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	03/21/2023

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 the Investigation of Complaint IN00403360. Complaint IN00403360 - Federal/state deficiencies related to the allegations are cited at F580 and F758. Survey dates: March 20 and 21, 2023. Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census Bed Type: SNF/NF: 107 Total: 107 Census Payor Type: Medicare: 7 Medicaid: 86 Other: 14 Total: 107 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 27, 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 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 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

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

Kaushik Patel | Executive Director | 04/05/2023

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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	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure the resident representative was notified when a new psychotropic medication was started for 1 of 3 residents reviewed for behaviors (Resident B). Findings include: Resident B's clinical record was reviewed on 3/20/23 at 9:11 a.m. Diagnoses included Alzheimer's disease, anxiety disorder, and major depressive disorder, recurrent. She admitted to the facility on 6/16/22 and discharged from the facility on 6/23/22. Medications during her facility stay included Paxil (antidepressant) 20 mg daily (6/19/22), Seroquel (antipsychotic) 100 mg twice daily and 200 mg at bedtime (6/16/22 - admitted with), and donepezil (Alzheimer's disease) 10 mg daily (6/16/22 - admitted with). A discharge MDS (Minimum Data Set), dated 6/23/22, indicated she was rarely/never understood. She wandered one to three days during the assessment period. She required extensive assistance for bed mobility, transfers, walk in her room and corridor, locomotion on and off the unit, toilet use and personal hygiene. She experienced two or more falls. She received an antipsychotic medication seven of seven days during the assessment period and an antidepressant medication five of seven days during the assessment period. On 6/18/22 at 8:37 p.m., an order for Paxil 20 mg,	F 0580	F 580 D Notification of Changes What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident B: no longer resides at the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial All residents that receive medication have documentation present in their clinical record that resident and/or representative was notified when a new psychotropic medication was initiated. Any identified without documentation will be corrected at the time of the initial audit. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿	04/10/2023

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	give one tablet by mouth one time a day related to recurrent major depressive disorder was entered into the electronic medical record. The medication administration record indicated she received her first dose of Paxil on 6/19/22 at 7:00 a.m. A late entry nurses note, dated 6/19/22 at 8:23 p.m. and created on 7/10/22 at 1:19 p.m., indicated the resident's husband was called for a discussion about her wandering in and out of other resident's rooms. She had put her fingers in male resident's ears, touched their faces, and kissed them. Her husband didn't think it was anything sexual, as she liked people and she had not been around anyone else much. The nurse had spoken to the Administrator, DON, and the psychiatric NP (Nurse Practitioner) about giving her a PRN (as needed) medication. The nurse explained to the resident's husband what a PRN medication was, and he thought it would be okay, as long as it wasn't very strong. During an interview with the ACU (Alzheimer's Care Unit) Director and LPN 6, on 3/20/23 at 2:28 p.m., the ACU Director indicated Resident B had been at the facility for a short respite stay. She would get into other's personal space and she was late in her Alzheimer's dementia. She was ambulatory and loved to hold hands and kiss others. They had called her husband and received verbal consent for psychiatric services, and it became a bigger deal later on when he had claimed he had not given consent. The husband was upset about her starting on Paxil. She wasn't making out with the male residents, it had been just a kiss, a peck sort of thing. LPN 6 indicated she guessed the Paxil may have been to treat her touching others. She didn't know why she had		Licensed staff were educated on the guideline for Notification of Changes to include but not limited to notification to resident and/or representative of changes in condition or treatments such as medication changes. On-going DNS or Designee will review all new orders during clinical review for any new psychotropic medications to ensure resident and/or representative was notified when a new psychotropic medication was started. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to	

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	put the progress notes in so late, she had no clue. She would usually try to put them in the day of, or within a couple days. During an interview with the DON, with the Nurse Consultant present, on 3/20/23 at 3:07 p.m., she indicated the psychiatric NP would not give the order for Paxil because she had not seen Resident B yet. The physician was notified and he gave the order. The resident's behaviors were touching another resident and being "lovey/feely" with the other resident. Multiple times, she had touched male resident's faces, kissing them and putting her fingers into the resident's ear. One behavior, but towards multiple people. They don't often have respite stays, but would change a resident's medication if they had behaviors, and they needed to. During an interview with LPN 12, on 3/21/23 at 9:42 a.m., she indicated when calling the doctor, he would ask for the resident's allergies, and she would call the family about the new order and then let the DON know. She would make sure the pharmacy got the new order and if they could pull the medication from EDK (Emergency Drug Kit) then she would. She would put in a nurses note referring to the new order. She would do it all at the same time. During an interview with LPN 6, on 3/21/23 at 9:48 a.m., she indicated whether it was the doctor or the NP, she would tell them what was going on with the resident. She would put a nurses note in the computer and notify the family all at same time, simultaneously. A current facility policy, titled "Notification of Changes," provided by the DON on 3/21/23 at 10:23 a.m., indicated the following: "The purpose		make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	

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	of this policy is to ensure the facility promptly informs...the resident's representative when there is a change requiring notification...Definitions..."Need to alter treatment significantly" means...commence a new form of treatment to deal with a problem (for example...therapy that has not been used on that resident before)...Compliance Guidelines...3. Circumstances that require a need to alter treatment...a. New treatment. This Federal tag relates to complaint IN00403360. 3.1-5(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose			

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	reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure a new psychotropic medication had an appropriate indication for use for 1 of 3 residents reviewed for behaviors (Resident B). Findings include: Resident B's clinical record was reviewed on 3/20/23 at 9:11 a.m. Diagnoses included Alzheimer's disease, anxiety disorder, and major depressive disorder, recurrent. She admitted to the facility on 6/16/22 and discharged from the facility on 6/23/22.	F 0758	F 758 D Free from Unnecessary Psychotropic Med/PRN Use What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident B: no longer resides at the facility How other residents having the	04/10/2023

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	Her medications during her stay included Paxil (antidepressant) 20 mg daily (6/19/22) Seroquel (antipsychotic) 100 mg twice daily and 200 mg at bedtime (6/16/22 - admitted with), and donepezil (Alzheimer's disease) 10 mg daily (6/16/22 - admitted with). A discharge MDS (Minimum Data Set), dated 6/23/22, indicated she was rarely/never understood. She wandered one to three days during the assessment period. She required extensive assistance for bed mobility, transfers, walk in her room and corridor, locomotion on and off the unit, toilet use and personal hygiene. She had experienced two or more falls. She received an antipsychotic medication seven of the seven days during the assessment period and an antidepressant medication five of seven days during the assessment period. She had a care plan for a respite stay at the facility and would like to make plans to discharge to her private home without home health services (7/26/22). Her goal was to help her with developing transition strategies that would make her leaving go smoothly (7/26/22). Her interventions were educate her or her care giver about her medications, their side effects and how and when she should take them, and help her make sure she had what she needed (7/26/22). She had a care plan for behaviors to include kissing other residents and holding other resident's hands, dated 7/26/22 (after her discharge). Her goal was her behavior would stop with staff intervention and support (7/26/22). Her interventions were to let her physician know if her behaviors were interfering with her daily living (7/26/22). Place her on 15-minute checks if ED and/or DON advise (7/26/22). Remind her that it		potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Initial The facility completed a review of all residents that receive psychotropic medication to ensure a new psychotropic medication had an appropriate indication for use documented in the clinical record. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ licensed staff were educated on the guideline for Behavioral Health Services to include but not limited to ensuing a new psychotropic medication has an appropriate indication for use and is documented in the clinical record. On-going monitoring or Designee will review all new orders during clinical review for any new psychotropic medications to ensure there is an appropriate	

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	was not appropriate to kiss others (7/26/22). Separate her from the other resident as necessary (7/26/22). Speak to her unhurriedly and in a calm voice (7/26/22). She had a care plan that she found comfort in making physical contact with peers, such as holding their hand, rubbing their back, kissing and accidental inappropriate touching when reaching out to touch others, dated 7/26/22 (after her discharge). Her goal was to help her keep distance from her peers (7/26/22). Her interventions were attempt to redirect her is she was being too intrusive with peers (7/26/22). Involve her in a one on one activity or group activities (7/26/22). A nurses note, dated 6/16/22 at 11:33 a.m. and created on 6/17/23 at 6:54 p.m., indicated she had arrived at the facility via her husbands' care. She was calm and cooperative. She was alert to herself, but confused to the time and the place. She ambulated in the hallway and wandered around the facility. She was there for a respite stay and would be at the facility for seven days. The MD (Medical Director) was notified and her medications were clarified. She had no signs or symptoms of pain and no complaints. She was easily redirected. A late entry behavior note, dated 6/17/22 at 3:00 p.m. and created on 7/14/22 at 12:00 p.m., indicated as she ambulated in the hallway, she passed a male resident and kissed him on the lips. She continued to ambulate down the hall. She was redirected to activities, given fluids and snacks, and the interventions were effective. A late entry nurses note, dated 6/17/22 at 3:00 p.m. and created on 7/14/22 at 12:02 p.m., indicated she was calm and cooperative. She was alert to herself		indication for use documented in the clinical record. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	

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	and confused to the time, place and other people. She ambulated in the hall with a slow and steady gait. She had no signs or symptoms of distress. She had no complaints of pain and no skin issues. Her husband and the MD was notified. 15-minute checks were in place. A nurses note, dated 6/17/22 at 6:24 p.m., indicated the ACU (Alzheimer's Care Unit) Director provided a psychosocial follow up with her regarding the incident that had occurred with the male resident. She walked the hallway holding the ACU Director's hand at time of the assessment. When ACU Director began to ask her questions, she began nonsensical speaking. She was unable to remember kissing the male resident and showed no signs or symptoms of emotional distress. On 6/18/22 at 8:37 p.m., an order for Paxil 20 mg, give one tablet by mouth one time a day related to recurrent major depressive disorder, was entered into the computer. The medication administration record indicated she received her first dose of Paxil on 6/19/22 at 7:00 a.m. A late entry nurses note, dated 6/19/22 at 8:23 p.m. and created on 7/10/22 at 1:19 p.m., indicated her husband was called for a discussion about her wandering in and out of other resident's rooms. She had been putting her fingers in male resident's ears, and touching their faces and kissing them. Her husband didn't think it was anything sexual, she liked people and she hadn't been around anyone else much. The nurse spoke to the Administrator, DON, and the psychiatric NP (Nurse Practitioner) about giving her a PRN (as needed) medication. The nurse had explained to			

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	the resident's husband what a PRN was and he thought it would be okay, as long as it wasn't very strong. A nurses note, dated 6/20/22 at 12:05 p.m., indicated the ACU Director provided psychosocial follow up with the resident regarding the incident that occurred on 6/17/22 with a male resident. She was sitting at the dining room table eating lunch at time of the assessment. When ACU Director began to ask her questions, she began nonsensical speaking, then stated "that's good" as she took a bite of her mashed potatoes. She was unable to remember kissing the male resident. She showed no signs or symptoms of emotional distress at that time. A nurses note, dated 6/21/22 at 1:32 p.m., indicated the ACU Director provided psychosocial follow up with her regarding the incident that occurred on 6/17/22 with a male resident. She walked around the ACU Director's office at time of the assessment. When ACU Director began to ask her questions, she began shaking her head no and nonsensical speaking. She was unable to remember kissing the male resident and showed no signs or symptoms of emotional distress. During an interview with the ACU Director and LPN 6, on 3/20/23 at 2:28 p.m., the ACU Director indicated Resident B had been at the facility for a short respite stay. She would get into other's personal space and she was late in her Alzheimer's dementia. She was ambulatory and loved to hold hands and kiss. They had called her husband and received verbal consent for psychiatric services. It had become a bigger deal later on, when he claimed he hadn't given consent. The husband was upset about her starting on Paxil. She wasn't			

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	"making out" with the male residents, it was just a kiss, a peck sort of thing. LPN 6 indicated she guessed the Paxil may had been for the resident's touching others. She didn't know why she would had put the progress notes in so late, she had no clue. She would usually try to put them in the day or within a couple days. During an interview with the DON, with the Nurse Consultant present, on 3/20/23 at 3:07 p.m., she indicated the psychiatric NP would not give the order for Paxil because she had not seen Resident B yet. The physician had been notified and he gave the order. The resident's behaviors were touching another resident and being "lovey/feely" with the other resident. Multiple times she had touched the male resident's faces, kissing and putting her fingers in the resident's ear. One behavior, but towards multiple people. They didn't often have respite stays, but would change a resident's medication if they had behaviors and they needed to. During an interview with QMA 4, on 3/21/23 at 9:25 a.m., she indicated she remembered that Resident B would wander in and out of people's rooms and she chewed on her shirts. When they tried to redirect her, she would try to smack or pinch. She couldn't recall her having had any sexual behaviors. During an interview with the DON, on 3/21/23 at 10:23 a.m., she indicated she was not sure why the care plans indicated they were initiated on 7/26/22, but when she looked at them on her computer, it reflected they were initiated on 6/16/22. A current facility policy, titled "Behavioral Health Services," provided by the DON on 3/20/23 at 2:25 p.m., indicated the following: "...Policy			

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	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Explanation and Compliance Guidelines...8. The resident and as appropriate the resident's family, are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as indicated. The care plan shall...f. Use pharmacological interventions only when non-pharmacological interventions are ineffective or when clinically indicated...11. Facility staff will implement person-centered approaches designed to meet the individual goals and needs of each resident, which includes non-pharmacological interventions...." This Federal tag relates to complaint IN00403360. 3.1-48(a)(4)			