| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155120 | A. BUILDING 00<br>B. WING | 05/12/2022 |

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| BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER | 745 N SWOPE ST<br>GREENFIELD, IN 46140 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00379555<br><br>Complaint IN00379555 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F760 and F880.<br><br>Survey dates: May 11 and 12, 2022<br><br>Facility number: 000050<br>Provider number: 155120<br>AIM number: 100266170<br><br>Census Bed Type:<br>SNF/NF: 96<br>Total: 96<br><br>Census Payor Type:<br>Medicare: 11<br>Medicaid: 58<br>Other: 27<br>Total: 96<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on May 17, 2022 | 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 on 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.<br>The facility respectfully requests a desk review of our responses to this survey. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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 | | | |

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

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| | professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered during a Medication Administration Observation during 4 observations with 4 staff providing medications to 1 of 8 residents. (Resident D and LPN 6)<br><br>Findings include:<br><br>During a Medication Administration Observation with LPN 6 on 5-11-22 at 12:56 p.m., she was observed to obtain Resident D's blood pressure at 121/83 prior to preparing his medication of Midodrine (used to aide low blood pressure) 10 milligrams and ordered to be given every 8 hours orally with additional physician orders to hold the medication if the systolic (top number) blood pressure is greater than 100. LPN 6 was observed to administer the Midodrine.<br><br>In review of Resident D's record of blood pressure readings from 5-9-22 to 5-11-22, there was not a blood pressure reading documented in the clinical record on 5-9-22, only one reading on 5-11-22, and two readings on 5-10-22. Review of the progress notes, dated 5-10-22 to 5-12-22, there were notations which indicated the medication was held for the 9:00 p.m. dose on 5-9-22 for an unspecified blood pressure, documented at midnight on 5-10-22; on 5-10-22 at 5:45 a.m., for the 5:00 a.m. dose, related to blood pressure of 142/76; on 5-10-22 at 9:48 p.m., for a blood pressure of 133/84 for the the 9:00 p.m., dose; and on 5-11-22 at 5:02 a.m., of an undocumented blood pressure for the 5:00 a.m., dose.<br><br>On 5-12-22 at 11:47 a.m., the Administrator | F 0684 | F684 Quality of Care<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident D: DNS clarified midodrine order with NP and discontinued medication per MD order.<br>LPN 6: LPN was educated immediately by Resource RN on medication administration with posttest provided.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken**<br>All residents that require medication administration have the potential to be affected by the same deficient practice.<br>**Initial audit**<br>DNS or Designee completed a review of all residents that require additional instructions with medications to ensure no abbreviations or symbols utilized and included appropriate supplemental documentation if necessary.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** | 06/02/2022 |

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| | provided a copy of a policy entitled, "Medication Administration," with a copyright date of 2022 and identified this as the current policy utilized by the facility. This policy indicated, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with the professional standards of practice, in a manner to prevent contamination or infection...Obtain and record vital signs, when applicable or per physician's orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters."<br><br>This Federal tag relates to Complaint IN000379555.<br><br>3.1-48(c)(2) | | Education<br>Clinical staff (Nurses/QMA) were educated on the guidelines for medication administration and how to put new orders in PointClickCare appropriately, including adding supplemental documentation if necessary.<br>On-going monitoring<br>DNS or Designee will monitor new orders received timely to ensure proper supplemental documentation and additional instructions for orders are documented appropriately.<br>These reviews are to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.<br>**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**<br>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 audits will continue based on QAPI recommendation. If none noted, then will complete audits based on a prn basis. | |
| F 0760<br>SS=D<br>Bldg. 00 | 483.45(f)(2)<br>Residents are Free of Significant Med Errors<br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any | | | |

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| | significant medication errors.<br>Based on interview and record review, the facility failed to ensure medications are provided to the correct resident for 1 of 5 residents reviewed for medication errors. (Resident B)<br><br>Findings include:<br><br>The clinical record of Resident B was reviewed on 5-11-22 at 10:21 a.m. Her diagnoses included, but were not limited to Alzheimer's disease, unspecified dementia without behaviors disturbances and cognitive communication deficit. She resided on a secured memory care unit. Her diagnoses did not include depression, any psychotic disorders or thyroid problems Her most recent Minimum Data Set (MDS) assessment, dated 3-25-22, indicated she was severely cognitively impaired, had no behaviors, used a wheelchair for mobility, her weight was stable at 136 pounds and received no medications for psychiatric disorders.<br><br>In an interview with a family member of Resident B on 5-12-22 at 9:20 a.m., she indicated Resident B is usually fairly shy with people she is not familiar with and the nurse on duty (LPN 3) did not work on the memory care unit very often. She indicated she still has no idea why LPN 3 would have given Resident B medications belonging to Resident C, who was not in the facility at the time. She described Resident B as normally alert and likes to observe what is going on around her and after she received the wrong medications, was very lethargic for several days.<br><br>A medication error document, dated 4-18-22, indicated LPN 3 documented the following information, "Patient had mistakenly been given another patient's medication that was absent from | F 0760 | **F760 Residents are Free of Significant Med Errors**<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident B: Medical record was reviewed for documentation that medications are given as ordered.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken**<br>All residents that receive medication administration have the potential to be affected by the same deficient practice.<br>Initial audit<br>DNS or Designee completed a 7 day look back of residents to ensure medications are documented and administered as ordered.<br>Education<br>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 PointClickCare.<br>Nurses educated on proper policy when a medication error occurs, including monitoring a resident's | 06/02/2022 |

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| | the facility. The patient had been given 75 mcg [micrograms] of levothyroxine [used for thyroid health], 81 mg [milligrams] of aspirin [used for cardiovascular health], 50 mg metoprolol [used for high blood pressure], 15 mg olanzapine [an anti-psychotic medication], 20 mg of Fetzima [an anti-depressant medication], and vitamin D3 [vitamin supplement]."<br><br>In an interview with LPN 3 on 5-11-22 at 2:44 p.m., he indicated he had given Resident B the wrong meds on 4-18-22 while he was working on the memory care unit. He indicated there was a QMA [qualified medication aide] who was working the medication cart. "I offered to help her out. The QMA had prepared some of the resident's meds and put them in their med cups in the cart. She told me that one of the cups was for Resident C and she was out on a leave of absence. There were no names on the cups, just had been sat in the cubbies in the top drawer where her meds were. I picked up the cup that I thought was for Resident B. I guess I thought the ladies looked alike and I didn't realize until Resident B had become lethargic that I might have given her the wrong medication." After all this, he indicated he was "talked to" by the facility's management team and was told about not giving meds someone else had prepared. "In report that morning, I was not told that Resident C was in the hospital." LPN 3 indicated the NP was in the building and had checked on the resident when she became lethargic. She first wanted to do labs, but once I told her what I had done and what meds she was given, she told us to just keep an eye on her and check her pretty often to make sure she was breathing okay and to see how alert she was. "I know I did do an SBAR [change in condition notation] and thought that I had documented her assessments in the computer notes. I do | | status every shift until resident is stable. Nurses educated that when a resident discharges to ensure all medications are discontinued in PointClickCare to eliminate medication errors.<br>On-going monitoring<br>DNS or Designee will complete medication administration audits with Nurses and QMAs to assure they are using the 5 rights of medication administration as well as the resident's picture on Point Click Care to assure the right resident receives the right mediation and ensure medications are administered and documented for all residents without medication errors These audits will be conducted on various shifts at various times daily x 6 weeks then then 2 days a week x 2 weeks, then monthly x 4 months.<br>**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**<br>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 audits will continue based on QAPI recommendation. If none noted, then will complete audits based on a prn basis. | |

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| | remember doing a risk assessment tool the day it happened and I thought I had documented how she was doing for later that day and the day or so after that."<br><br>A "Change of Condition," note, dated 4-18-22 at 1:14 p.m. was sent to Resident B's medical team, indicating, "Situation: Patient had noticeable declines in alertness and started becoming increasingly drowsy and nonresponsive. Upon examination it was discovered that the patient had received another patient's medication. Background: Patient is 94 year old female with history of Alzheimer's dementia and cognitive communication deficit. Patient has no known allergies. Assessment: Patient was responsive to speech and would respond when her name was stated by could not tell me her location or day of birth. Patient possessed oxygen of 100, a BP of 126/40, a pulse of 61, a temp of 97.2, and a respiratory rate of 14. Patient possessed clear lung sounds and audible S1 and S2. Response: Patient will be continued to be monitored for signs of decline. Family informed of incident NP informed of incident."<br><br>No other documentation was included in the progress notes by facility staff to indicate the resident's mental status or physical status, until the below alert note and Interdisciplinary Team's (IDT) note on 4-21-22. On the medication administration record (MAR), her blood pressure was documented every 4 hours for 24 hours. The MAR also included documentation of Covid-19 monitoring on a daily basis at 5:00 a.m. This monitoring included the resident's status for fever, feeling feverish/chills, cough, shortness of breath or difficulty breathing, fatigue, sore throat, runny or stuffy nose, muscle pain, body aches, headache, nausea, diarrhea, loss of taste or sense | | | |

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of smell. The monitoring also included checking her temperature and oxygen saturation rates.

Resident B's clinical record indicated she was seen and evaluated by NP 4 on 4-18-22 at 1:05 p.m., due to concerns related to new onset lethargy. Notes indicated Resident B appeared "obtunded [decreased level of alertness]. Arousable to sternal rub. Nonverbal. Speech clear...B/P 130/85 and HR 55...Per CNA, pt had just previously taken a large BM. ? [sign for question] vagal response."

NP 4 visited Resident B again on 4-19-22 at 4:13 p.m. Her notes indicated at that time Resident B was "Awake and alert. Oriented x1 [to self only]. NAD [no acute distress]...It was discovered that pt was given wrong medication including olanzapine. VS [vital signs] stable and pt alert."

NP 5 visited Resident B on 4-20-22 at 11:28 a.m. Her notes indicated Resident B had previously received wrong medications. It indicated the resident appeared to be back to her normal baseline with her dementia diagnosis.

An "Alert Note", dated 4-21-22 at 9:29 a.m., indicated, "Documented 25% or less intake for 2 meals or more in 1 day. NP [nurse practitioner] in house and [other] NP seen the past 2 days. Resident was up for lunch yesterday and more talkative. Resident was asking for food at that times [sic]. Trays had just arrived."

An interdisciplinary team (IDT) note, dated 4-21-22 at 11:40 a.m. indicated, "IDT reviewed in meeting and resident has been seen daily by both Optum and general NP. DNS has also visited. Vitals remain stable. Resident was seen up at the dining room table to eat lunch yesterday and was

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| | asking for food. A snack was provided whileshe waited. Daughter was updated. No further monitoring needed at this time."<br><br>A review of Resident B's medication list at the time of receiving another resident's medications indicated she was not ordered to receive any of the medications she received.<br><br>In an interview on 5-12-22 at 1:15 p.m., with the Director of Nursing (DON), she indicated she had spoken with LPN 3 to try to clarify some issues. She indicated LPN 3 clarified he was in the process of orienting a new agency QMA and was side by side with her at the resident's doorway. He observed the QMA prepare the meds and then they took the medcart down to dining room, thinking Resident B was Resident C. He shared he even asked another CNA which resident was Resident C and the aide just pointed and said that was her there.<br><br>In an interview on 5-12-22 at 1:15 p.m., with the Corporate Nurse, she indicated Resident B had not received her routine morning medications that day and it was documented that the doctor had been notified of that.<br><br>On 5-11-22 at 1:20 p.m., the DON provided a copy of a policy entitled, "Medication Errors," which had a copyright date of 2022 and was indicated to be the current policy utilized by the facility. This policy indicated, "It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors...1. The facility shall ensure medications will be administered as follows: a. According to physician's orders...c. In accordance with | | | |

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| | accepted standards and principles which apply to professionals providing services...3. Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines: a. Resident Condition...b. Drug Category...c. Frequency of Error...4. The facility will consider factors indicating errors in medication administration, including, but not limited to the following: a. Medication not administered not in accordance with the prescriber's orders...c. Medications administered not in accordance with professional standards and principles...7. To prevent medication error and ensure safe medication administration, nurses should verify the following information: a. Right medication, dose, route and time of administration. b. Right resident and right documentation. 8. If a medication error occurs, the following procedures will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. b. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. c. Document actions taken in the medical record. d. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report."<br><br>On 5-12-22 at 11:47 a.m., the Administrator provided a copy of a policy entitled, "Medication Administration," with a copyright date of 2022 and identified this as the current policy utilized by the facility. This policy indicated, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with the professional standards of practice, in a manner to prevent contamination | | | |

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| | or infection...Identify resident by photo in the MAR (medication administration record)..."<br><br>This Federal tag relates to Complaint IN000379555.<br><br>3.1-48(c)(2) | | | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other | | | |

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| | persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>Based on observation, interview and record | F 0880 | | 06/02/2022 |

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| | 155120 | A. BUILDING 00<br>B. WING | 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER | 745 N SWOPE ST<br>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 |
|---|---|---|---|---|
| | review, the facility failed to ensure a staff member's bare hands did not come into contact with a resident's medication during a Medication Administration Observation during 4 observations with 4 staff providing medications to 1 of 8 residents. (Resident E and QMA 7)<br><br>findings include:<br><br>During a Medication Administration Observation with QMA 7 on 5-11-22 at 4:34 p.m., she was observed to prepare Resident E's medication of Buspirone 10 milligrams, 2 pills, a total of 20 milligrams, physician-ordered for three times daily for anxiety. QMA 7 was observed to empty the packet with these 2 pills into her bare hands prior to placing in a packet and crushing the medication and placing the crushed medication into pudding for consumption.<br><br>QMA 7 was then observed to obtain Divalproex 125 milligrams, 3 tablets, physician ordered to receive a total of 375 milligrams, total, twice daily for mood stabilization. QMA 7 was then observed to open the capsules with her bare hands and empty them into pudding for consumption. QMA 7 indicated she was unaware the practice of her bare hands coming in contact with a resident's medication was not an acceptable practice, specific to infection control concerns.<br><br>On 5-12-22 at 11:47 a.m., the Administrator provided a copy of a policy entitled, "Medication Administration," with a copyright date of 2022 and identified this as the current policy utilized by the facility. This policy indicated, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with the professional standards | | **F 880 Infection Prevention & Control**<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>QMA 7 was educated immediately by the DNS for proper medication administration including not touching medications with bare hands.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken**<br>All residents that receive medication administration have the potential to be affected by this same deficient practice.<br>Initial audit<br>DNS or Designee completed an inservice for all Nurses/QMAs on medication administration including not touching medications with bare hands for infection control.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**<br>Education<br>Clinical staff (Nurses/QMAs) were educated on the guidelines for medication administration including not touching medications with bare hands. | |

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| | of practice, in a manner to prevent contamination or infection...Remove medication from source, taking care no to touch medication with bare hand."<br><br>This Federal tag relates to Complaint IN000379555.<br><br>3.1-48(c)(2) | | On-going monitoring<br><br>DNS or Designee will complete medication administration audits with Nurses and QMAs to assure they are not touching the medication with bare hands. These audits will be conducted on various shifts at various times daily x 6 weeks then 2 days a week x 2 weeks, then monthly x 4 months.<br><br>**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**<br>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 will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis. | |