STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	745 N SWOPE ST GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00400198, IN00400653, IN00402552, IN00403762 and IN00408363. Complaint IN00400198. No deficiencies related to the allegations are cited. Complaint IN00400653. No deficiencies related to the allegations are cited. Complaint IN00401552. Federal/state deficiency related to the allegations is cited at F760. Complaint IN00403762. No deficiencies related to the allegations are cited. Complaint IN00408363. Federal/state deficiency related to the allegations is cited at F760. Survey dates: May 8, 9, 12 and 15, 2023 Facility number: 000050 Provider number: 155120 AIM number: 100266170 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 5 Medicaid: 71 Other: 23 Total: 99 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rena Whichard	RN/DNS	05/31/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Quality review completed on May 19, 2023			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure medications were administered to the correct resident or in the correct manner for 2 of 3 residents reviewed for medication errors. (Residents H and K) Findings include: 1. The clinical record for Resident H was reviewed on 5/12/2023 at 12:45 p.m. Her medical diagnoses included, but were not limited to, heart failure and edema. The quarterly minimum data set assessment, dated 4/14/2023, indicated that Resident H was cognitively intact. A medication error report for Resident H, dated 5/7/2023, indicated Resident H had received the following medications in error: -Vitamin B12 Oral Tablet Extended Release 1000 MCG [microgram] Cyanocobalamin), a vitamin supplement. -Vitamin B-12 (Riboflavin), a vitamin supplement. -Divalproex Sodium Tabled Delayed Release 500 MG [milligram], an anti-seizure medication. -Docusate Sodium Capsule 100 MG, a medication used for constipation relief. -Motegrity Oral Tablet 2 MG (Prucalopride Succinate), a medication for use with chronic idiopathic constipation. -Keppra 1000 mg, an anti-seizure medication. These medications were not physician-ordered for Resident H.	F 0760	p paraid="738692707" paraeid="{7575b5c3-b80a-48d0-a956-cc2067a1c65a}{179}" >F760: Residents are Free from Significant Med Errors What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident H and Resident G medications were reviewed for documentation that medications are given as ordered to the appropriate individual. ·Resident K route of medication reviewed with added direction to prevent further occurrences. ul class="BulletListStyle2 SCXW173426691 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color:	06/09/2023

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	In an interview with Resident H on 5/12/2023 at 1:25 p.m., she indicated that on the morning of 5/7/2023, she was given the wrong medication. A nurse that she did not know the name of, came in and gave her medications in a cup. The nurse did not identify herself, address the resident by name, or explain what the medications were for. Resident H indicated she did not question the medications because she was to be starting a new medication for her edema and she believed that's why there were more pills than usual. After taking these medications, she reported feeling ill, having diarrhea, being dizzy, and having no appetite. The quarterly minimum data set assessment, dated 3/21/2023, indicated that Resident G was cognitively intact. In an interview with Resident G on 5/12/2023 at 1:35 p.m., she indicated that on the morning on 5/7/2023, her roommate (Resident H) was given her seizure medication by accident. She believed around 6:30 to 7 a.m., that morning, she realized she had not received her early morning and she alerted QMA 1. She overheard staff in the hallway saying that Resident H had taken Resident G's seizure medication. She received her usual morning medications around 8:30 a.m., that morning by QMA 1. Resident G indicated that Resident H was having diarrhea and would not eat for 5/7/2023 and 5/8/2023, so she stayed in the room to keep an eye on Resident H. In an interview with the DON on 5/12/2023 at 2:30 p.m., she indicated she would expect staff to verify a resident by their photo as well as verbally introducing themselves to the resident and calling the residents by their preferred names during encounters.		transparent; overflow: visible; cursor: text; list-style-type: circle; font-family: verdana;" The professional responsible for Medication Error asked to not return to facility. How will other residents having the potential to be affected by the same deficient practices be identified and what corrective action will be taken? ·All residents have the potential to be affected by the same deficient practice. ·All residents that receive medication via a specified route have the potential to be affected by the same deficient practice. Initial Audit: p paraid="1240564716" paraeid="{db71413c-86e2-450a-beb6-d47553e317b2}{44}" >DNS or Designee completed an audit of a	

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	2. During a medication pass observation on 5-12-23 at 9:10 a.m., with QMA 4, she was observed to prepare Resident K's morning medications for administration and administered 12 medications orally. The physicians's order for cyanocobalamin sublingual (under the tongue) (vitamin B-12) 1000 micrograms daily sublingual as a supplement. In an interview with QMA 4 on 5-12-23 at 10:45 a.m., she indicated she had given this vitamin orally, not under the tongue. A policy entitled, "Medications Administration," was provided by the Corporate Nurse on 5-15-23 at 12:45 p.m., with a copyright date of 2022. The policy indicated, "Medications are administered...as ordered by the physician...Identify the resident by photo in the MAR (medication administration record)...If other than PO [oral] route, administer in accordance with facility policy for the relevant route of administration (i.e., injection, eye, ear, rectal, etc.)." This Federal tag relates to Complaint IN00401552 and Complaint IN00408363. 3.1-48(c)(2)		7 day look back to ensure that medication was given appropriately. DNS or Designee completed an audit of specified routes (: sublingual, buccal, enteral, etc...) and updated instructions to ensure that administration is the correct route. What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Education: Nurses and QMAs received education on the medication administration guidelines to include but not limited to ensuring medications are administered as ordered and documented including using the 5 rights of medication administration and identifying resident according to picture on . Nurses on proper policy when a medication error occurs, including monitoring a resident status every shift until resident is stable.	

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			Nurses to report any suspected medication error timely to family and to document in . On-going monitoring: DNS or designee will complete medication administration audits with Nurses and QMA's to assure the right resident receives the right medication and ensure that medication using picture on system and are administered and documented for all resident without medication errors. These audits will be conducted on various shifts at various times weekly x and then monthly x 5 1/2 months. ul class="BulletListStyle1 SCXW173426691 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" How will the corrective action be monitored to ensure the deficient practice will not reoccur and what quality assurance practices will be put into place?	

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			·Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations as and IDT. If issues or trends are identified, then the audits will continue based on QAPI recommendations. If no trends or errors are identified, then audits will be completed on a PRN basis. The creation and submission of this Plan does not constitute an admission by the provider of any conclusions set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the State Report Plan of Correction be considered the Letter of Credible Allegation. The provider alleges compliance as of 06/09/2023. The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of post-survey revisit.	