STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, IN 47304

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 16, 17, 18, 19, 22, and 23, 2023 Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 2 Medicaid: 83 Other: 18 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 1, 2023.	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements.¿¿ ¿ The facility respectfully requests a desk review of our responses to this survey.¿	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaushik Patel	Executive Director	06/15/2023

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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	at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.			
	Based on interview and record review, the facility failed to resolve resident council concerns related to long call light wait times. Findings include: During record review on 5/18/23 at 10:29 a.m., the resident council record binder for the April 2023 meeting indicated resident discussion of the need for more CNAs and concerns regarding lengthy call light response times.	F 0565	F 565 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Follow up was completed with resident 40, 24, and 42 regarding call light timeliness to ensure that concern had been addressed and resident satisfied with resolution.	06/16/2023

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	During the Resident Council interview on 5/19/23 at 11:00 a.m., attendees indicated the average call light wait time to be 20-30 minutes, and wait times could be up to one hour. Those present indicated many had called family members and asked for help. Those relatives had then called the nurse's station to request assistance for their family member. This had been mentioned at previous meetings over the last several months. During the Resident Council interview, Resident 75 indicated staff advised the situation would be discussed with the management team and follow up would be communicated back to the Resident Council. This had not been done. Resident 40 indicated he experienced an avoidable incontinent episode due to the time it took staff to respond to his call light. The call light had been on approximately one hour. Resident 24 indicated he experienced increased pain and discomfort from not being repositioned in a timely manner. The call light had been on approximately one hour. During follow-up interviews, residents indicated the following: On 5/19/23 at 3:24 p.m., Resident 42 indicated she had multiple falls but had not utilized the call light due to long wait times for assistance. She felt she could complete her task well before staff arrived. On 5/22/23 at 9:40 a.m., Residents 24 and 40 indicated they utilized the large wall clock in their room, and their personal cell phones, to track the timeframe for assistance to arrive. During an interview on 5/22/23 at 9:45 a.m., CNA		-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken All residents have ability to be by the alleged deficiency ED and DNS met with resident counsel to review concerns regarding call light response to identify any ongoing issues. Follow up completed in resident counsel with response to concern. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with Activities and IDT team regarding new Resident Council Forms including follow up for grievances noted in resident council. Education completed with all staff regarding call light timeliness and notification to ED/ DNS if call lights are unable to be answered timely. Team will complete Patient Advocate rounds at least 5x per week with focus on but not limited to, Call light response and will report any negative findings to the ED.	

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	10 indicated residents complained they waited a long time for assistance after using the call light button. The 200 hall was short-staffed, which made her feel rushed, and prevented her from completing tasks timely. During an interview on 5/22/23 at 1:57 p.m., CNA 9 indicated the other nursing staff had complained to her about her inability to answer call lights in a timely manner. She felt the 200 hall unit was often short-staffed. During an interview and review of the grievance tracking log on 5/22/23 at 11:30 a.m., the Administrator indicated Resident Council concerns were entered into the grievance tracking log. The incidents reported on 2/1/23, 1/28/23, and 1/27/23 regarding lengthy call lights wait times had been reviewed. The resolutions documented were staff education and audits. A facility in-service log provided by the DON on 5/22/23 at 3:23 p.m., indicated a call light timeliness in-service was held February 2023. She did not provide any audit information. A current, undated, facility policy titled, "Resident Council Meetings," provided by the Administrator on 5/22/23 at 11:30 a.m., indicated the following: " ...Policy Explanation and Compliance Guidelines: ...7. The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and communicate its decisions to the Council ...." 3.1-3(l)		Call light Audits to be ED or designee on alternating shifts 5X weekly X 2 weeks, 3X times weekly X2 weeks, weekly X 4 weeks and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.	
F 0600 SS=D	483.12(a)(1) Free from Abuse and Neglect			

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Bldg. 00	§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect the resident's right to be free from sexual abuse when a resident with severe cognitive impairment (Resident 22) was groped and kissed by a cognitively intact resident (Resident 59) with known sexually aggressive behavior for 2 of 3 residents reviewed for mood and behaviors. Findings include: Review of a facility reportable incident, dated 5/13/23, indicated Resident 59 moved towards Resident 22 in the dining room. Resident 22 yelled "no." A staff member who was present in the dining room attempted to intervene and Resident 59 touched Resident 22's breast. 1. Resident 59's clinical record was reviewed on 5/18/23 at 10:47 a.m. Diagnoses included, cerebral infarction, other sexual dysfunction not due to a substance or known physiological condition, and end stage renal disease.	F 0600	F 600 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 59 was placed on supervision until alternative placement . Resident 22: Clinical record was and plan of care reflects current needs. Social Services continues to follow for psychosocial welling being. No further events identified. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken	06/16/2023

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	A current care plan, revised on 5/3/23, indicated the resident had behaviors such as kissing residents, holding hands, and inappropriate touching. Interventions included 15-minute monitoring (2/6/23) and separate from other residents as necessary (4/1/22). A current care plan, initiated 5/18/23, (following the 5/13/23 event) indicated the resident demonstrated sexually inappropriate behaviors such as fondling, inappropriate touching, and requested to touch female staff members and female residents. The clinical record lacked ongoing behavior tracking/monitoring for inappropriate sexual behaviors from 3/8/23 to 5/13/23, and 15-minute checks or one on one monitoring from 3/8/23 to 5/13/23. Review of a Psychiatry Progress Note, dated 5/9/23 at 7:32 p.m., indicated the resident was seen by the provider for continued, multiple episodes of sexually inappropriate behaviors towards staff during activity of daily living care. The assessment and plan indicated to continue appropriate behavioral interventions, psychotherapeutic communication, and change paroxetine (depression medication) to 40 milligrams daily. A progress note, dated 5/13/23 at 1:41 p.m., indicated Resident 59 moved from a table by himself to the table where Resident 22 was seated. Staff witnessed Resident 22 yelling "no." When staff intervened, Resident 59 had his hand up Resident 22's shirt, squeezed her left breast, and kissed Resident 22's right side of her face. When Resident 59 was separated and educated regarding the unacceptable behavior, he used		All residents with sexual behavior history were audited for appropriate nonpharmacological interventions and diversion activities. Plan of care and Kardex were reviewed and reflect the residents current care needs and interventions. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education with all staff regarding the guideline for Behavior Health Services to include implementation of non-pharmacological interventions and resident specific diversion activities. Education completed with nurses on the guideline for Behavior Health Services to include but not limited to documentation of intervention effectiveness and measure to take when behaviors or interventions are no longer effective. IDT education on Behavior Health Services follow up to ensure nonpharmacological interventions and diversional activities initiated. Behaviors to be reviewed during	

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	both hands and grabbed the staff member's buttocks. Resident 59 was moved away from other residents. A progress note, dated 5/15/23 at 9:41p.m., indicated the resident was sexually inappropriate with the CNA who provided one on one monitoring. He grabbed the CNA's arm and pulled her towards him and continued to stare at the female staff and licked his lips toward them. The resident was reminded the behavior was inappropriate. A progress note, dated 5/17/23 at 7:24 p.m., indicated the resident attempted to hold staff's hands and blew kisses at the staff. The resident was reminded the behavior was inappropriate. The reminder was ineffective. A progress note, dated 5/17/23 at 9:08 p.m., indicated the resident tried to hold the hand of his staff member who provided one on one monitoring. He blew her kisses and told her all he needed was a few minutes of her time. The staff member asked him to stop, and he asked why. A progress note, dated 5/17/23 at 9:08 p.m., indicated the physician rounded on the resident and changed the paroxetine (depression medication) to 60 milligrams daily. The clinical record lacked resident specific diversion activities and non-pharmacological interventions during dates and times of inappropriate sexual behaviors. Current orders included the following: one on one supervision every shift related to other sexual dysfunction (5/13/23) and 15-minute monitoring every shift for inappropriate sexual behavior		clinical review for effectiveness of interventions. New interventions will be updated for any behavior identified as interventions ineffective. Behavior reviews to be completed 5X weekly X 4 weeks, 3 X weekly X 4 weeks, weekly X 4 weeks, then monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.	

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	(5/13/23). Current medications included paroxetine hydrochloride (depression) - give 60 milligrams daily (5/17/23) and medroxyprogesterone acetate (contraceptive used off-label for sexual dysfunction)- inject 150 milligrams intramuscularly once every Saturday (5/14/23). The most recent significant change MDS assessment, dated 4/26/23, indicated the resident was cognitively intact. The resident required extensive assistance for bed mobility, toileting, and transfers. He required limited assistance to walk in the room and for locomotion on and off the unit. The resident used a wheelchair for mobility. 2. Resident 22's clinical record was reviewed on 5/18/23 at 10:01 a.m. Diagnoses included, intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, hemiplegia and hemiparesis following cerebral infarction affecting right nondominant side, cognitive communication deficit, other abnormalities of gait and mobility, dementia without behavioral disturbance, and anxiety disorder. The most recent annual Minimum data Set (MDS) assessment, dated 4/4/23, indicated the resident was severely cognitively impaired. The resident required extensive assistance from one staff member for bed mobility, transfers, and locomotion on and off the unit. The resident used a wheelchair for mobility. A current care plan, revised 4/11/23, indicated a history of trauma affected the resident negatively. The resident had a history of sexual violence			

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	(rape). A progress note, dated 5/13/23, indicated staff heard Resident 22 say "no." When staff turned around, Resident 59 had his hand under Resident 22's shirt, squeezed her breast, and kissed Resident 22's face. Resident 22 thanked staff for intervening. She indicated she was okay, but she hadn't liked it. During an interview on 5/23/23 at 10:05 a.m., Qualified Medication Aide (QMA) 12 indicated she was present in the dining room during lunch on 5/13/23. She was assisting another resident with their meal. Resident 59 sat in his wheelchair at a table by himself, near another male resident. Resident 59 was very self-mobile in his wheelchair. She noticed he left the table and went towards the hallway between the dining room and the front desk. She was unaware he had turned around to return to the dining room. After approximately two minutes, Resident 22 yelled "stop do not touch me." Resident 59 was kissing Resident 22's cheek and had his hand up Resident 22's shirt. When the QMA approached, Resident 22 indicated she was okay. Resident 59 had been on frequent monitoring prior to his transfer from the Memory Care Unit, but the frequent monitoring was not continued on the C Unit after he transferred. During an interview on 5/23/23 at 11:12 a.m., LPN 7 indicated she was on duty on 5/13/23 when Resident 59 inappropriately touched Resident 22. This was sexual abuse. Resident 59 did not have any frequent monitoring in place at the time of the event on 5/13/23. The 15-minute monitoring had not been re-initiated once he transferred from the dementia unit to the C Unit. She was unaware of any specific interventions initiated when the			

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	resident had hypersexual behaviors exhibited with staff, which had occurred on 5/3/23 and 5/8/23. Resident 59 was placed on monitoring every 15 minutes, and one on one monitoring after the event on 5/13/23. Other than the psychiatric visit and frequent monitoring, she was unaware of any resident specific interventions put into place for diversions or behavior management. The facility was working to get the resident's dialysis set up at another facility, so he could be transferred to an all-male building. During an interview on 5/23/23 at 11:43 a.m., the Social Services Director (SSD) indicated she was aware Resident 59 had a history of inappropriate sexual behavior, prior to his transfer from the Memory Care Unit on 2/7/23. She was not made aware of any further hypersexual behavior from Resident 59 until the event on 5/13/23. She was not aware of interventions in place to prevent further inappropriate touching. Social Services had not been involved when Resident 59 had hypersexual behavior towards staff members on 5/3/23 and 5/8/23. Social Services had not created a plan to prevent further inappropriate sexual behaviors with residents or staff. During an interview on 5/23/23 at 12:26 p.m., the DON indicated she was aware of Resident 59's previous history of inappropriately touching a resident in February 2023. Resident 59's frequent monitoring was not in place when the sexual abuse occurred on 5/13/23. A current, undated, facility policy, titled "Abuse, Neglect and Exploitation," provided by the DON on 5/16/23 at 12:30 p.m., indicated the following: "Policy: It is the policy of this facility to provide protections for the health, welfare and right of each resident by developing and implementing			

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	written policies and procedures that prohibit and prevent abuse... Definitions: ..."Abuse" ... Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse... III. Prevention of Abuse, Neglect and Exploitation... The facility will implement policies and procedures to prevent and prohibit all types of abuse... B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur...D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict... E. Ensuring the health and safety of each resident...." No further information was provided prior to exit on 5/23/23. 3.1-27(a)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to following physician's orders regarding medication administration parameters for acetaminophen for 1 of 14 residents observed for	F 0684	F 684 -what corrective action(s) will be accomplished for those residents found to have been	06/16/2023

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	medication administration. (Resident 58) Findings include: Resident 58's clinical record was reviewed on 5/23/23 at 11:17 a.m. Diagnoses included chronic viral hepatitis C and chronic pain. Current physician's order, included the following: a. Acetaminophen 500 (to treat pain) mg (milligrams), one tablet every eight hours for pain. The order contained instruction not to exceed three grams (3000 mg) of acetaminophen in 24 hours from all sources (10/26/22). b. Excedrin Migraine (aspirin 250 mg, acetaminophen 250 mg, caffeine 65 mg) (to treat migraine headaches), two tablets every four hours as needed for headache (4/12/23). c. Percocet (oxycodone 10 mg, acetaminophen 325 mg) (to treat pain), one tablet every four hours as needed for right ankle and joint pain of the right foot (4/12/23). A review of the electronic medication administration record (eMAR) for April 2023 indicated the following: On 4/14/23, the resident received the scheduled acetaminophen 500 mg, every eight hours. The resident received a dose of Percocet, containing 325 mg of acetaminophen, at 4:06 a.m., 9:16 a.m., 3:12 p.m., 7:40 p.m., and 11:30 p.m. The total amount of acetaminophen administered in a 24 hour period on 4/14/23 totaled 3125 mg. On 4/20/23, the resident received the scheduled acetaminophen 500 mg, every eight hours. The		affected by the deficient practice MD was notified of resident 58 exceeding recommended acetaminophen and orders updated with reduction in amount of Acetaminophen in a period. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed of all residents with current orders for acetaminophen to ensure that orders did not allow for exceeding per day. Audit completed of last 7 days to ensure that no other maximum does of 3000mg of acetaminophen. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education was completed with nurses and QMA regarding orders for acetaminophen and recommendation to not exceed per day. New Order monitoring to be completed to ensure maximum dose of acetaminophen cannot be exceeded. These audits will be completed by the DNS or designee 5X weekly X 2 weeks, 3X weekly X 2 weeks, weekly X 4 weeks, and monthly thereafter. DNS or designee will review Administered PRN Acetaminophen during clinical review to ensure the dosing did not exceed in a period. 5X weekly X 2 weeks, 3X weekly X 2 weeks,	

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	resident received a dose of Excedrin, containing 500 mg of acetaminophen, at 7:16 a.m. and 7:23 p.m. The resident received a dose of Percocet, containing 325 mg of acetaminophen at 4:22 p.m. and 10:54 p.m. The total amount of acetaminophen administered in a 24 hour period on 4/20/23 totaled 3150 mg. On 4/23/23, the resident received the scheduled acetaminophen 500 mg, every eight hours. The resident received a dose of Percocet, containing 325 mg of acetaminophen, at 1:46 a.m., 7:51 a.m., 1:05 p.m., 7:00 p.m., and 11:39 p.m. The total amount of acetaminophen administered in a 24 hour period on 4/23/23 totaled 3125 mg. On 4/29/23, the resident received the scheduled acetaminophen 500 mg, every eight hours. The resident received a dose of Excedrin containing 500 mg of acetaminophen at 11:23 a.m. and 11:13 p.m. The resident received a dose of Percocet, containing 325 mg of acetaminophen at 2:43 a.m. and 7:52 a.m. The total amount of acetaminophen administered in a 24 hour period on 4/29/23 totaled 3150 mg. During an interview on 5/23/23 at 2:15 p.m., the DON indicated the resident should not have been administered the medication when exceeding the ordered parameter of 3000 mg. The facility had no specific policy regarding following physician orders. No other information was provided at exit. Review of an online article titled "Acetaminophen Overdose: What You Need to Know," retrieved from www.healthline.com, indicated the following: "...According to the U.S. Food and Drug		weekly X 4 weeks, and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.	

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	Administration (FDA), taking too much acetaminophen can damage your liver. The recommended maximum daily dose is 4,000 milligrams (mg) per day for adults. However, the difference between a safe dose of acetaminophen and one that may harm the liver is very small. McNeil Consumer Healthcare (the maker of Tylenol) lowered their recommended maximum daily dose to 3,000 mg. Many pharmacists and healthcare providers agree with this recommendation...." 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder			

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	receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure staff promptly obtained urinary catheter orders and utilized proper urinary catheter assessment and management techniques for 1 of 2 residents reviewed for a urinary catheter. (Resident 29) Finding includes: During an interview on 5/17/23 at 10:12 a.m., with Resident 29, his suprapubic urinary catheter drainage bag was hung on the right side of his bed. It was the size of a urinary catheter leg bag (typically used for ambulatory resident to conceal under their clothing). The drainage bag contained only a trace of urine in the bottom of the drainage tube. This had been a problem since 5/16/23, and he had discussed it with the CNAs when they came to empty his drainage bag. It was not uncommon for the urinary catheter to be clogged because he had a lot of calcium in his body. They had not flushed his suprapubic catheter, nor changed it, since it had stopped draining appropriately. They would not flush the suprapubic catheter. During an interview on 5/18/23 at 12:16 p.m., the resident indicated he was not feeling well and did not plan to eat. His urinary catheter was still not	F 0690	F 690 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice MD was updated on resident 29 change in condition and catheter orders were updated for use of catheter, catheter flush and change schedule. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed with all residents with catheters to ensure orders were in place for the catheter, care and maintenance of the catheter. -what measures will be put into place and what systemic changes will be made to ensure that the	06/16/2023

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	draining correctly. The resident indicated the drainage bag was laying on the bed beside him, under his blanket. Staff were aware of the lack of drainage, but they had not responded to him with a plan of action. The catheter had not been flushed, nor changed, since the output had decreased. The staff told him they were unable to flush his catheter because it might cause an infection from bacteria. He was unable to manage his own catheter. The CNAs typically came to empty his catheter each shift and were aware the catheter was still not draining correctly. Resident 29's clinical record was reviewed on 5/18/23 at 4:28 p.m. Diagnoses included, obstructive and reflux uropathy, difficulty in walking, and spinal stenosis of the lumbar region with neurogenic claudication. Orders included, record urinary output every shift for suprapubic catheter use. The clinical record lacked current orders for the urinary catheter, catheter flush, and change schedule of the resident's urinary catheter. A quarterly Minimum Data Set (MDS) assessment, dated 4/2/23, indicated the resident was cognitively intact. He required extensive assistance for bed mobility, transfers, dressing, and toileting. The resident had an indwelling catheter. A current care plan, last revised on 2/21/23, indicated the resident was at risk for alteration in elimination of bowel and bladder related to obstructive uropathy and urinary retention. The resident's suprapubic catheter was dislodged on 2/21/23. Interventions included the following: change the catheter as ordered/needed for decreased output or occlusion (11/1/22), change		deficient practice does not recur Education completed with nurses on the guideline for catheters to include initiation of orders, catheter assessment, and catheter management, and notification of changes with catheters. Clinical staff were educated catheter management including notification of decreased output and resident concerns. DNS or designee will review daily during clinical review: progress notes for change in condition of catheter, MAR/TAR monitoring for catheter output, and new admission monitoring for initiation of catheter orders for all new admission and newly ordered catheters. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.	

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	catheter bag as ordered/needed (9/14/22), irrigate catheter as ordered (9/14/22), check catheter tubing for proper drainage and positioning (9/14/22), and monitor and report for signs and symptoms of urinary tract infections (9/14/22). The clinical record lacked progress notes regarding the suprapubic catheter from 5/16/23 to 5/19/23. (The dates the resident had concerns of his urinary output.) A Nurse's Note, dated 5/19/23 at 5:54 a.m., indicated the resident reported his suprapubic urinary catheter was still not draining. Review of the resident's urinary output indicated four out of nine shifts of urinary output from 4/16/23/ to 4/18/23 lacked any urine output. This included one shift on 4/16/23 and all three shifts on 4/18/23. This was a significant decrease in the resident's normal output each shift. His urine output ranged from 200 milliliters to 600 milliliters each shift the remainder of the month of May. During an interview on 5/19/23 at 11:17 a.m., CNA 8 indicated changes in mental status, urine odor, urine color, or urine output were potential indicators of urinary tract concerns. The resident's catheter was not draining a couple of days ago. CNAs emptied the urinary drainage bags and reported the urinary output to the nurse on the unit for each shift. Nurses entered the urinary output in the clinical record. CNA 8 had reported the urinary output concern to LPN 5 a couple of days ago when she recognized the catheter was not draining correctly. During an interview on 5/19/23 at 2:00 p.m., the resident indicated RN 13 had manipulated the tubing to his urinary catheter early in the morning			

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	on this date. The catheter began draining again and he was feeling better now that it was draining. The catheter was not flushed and had not been flushed or changed since he had problems with it draining on 5/16/23. Staff put briefs on him because he was having urine spill out of his penis since the urinary catheter was clogged. He did not have urine draining from his penis when the catheter drained correctly. The urinary drainage bag was half full of yellow urine and hung on the right side of the resident's bed during the observation. He spoke with nursing staff about the catheter being clogged and they indicated they do not flush a suprapubic catheter at this facility. During a catheter care observation on 5/19/23 at 2:22 p.m., the resident's suture attached to the suprapubic catheter tubing was not intact and was approximately one fourth of an inch from the resident's insertion site. A securement device was not attached to the resident's body to prevent dislodgement of the catheter before or after the catheter care was completed. The resident discussed his concern with LPN 5 and LPN 6 (during the catheter care observation) that the weight of the urine in the drainage bag, with the elastic strap, allowed the catheter to be pulled taught. During an interview on 5/19/23 at 2:33 p.m., LPN 5 indicated she provided regular care for the resident. She had not recognized the resident's decreased output the last couple of days. LPN 5 had worked on 5/16/23, 5/17/23, 5/18/23 and 5/19/23. She was not aware when the resident's catheter had last been flushed because they did not have any orders to flush the catheter. The physician should have been contacted to obtain orders when they did not have the order in the			

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	resident's clinical record. During an interview on 5/19/23 at 2:34 p.m., LPN 6 indicated she provided regular care for the resident. She had not recognized the resident's decreased output the last couple of days. LPN 6 had worked on 5/16/23, 5/17/23, 5/18/23 and 5/19/23. She was not aware when the resident's catheter had last been flushed because they did not have any orders to flush the catheter. The physician should have been contacted to obtain orders when they were not in the resident's clinical record. During an interview on 5/19/23 at 2:51 p.m., LPN 5 indicated orders for the catheter had not been re-activated when the resident returned from the Urologist on 4/26/23. The clinical record lacked orders for the suprapubic catheter, a catheter flush, or a catheter change since the orders were discontinued on 2/26/23. Orders that were missing or unclear should have been clarified with the urologist, at the number provided on the discharge instructions, when the resident returned to the facility. A catheter with inappropriate drainage should have been flushed or changed when a urinary catheter flush was unsuccessful. During an interview on 5/19/23 at 3:00 p.m., LPN 6 indicated the physician should have been notified immediately with urinary catheter changes such as a change in the resident's urine, clogging of a catheter, drainage around the site, or dislodged sutures. During an interview on 5/19/23 at 4:00 p.m., the DON indicated the physician was notified of the resident's suprapubic catheter concerns on 5/19/23. Urinary catheter orders for management of the resident's suprapubic urinary catheter			

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	should have been in place. Urinary concerns should have been brought to the physician's attention immediately. A current, undated, facility policy, titled "Indwelling Catheter Use and Removal," provided by the DON on 5/19/23 at 4:00 p.m., indicated the following: "Policy: It is the policy of this facility to ensure that indwelling urinary catheters that are inserted or remain in place are justified or removed according to regulations and current standards of practice... Compliance Guidelines: 4. If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to: ...f. Ongoing monitoring for changes in condition related to potential catheter-associated urinary tract infections, recognizing, reporting and addressing such changes... 7. Additional care practices include: a. Recognition and assessment for complications and their causes, and maintaining a record of any catheter-related problems... d. Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to... dislodgement of the catheter; and e. Securement of the catheter to facilitate flow of urine... 8. Catheters and drainage bags should be changed based on clinical indications such as infection, obstruction, or when the closed system is compromised...." 3.1-41(a)(2)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health			

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	care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to develop and implement behavioral programming regarding sexually inappropriate behaviors for 1 of 3 residents reviewed for mood and behaviors. (Resident 59) Finding includes: Resident 59's clinical record was reviewed on 5/18/23 at 10:47 a.m. Diagnoses included, cerebral infarction , other sexual dysfunction not due to a substance or known physiological condition, and end stage renal disease. Current orders included the following: one on one supervision every shift related to other sexual dysfunction (5/13/23) and 15-minute monitoring every shift for inappropriate sexual behavior (5/13/23). The most recent significant change MDS assessment, dated 4/26/23, indicated the resident was cognitively intact. A current care plan, revised on 5/3/23, indicated the resident had behaviors such as kissing residents, holding hands, and inappropriate touching. Interventions included, 15-minute monitoring (2/6/23) and separate from other residents as necessary (4/1/22). A current care plan, initiated 5/18/23, indicated the resident demonstrated sexually inappropriate	F 0740	F 740 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 59 on one-on-one supervision until alternative placement was found. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken All residents with sexual behavior history audited for appropriate interventions and diversion activities. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education with all staff regarding the guideline for Behavior Health Services to include implementation of non-pharmacological interventions	06/16/2023

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	behaviors such as fondling, inappropriate touching, and requested to touch female staff members and female residents. The resident exhibited inappropriate sexual behaviors as follows: a. 2/6/23 at 9:22 a.m. - placed his hand down the back of a female resident's pants b. 5/3/23 at 3:10 a.m. - sexual behavior towards staff c. 5/8/23 at 2:00 a.m. - sexual behavior towards staff d. 5/13/23 at 12:30 p.m. - groped a female resident's breast and kissed her face e. 5/15/23 at 9:41 p.m. - sexual behavior towards staff f. 5/17/23 at 7:24 p.m. - sexual behavior towards staff g. 5/17/23 at 9:08 p.m. - sexual behavior towards staff Review of a Psychiatry Progress Note, dated 5/9/23 at 7:32 p.m., indicated the resident was seen by the provider for continued, multiple sexually inappropriate behaviors towards staff during activity of daily living care. The assessment and plan was to continue appropriate behavioral interventions and psychotherapeutic communication. The clinical record lacked ongoing behavior tracking/monitoring for sexual behaviors from 3/8/23 to 5/13/23. The clinical record lacked resident specific diversion activities and non-pharmacological interventions during dates and times of inappropriate sexual behaviors.		and resident specific diversion activities. Education completed with nurses on the guideline for Behavior Health Services to include but not limited to documentation of intervention effectiveness and measure to take when behaviors or interventions are no longer effective. IDT education on Behavior Health Services follow up to ensure nonpharmacological interventions and diversional activities initiated. Behaviors to be reviewed during clinical review for effectiveness of interventions. New interventions will be updated for any behavior identified as interventions ineffective. Behavior reviews to be completed 5X weekly X 4 weeks, 3 X weekly X 4 weeks, weekly X 4 weeks, then monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits	

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	During an interview on 5/23/23 at 11:12 a.m., LPN 7 indicated she was on duty on 5/13/23 when Resident 59 inappropriately touched Resident 22. She was unaware of any specific interventions initiated when the resident had hypersexual behaviors exhibited with staff on 5/3/23 and 5/8/23. Resident 59 was placed on 15-minute monitoring and one on one monitoring since the event on 5/13/23. Other than the psychiatric visit and frequent monitoring, she was unaware of any resident specific interventions put into place for diversions. During an interview on 5/23/23 at 11:43 a.m., the Social Services Director (SSD) indicated she was aware Resident 59 had a history of inappropriate sexual behavior prior to his transfer from the Memory Care Unit on 2/7/23. She was not made aware of any further hypersexual behavior from Resident 59 until the above mentioned event on 5/13/23. She was not aware of interventions in place to prevent further inappropriate touching. Social Services had not been involved when Resident 59 had hypersexual behavior towards staff members on 5/3/23 and 5/8/23. Social Services had not created programming to prevent further inappropriate sexual behaviors with residents or staff. During an interview on 5/23/23 at 12:04 p.m., the Activity Director was not aware of any specific diversion activities provided for Resident 59. During an interview on 5/23/23 at 12:26 p.m., the DON indicated she was aware of Resident 59's previous history of inappropriately touching a resident in February 2023. She was not aware of other resident specific interventions implemented when the resident displayed inappropriate sexual behaviors with staff on 5/3/23 and 5/8/23.		based on QAPI recommendations, otherwise will review on a prn basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, IN 47304

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	No additional information was provided prior to exit on 5/23/23. A current facility policy, undated, titled "Behavioral Health Services," provided by the DON on 5/23/23 at 3:10 p.m., indicated the following: "Policy: It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning. Definitions: ..."Non-pharmacological intervention" refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being... Policy Explanation and Compliance Guidelines: ...3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety... 11. Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmacological interventions... 12. The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility...." 3.1-37(a)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;			

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	Based on observation, interview, and record review, the facility failed to prime insulin pens to ensure accurate dose administration for 2 of 14 residents observed for medication administration. There were 25 opportunities with 2 errors, resulting in a 8% medication administration error rate. (Residents 43 and 6) Findings include: During an observation of medication administration for Resident 43 on 5/18/23 at 10:48 a.m., LPN 11 was observed preparing an aspart insulin pen (to treat diabetes). After sanitizing her hands and the lip of the top of the pen, she applied a new needle onto the pen and dialed a dose of six units. She used an alcohol swab to prepare the resident's skin and administered the injection into the resident's abdomen. During an observation of medication administration for Resident 6 on 5/28/23 at 12:19 p.m., LPN 11 was observed preparing an aspart insulin pen. After sanitizing her hands and the lip of the top of the pen, she applied a new needle onto the pen and dialed a dose of two units. She used an alcohol swab to prepare the resident's skin and administered the injection into the back of the resident's arm. During an interview at the time of the observation, LPN 11 indicated she did not know about priming the insulin needle. During an interview on 5/23/23 at 11:13 a.m., the DON indicated the needle should be primed with two units of insulin when using an insulin pen prior to administering insulin to the resident. A current, undated, facility policy titled, "Insulin	F 0759	F 759 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 6 and resident 43 orders and assessment completed to ensure no adverse reaction noted following insulin administration. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken The facility completed a 7 day look back of Blood Sugar readings and orders for insulin to ensure no adverse effects identified. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with all nurses and QMAs on insulin pens to include priming of insulin needles. DNS or designee to complete medication administration audits to monitor proper insulin injections. include a random selection of QMAs and nurses as well as include all 3 shifts. Audits will be completed 5X weekly X 2 weeks, 3x weekly X2 weeks,	06/16/2023

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	Pen," provided by the DON on 5/23/23 at 11:01 a.m., indicated the following: "Policy Explanation and Compliance Guidelines:...6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir....11. Procedure:...h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears .... " 3.1-48(c)(1)		weekly X 4 weeks, then monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.	