on 4/26/22 at 2:26 p.m. Resident C's diagnoses included, but not limited to, chronic obstructive pulmonary disease, diabetes mellitus, atrial fibrillation, and congestive heart failure. A SLUMS conducted on 1/7/21 indicated, Resident C had normal cognition. A Physician's order dated 12/22/20 indicated, Resident C may self-administer medications with or without reminders and may go out on a leave of absence with medications. Resident C's clinical record did not contain a self-administration of medication assessment. 3. The clinical record for Resident D was reviewed on 4/26/22 at 2:20 p.m. Resident D's diagnoses included, but not			

limited to, hypertension, congestive heart failure and coronary artery disease.

A SLUMS conducted on 4/22/20 indicated, Resident D had mild neurocognitive disorder.

Resident D's clinical record did not contain a physician's order for Resident D to self-administer medications. The last self-administration assessment was completed on 10/25/21.

An interview with ED (Executive Director) was conducted on 4/26/22 at 1:37 p.m. ED indicated, residents who wish to self-administer their own medications should have had a self-administration assessment done on admission to the facility.

An interview with DON (Director of Nursing) was conducted on 4/26/22 at 2:56 p.m. DON indicated, she was unable to locate a physician's order for Resident D to self-administer medications nor could she locate Resident B's nor Resident C's completed self-administration assessments. DON indicated self-administration assessments were to to occur bi-annually to coincide with the bi-annual evaluations.

A Resident Self-Management of Medications policy was received on 4/26/22 at 9:52 a.m. from

	ED. The policy indicated, "1. Some Residents may prefer to manage all or part of their medications without our assistance. If this is the case, first verify that the Resident's physician has indicated that the Resident is capable of self-administering medications or is capable of self-administering medications with assistance by checking 'yes' on the Physician Move-In Report...2. If the physician has checked 'yes' to indicate the Resident is capable of self-administration, the Wellness Director should conduct a Medication Self Administration Assessment...If the Wellness Director and/or ED do not feel that the Resident has this capability, discuss the results with the physician...3. Self Medication assessments should be done as indicated by state regulations but if no regulation, quarterly at minimum...If the physician will not approve a self-administration plan, inform the Resident of the physician's decision and that State regulations will not allow self-medication without a physician's order...If the Resident does not choose to obtain a physician's order, self-medication cannot occur." This state finding relates to Complaint IN00377559			

R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to administer a resident's pain and anxiety medications as ordered which caused the resident to experience signs/symptoms of withdrawal and subsequently called 911 for transport to local emergency room. (Resident B) Findings include: The clinical record for Resident B was reviewed on 4/26/22 at 9:14 a.m. Resident B's diagnoses included, but not limited to, asthma, tardive dyskinesia (a conditions affecting the nervous system, often caused by long-term use of some psychiatric medications), major depressive disorder, anxiety, fibromyalgia, migraine, scoliosis, and lumbar degenerative disc disease. Resident B was admitted to the facility on 2/18/22.	R 0241	R 241 1. Residents B admission evaluation has been completed. 2. The Community reviewed each resident’s record to determine which residents if any, could be affected by the alleged deficient practice. 3. The Executive Director and/or Wellness Director will in-service nursing staff on administering a resident's pain and anxiety medications as ordered and ensuring complete and accurate documentation of all medications, including refusals. In addition, nursing staff will be educated to contact the Wellness Director is a medication is not available. 4. The Wellness Director or designee will audit 5 residents charts and Medication	06/06/2022

	A SLUMS (St. Louis University Mental Status Exam) conducted on 2/21/22 indicated, Resident B had mild neurocognitive disorder. A Physician's order placed on 2/18/22 indicated, Resident B may self-administer medications with or without reminders and may go out on a leave of absence with medications. Resident B's clinical record did not contain a self-administration of medication assessment. An interview with Resident B was conducted on 4/26/22 at 10:03 a.m. Resident B indicated, on 3/29/22, she had opened a new box of what she believed to be was her nasal spray and administered the nasal spray to herself. She stated, she had a reaction immediately following the administration of the spray and that the left side of her body "went limp". It was then, that she realized that she had not given herself the ipatropium nasal spray but, instead it was Narcan (medication to treat known or suspected opioid overdoses). She pressed her call button for staff to come, called the receptionist at the facility for help, and then called 911 for assistance. She indicated, while she was at the emergency room, staff from the facility called her daughter and		Admisnistration Records weekly for one month then monthly for five months to ensure medications are administered as prescribed. 5. Systemic changes will be completed: June 6, 2022	

told her that the resident's medications where all over the room and that they removed all her medications from the room. She indicated, she returned to the facility later the same day and went 48 hours without being given any of her medications. She stated, she was on 3 different blood pressure medication, 3 medications for depression, and medications for pain. She indicated, after 48 hours of not getting pain medications, she was going "into withdrawals" so she called 911. Resident B stated, she was taken to the hospital and they gave her a medication to "stop the withdrawals".

An interview with UM(Unit Manager) 2 was conducted on 4/26/22 at 1:09 p.m. UM 2 indicated, she had not removed any medications from Resident B's room. It wasn't until 3/30/22 that she and DON went through the medications from Resident B's room. She indicated, they used a "pill identifier" to identify each individual pill. She indicated, she then marked down the quantity of each controlled medication on a Controlled Drug Record for each controlled medication respectively.

An interview with DON(Director of Nursing) was conducted on 4/26/22 at 1:25 p.m. DON

indicated, on 3/29/22, she and ED (Executive Director) went into Resident B's room after she had been taken to the emergency room and removed all of her medications. DON indicated, there were medications out on counters, in drawers, loose pills found in a plastic bag in a corner of her room. She stated, they were just out everywhere and all mixed up. She had placed the medications in her office until the next day when she and UM 2 went through them.

An interview with ED was conducted on 4/26/22 at 1:37 p.m. ED indicated, she and DON had removed medications from Resident B's room on 3/29/22. She indicated, they gathered them up and put them all into the plastic bag that was in Resident B's room. She stated, pills were all over the room and were mixed together.

Resident B's Controlled Drug Records for Norco (an opioid pain medication) 5/325 mg tablets, Lyrica (a pain medication) 200 mg tablets, lorazepam (anti-anxiety medication) 1 mg tablets, and morphine sulfate ER (pain medication,extended release) 30 mg tablets were received on 4/26/22 at 11:36 a.m. from DON (Director of Nursing). The controlled drug sheets created on 3/30/22 for each medication

found in Resident B's room were as follows:

-Norco 5/325 mg tablets; 20 tablets

-Lyrica 200 mg tablets; 8 tablets

-pregabalin (generic for Lyrica) 200 mg tablets; 60 tablets

-morphine sulfate ER 30 mg tablets; 10 tablets

-lorazepam 1 mg tablet; 3 tablets

The Norco control sheet indicated, the first administration of Norco 5/325 mg tablets since removing the medication from Resident B's room was on 3/31/22 at 2 a.m.

The Lyrica/pregabalin control sheets indicated, the first administration of Lyrica/pregabalin since removing the medication from Resident B's room was on 3/31/22 at 7 p.m.

The morphine sulfate control sheet indicated, the first administration of morphine sulfate 30 mg tablet since removing the medication from Resident B's room was on 3/31/22 at 7 p.m.

The lorazepam control sheet indicated, the first administration of lorazepam 1 mg tablet since removing the medication from

Resident B's room was on 3/31/22 at 7 p.m.

Resident B's March MAR (medication administration record) did not indicate any doses of Norco, Lyrica/pregabalin, morphine sulfate or lorazepam were administered on 3/30/22. Resident B's April MAR indicated, on 4/15/22, no administrations of Norco were documented.

Emergency room notes for Resident B's 3/31/22 visit to the emergency room at [local hospital's name] were received on 4/27/22 at 9:54 a.m. The emergency room record contained the following notes:

1. A social services note dated 3/31/22 at 10:25 a.m. indicated, Resident B presented to the ER (emergency room) voluntarily for withdrawal and suicidal ideation without a plan. Under Assessment, Resident B "was in the ER on 3/29/22 after accidentally ingesting Narcan at her assisted living. Per notes, her assisted living has taken her medication due to concerns with her confusing medications, and are now dispensing it to her. She has make numerous phone calls to [sic, hospital's name] to report she is not receiving her medications. [sic, resident's first name] is cooperative for the assessment. She reports that

she is not getting her medication at the assisted living facility. She feels she was not given her antidepressants last night and reports that she is not receiving her Lorazepam. Also does not feel that she is receiving her Morphine. She feels like she is in withdrawal - reporting feeling 'hot and cold'. Admits she called the ambulance today because she wanted to come to the hospital to 'get relief from this withdrawal'....She is focused on her medications not being administered and receiving medications in the ER to alleviate withdrawal and pain...Reports she gets [local pharmacy's name] simple dose and that nursing staff took it yesterday as well." Under Collateral of social services note, it indicated, "When [sic, DON's name] asked her why she called 911 because staff did not know that she had called today), she stated 'I am addicted to Morphine and Norco and I am in withdrawal'".

2. ER physician's note dated 3/31/22 at 3:56 p.m. indicated, "The patient presented with complaints of diaphoresis, nausea, anxiety and restlessness in the setting of sudden decrease in opiate intake and apparent accidental naloxone exposure."

An interview with Resident B's pharmacy was conducted on

4/27/22 at 2:46 p.m. The compliance officer from the pharmacy indicated, on 4/15/22, the pharmacy had dispensed 180 tablets of Norco 5/325 mg for Resident B.

This state finding relates to complaint IN00377559.

Based on interview and record review, the facility failed to administer a resident's pain and anxiety medications as ordered which caused the resident to experience signs/symptoms of withdrawal and subsequently called 911 for transport to local emergency room. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 4/26/22 at 9:14 a.m. Resident B's diagnoses included, but not limited to, asthma, tardive dyskinesia (a conditions affecting the nervous system, often caused by long-term use of some psychiatric medications), major depressive disorder, anxiety, fibromyalgia, migraine, scoliosis, and lumbar degenerative disc disease. Resident B was admitted to the facility on 2/18/22.

A SLUMS (St. Louis University Mental Status Exam) conducted on 2/21/22 indicated, Resident B had mild neurocognitive disorder.

A Physician's order placed on 2/18/22 indicated, Resident B may self-administer medications with or without reminders and may go out on a leave of absence with medications.

Resident B's clinical record did not contain a self-administration of medication assessment.

An interview with Resident B was conducted on 4/26/22 at 10:03 a.m. Resident B indicated, on 3/29/22, she had opened a new box of what she believed to be was her nasal spray and administered the nasal spray to herself. She stated, she had a reaction immediately following the administration of the spray and that the left side of her body "went limp". It was then, that she realized that she had not given herself the ipatropium nasal spray but, instead it was Narcan (medication to treat known or suspected opioid overdoses). She pressed her call button for staff to come, called the receptionist at the facility for help, and then called 911 for assistance. She indicated, while she was at the emergency room, staff from the facility called her daughter and told her that the resident's medications where all over the room and that they removed all her medications from the room. She indicated, she returned to the facility later the same day

and went 48 hours without being given any of her medications. She stated, she was on 3 different blood pressure medication, 3 medications for depression, and medications for pain. She indicated, after 48 hours of not getting pain medications, she was going "into withdrawals" so she called 911. Resident B stated, she was taken to the hospital and they gave her a medication to "stop the withdrawals".

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Resident B's March MAR (medication administration record) did not indicate any

doses of Norco, Lyrica/pregabalin, morphine sulfate or lorazepam were administered on 3/30/22. Resident B's April MAR indicated, on 4/15/22, no administrations of Norco were documented.

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	feel that she is receiving her Morphine. She feels like she is in withdrawal - reporting feeling 'hot and cold'. Admits she called the ambulance today because she wanted to come to the hospital to 'get relief from this withdrawal'....She is focused on her medications not being administered and receiving medications in the ER to alleviate withdrawal and pain...Reports she gets [local pharmacy's name] simple dose and that nursing staff took it yesterday as well." Under Collateral of social services note, it indicated, "When [sic, DON's name] asked her why she called 911 because staff did not know that she had called today), she stated 'I am addicted to Morphine and Norco and I am in withdrawal'". 2. ER physician's note dated 3/31/22 at 3:56 p.m. indicated, "The patient presented with complaints of diaphoresis, nausea, anxiety and restlessness in the setting of sudden decrease in opiate intake and apparent accidental naloxone exposure."			

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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