| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155834 | A. BUILDING 00<br>B. WING | 06/12/2023 |

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| BRICKYARD HEALTHCARE - WILLOW SPRINGS CARE CENTEI | 2002 WEST 86TH STREET<br>INDIANAPOLIS, IN 46260 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00409512, IN00409907 and IN00410324. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy.<br><br>Complaint IN00409512 - Federal/State deficiencies related to the allegations are cited at F600.<br><br>Complaint IN00409907 - Federal/State deficiencies related to the allegations are cited at F600 and F839.<br><br>Complaint IN00410324 - No deficiencies related to the allegations are cited.<br><br>Survey dates: June 8, 9, 10 and 12, 2023<br><br>Facility number: 013738<br>Provider number: 155834<br>AIM number: 100272170<br><br>Census Bed Type:<br>SNF/NF: 58<br>Total: 58<br><br>Census Payor Type:<br>Medicare: 3<br>Medicaid: 54<br>Other: 1<br>Total: 58<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review was completed on June 21, 2023. | F 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Sonia Patel | Executive Director | 06/27/2023 |

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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| F 0600<br>SS=J<br>Bldg. 00 | 483.12(a)(1)<br>Free from Abuse and Neglect<br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>Based on interview and record review, the facility failed to ensure a resident was free from neglect when a facility staff member failed to thoroughly assess the resident, report accurate information to the management staff regarding the resident's condition, and notify the physician timely when the resident experienced a change of condition for 1 of 3 residents reviewed for neglect (Resident B). Resident B coded and was sent to the hospital where she later passed away.<br><br>The Immediate Jeopardy began on May 19, 2023, between 8:00 and 8:30 a.m., when a CNA noticed Resident B was not responding as normal and went to the Assistant Director of Nursing (ADON) office for help after she had notified LPN 1 and did not feel LPN 1 took her seriously. LPN 1 indicated to the ADON she checked the resident, and her vitals were within normal limits and her blood sugar was low. At approximately 11:30 a.m., the CNA contacted the ADON for help a second time due to the resident was still declining and | F 0600 | Preparation or excecution of the Plan of Correction does not constitute admission or agreement or conclusion set forth on the statement of deficiencies. The Plan of Correction is prepared and excecuted solely because it is required by the position of Federal and State law. The Plan of Correction is submitted to respond to allegations of noncompliance cited during Complaint Survey ending on 6-12-23. Please accept this Plan of Correction as the provider's credible allegation of compliance.<br><br>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.<br>- Resident B: No longer resides at | 06/26/2023 |

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| | LPN 1 was not responding to the CNAs request to re-evaluate the resident, the resident then coded, was sent to the hospital, and later passed away. The Executive Director (ED) and Director of Nursing (DON) were notified of the immediate jeopardy at 4:25 p.m., on 6/09/23. The immediate jeopardy was removed on 6/10/23, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Finding includes:<br><br>An anonymous complaint sent to the Indiana Department of Health indicated, on 5/19/23, it was reported to the nurse a female resident was not responding several times, the resident then coded and died from neglect.<br><br>The record for Resident B was reviewed on 6/9/23 at 9:35 a.m. Diagnoses included, but were not limited to, nonrheumatic mitral (valve) stenosis, nonrheumatic aortic (valve) stenosis, atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertension, end stage renal disease, anemia in chronic kidney disease, hypotension of hemodialysis, dependence on renal dialysis, personal history of sudden cardiac arrest, dependence on supplemental oxygen, and chronic respiratory failure with hypoxia.<br><br>The progress notes for Resident B were reviewed and indicated the following:<br>a. On 5/19/23 at 7:58 a.m., entered as a late entry on 5/22/23 at 4:35 p.m., LPN 1 indicated she went to give medications to the resident when the resident was observed lethargic. Vital signs were taken, and the resident's blood pressure was | | the facility.<br><br>2. 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 have the potential to be affected. When a change i condition is reported to the charge nurse or manager, the charge nurse or manger will go and assess the resident him or herself.<br>- All residents were assessed and vitals signs completed to identify change in condition and notification was made to physician of any noted changes.<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- All licensed nurses were educated by the DON/designee on change of condition and physician notification regulations, as well as facility policy and procedure.<br>- All staff were educated on Abuse, Neglect, and Exploitation policy to include timely reporting.<br>- When a change of condition is reported to the management, management is to go and assess resident him or herself.<br>- All nurse aides were educated by the DON/designee on change of condition regulations to promote their situational understanding and | |

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| | 77/44. The resident was given her medications along with her midodrine medication she received three times a day (a medication used to treat orthostatic hypotension which was a sudden fall in blood pressure which occurred when a person assumed a standing position). The resident was able to swallow her pills whole with water.<br><br>b. On 5/19/23 at 7:59 a.m., entered as a late entry on 5/22/23 at 4:51 p.m., LPN 1 indicated the resident's oxygen was 67% and her oxygen was turned up to 5 lpm (liters per minute). Her oxygen returned to 97% then went back to 87% on 5 lpm currently at that time.<br><br>c. On 5/19/23 at 11:50 a.m., entered as a late entry on 5/22/23 at 11:39 a.m., the ADON (Assistant Director of Nursing) indicated at approximately 11:40 a.m., she was notified by the floor CNAs to assess the resident. Resident was found lethargic and unresponsive to sternal rub. The resident's vital signs were checked, and the resident was found to be hypotensive and hypoxic. The ADON ran down the hall to get the physician. LPN 1 was notified to call 911. Emergency interventions were implemented once no pulse was detected. Code Blue was called, crash cart was obtained, and compressions were initiated. EMS arrived at approximately 12:05 p.m. and took over emergency interventions.<br><br>d. On 5/19/23 at 12:00 p.m., entered as a late entry on 5/22/23 at 12:14 p.m., the Unit Manager indicated at approximately 11:51 a.m., she was notified by the ADON to come help with an emergency. She went to get the Ambu bag and crash cart. Approximately 12:09 p.m., LPN 1 started giving compressions. At 12:10 p.m., the DON took over for the nurse and at 12:16 p.m., EMS arrived. | | facilitate communication with the licensed nurses.<br><br>4. 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>-Director of Nursing/designee will review documentation during daiy clinical review for change in condition that may need further investigation or intervention.<br>- An Ad hoc Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) with a focus on physician notification of resident changes of condition.<br>- The Director of Nursing/designee will complete chart audits/health documents assessment for 3 residents weekly for 4 weeks, then 2 residents weekly for 2 weeks, then 2 residents a month for 2 months.<br>- The regional nurse consultant/designee will visit facility (weekly x 5 weeks, monthly thereafter for 6 months, if no trends are identified monitoring will continue as PRN) to provide general oversight and monitoring of the PIP.<br><br>5. Date of Compliance.<br>6-26-23 | |

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e. On 5/19/23 at 12:08 p.m., entered as a late entry on 5/22/23 at 11:34 p.m., the DON indicated a code blue was called overhead. He entered the resident's room and relieved the staff nurse doing compressions until EMS arrived.

f. On 5/19/23 at 2:19 p.m., LPN 1 documented the resident was observed cold, diaphoretic, lethargic and unresponsive. Vital signs were unstable with a blood pressure of 77/44, pulse was 41 and was weak and thready. Blood sugar was 148 at 7:00 a.m., and 223 at 11:20 a.m. She called for help from the ADON and physician. The resident's oxygen saturation was 46% on 5 lpm per mask. Compressions were started by LPN 1, then the DON took over compressions as LPN 1 went to call 911. EMS arrived on site and took over. The resident was unstable when she left.

The vital signs for Resident B, on 5/19/23, were reviewed and the following were documented:
a. On 5/19/23 at 7:00 a.m., the resident's blood pressure was 99/55, respirations were 18 breaths per minute, heart rate was 59 beats per minute, oxygen saturation was 67% with oxygen via nasal cannula, and her blood sugar was 148.

b. On 5/19/23 at 9:22 a.m., the resident's blood pressure was 132/52, heart rate was 86 beats per minute, and her blood sugar was 148.

c. On 5/19/23 at 11:54 a.m., the resident's blood pressure was 77/44, respirations were 18 breaths per minute, heart rate was 58 beats per minute, oxygen saturation was 55% with oxygen via nasal cannula, and her blood sugar was 223.

A written statement by CNA 2, undated, indicated she went to check on Resident B and get her

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| | ready for dialysis. She noticed she was not herself and notified the nurse. The nurse went to check on her, indicated everything was normal and gave her medications. She still was not acting herself; she did not see the nurse, so she went the Unit Manager. The Unit Manager found the nurse, the nurse said her blood sugar was low, so the resident was given sugar water. She was asked to keep an eye on the resident. She noticed how "loud she was snoring" and told the nurse something was wrong, and she was not any better. The nurse said when the sugar was low it took a minute to get back up. CNA 2 saw the ADON and asked her to please come look at the resident as she was not herself. The ADON took all vitals and had the doctor come to her room.<br><br>A written statement by the Unit Manager, dated 5/19/23, indicated CNA 2 told her Resident B was not acting right. She went to the resident's room. She asked the resident's nurse what was wrong and was told her blood sugar was low. The Unit Manager could not get the resident to drink orange juice, so she gave her some sugar water. She said the resident's name and the resident responded. She then left and went to morning meeting. After morning meeting, she heard a call from the ADON, there was an emergency upstairs. The physician, ADON, and CNA were in the resident's room. Code blue was called, and she went to get the crash cart and AED. Emergency Medical Services (EMS) arrived and took over compressions.<br><br>A written statement by the ADON, dated 5/19/23, indicated at 8:00 a.m., she was informed by the floor nurse Resident B had a low blood sugar. She went to the resident's room and noted the resident was verbally responsive and able to drink a cup of orange juice and took a few bites of her breakfast. | | | |

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| | She informed the resident's nurse to monitor for signs and symptoms of hypoglycemia. After morning meeting, she returned to the floor and was informed by the resident's nurse the resident was stable. At approximately 11:40 a.m., the second floor CNAs approached her in her office and requested her to come assess the resident because they were concerned, their reports to the nurse were not being acknowledged and the resident was lethargic. When she arrived in the room, the resident was lethargic and not responding to her name or sternal rubs. LPN 1 had followed her into the room. She asked LPN 1 what the resident's last blood pressure was and was told it was in the 140's. The ADON left the room to obtain a stethoscope, manual blood pressure cuff, and other equipment to assess the resident. The resident's blood pressure when taken with the manual cuff was 70/42. The ADON had a hard time obtaining the resident's oxygen saturation and asked LPN 1 what the resident's oxygen saturation was this morning. LPN 1 indicated it was 67% and she had bumped the resident oxygen up to 5 lpm from her ordered 2 lpm via nasal cannula. The ADON asked LPN 1 if she notified the physician regarding the low oxygen level and if she had reassessed the resident. LPN 1 did not directly answer and began to get off the subject. The second floor CNA remained with the resident while the ADON ran to get the physician. Emergency interventions were immediately implemented.<br><br>A hospital ER (Emergency Room) Exam and Disposition, dated 5/19/23 at 1:36 p.m., indicated Resident B was brought into the ER, on 5/19/23 at 12:55 p.m., for a cardiac arrest (no respirations and no pulse). She did not feel well that morning and did not go to dialysis. According to the physician at the facility, who came with the resident to the | | | |

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| | ER, she had an episode of being short of breath and complained of shortness of breath, then began having agonal respirations. After the EMS (Emergency Medical Services) arrived at the facility, the resident was intubated by the physician attending to her care while at the facility. EMS ran the code, while the physician intubated her. When she was received in the ER, she was unresponsive, with an ET (Endotracheal tube-to help a resident breathe easier) and CPR (Cardiopulmonary Resuscitation) was in progress. Her respirations became agonal, then she cardiac arrested at that the facility. The ER physician indicated it was unclear how long Resident B was down, but she received three doses of epinephrine (a medication, which helps start a resident's heart after it had stopped). She had a brief second round of CPR in the ER after arriving at the hospital. Resident B passed away on 5/20/23 at 2:08 a.m.<br><br>A hospital discharge summary, dated 5/20/23 at 6:46 p.m., indicated Resident B presented to the ER after being seen by the facility physician for complaints of not feeling well. The resident had agonal breathing and quickly developed cardiac arrest for 35-40 minutes. Resuscitation efforts were achieved on arrival to the ER, then she had a second cardiac arrest in the ER, which lasted less than 10 minutes. She was placed on four pressor medications (medications used to help keep her blood pressure up). She was intubated and shocked at the facility. The resident remained unresponsive without any sedation. Her condition continued to deteriorate overnight and even though she was on the ventilator for breathing support, she continued to desaturate and was unable to obtain adequate oxygenation. She passed away on 5/20/23. Resident B's number one diagnosis was acute hypoxic respiratory failure | | | |

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| | due to cardiac arrest.<br><br>During an interview, on 6/8/23 at 11:18 a.m., CNA 3 indicated on 5/19/23, before breakfast, she went into Resident B's room to get her up for dialysis and she would not get up because she was in a deep sleep and would not open her eyes, which was not normal for her. She immediately went to LPN 1, who was the resident's nurse and informed her the resident was not acting "like herself." She and CNA 2 went back into her room, between 8:00 and 8:30 a.m., to try to get her up and she was still in the deep sleep and was clammy. CNA 2 immediately went to LPN 1 and informed her the resident was not "right" and she was clammy. LPN 1 told CNA 2 the resident's vital signs were "fine." CNA 2 told LPN 1 again this was not the normal for this resident. Before 9 a.m., CNAs 2 and 3 went to ask the Unit Manager to assess the resident because they did not believe LPN 1 was doing everything she could for Resident B. The Unit Manager (UM) and the Assistant Director of Nursing (ADON) went to her room to check on her, then they left the floor. The UM gave the resident some sugar water for her low blood sugar. CNAs 2 and 3 went to LPN 1, two to three additional times to tell her Resident B's condition was declining. They believed LPN 1 was not responding to their updates on the resident's condition. When the ADON came back to the floor before lunch, CNA 2 asked her to assess the resident because her condition was declining, and LPN 1 was not responding to their requests to help Resident B. The ADON and the resident's physician went to her room and were preparing to start a code on her. 911 had been called, LPN 1 was doing chest compressions, then the DON took over for her, while the ADON and the physician was at the head of the bed with the ambu mask. | | | |

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| | During an interview, on 6/8/23 at 11:38 a.m., the Unit Manager indicated on 5/19/23 at approximately 8:00 a.m., CNA 2 asked her to assess Resident B because she was "a little bit out of it." The resident could talk, and her blood sugar was 67. She told LPN 1 to give the resident some sugar water because she would not drink the orange juice. She went to the morning meeting at approximately 9:00 a.m., and got out at approximately 10:30 a.m. She went on to do other things, while the ADON went to her office. At approximately 11:51 a.m., a call came over the overhead speakers for a Code Blue for the second floor. When she got to Resident B's room, CNA 2, RN 3, and the resident's physician was in the room with the resident. The physician was listening to the resident's lungs, the ADON was feeling for a pulse and CNA 2 was doing whatever they asked her to do. 911 was called. Approximately 12:00 p.m., she went and got the ambu bag, the crash cart, and the AED machine. LPN 1 started CPR, then the DON took over the compressions and the ADON was using the ambu bag. The resident was going "downhill" before EMS arrived. EMS took over once they arrived at the facility. LPN 1 was terminated from the facility for "Neglect and Gross Misconduct" and the incident with Resident B played a part in her being terminated from the facility.<br><br>During an interview, on 6/8/23 at 12:21 p.m., the ADON indicated on 5/19/23 between 8:00 a.m., and 8:30 a.m., CNA 2 and 3 came to her and asked her to check Resident B. The ADON was told Resident B had a low blood sugar. She did not verify the resident had a low blood sugar that morning. The Unit Manager gave the resident sugar water and told the CNAs to make sure she ate her breakfast. The ADON went to the morning | | | |

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| | meeting around 9:00 a.m., and got out around 11:00 a.m., and at 12:00 p.m., she went to her office. She was retrieved from her office by CNA 2 and 3 to assess Resident B because they had asked LPN 1 to check on her throughout the morning and she would not do it. As soon as she went into the room, LPN 1 followed her in the room. Resident B was not responding to verbal stimuli or a hard sternal rub. Her blood pressure was "super low" and her oxygen (O2) was in the 70's on 5 L/min (liters/minute) of oxygen. The physician order was for 2 L/min. When she asked LPN 1 why she was on 5 L/min, LPN 1 indicated her O2 sats were low (67%) that morning, so she "bumped" her oxygen up to 5 L/min. LPN 1 had told the ADON the resident's blood sugar was low that morning not her oxygen level. She placed her on a non-rebreather oxygen mask, then ran to get the resident's Physician, who was in the building at that time. When the ADON was questioning LPN 1 regarding the resident's condition status, between 8:00 a.m. and 8:30 a.m., LPN 1 should have given her the correct information about her oxygen levels being low instead of her blood sugar being low, because she would have been sent out to the hospital then. The ADON indicated this was "plain and simple Neglect of a resident" by LPN 1. LPN 1 had issues prior to that incident, she was given verbal counseling for issues such as; leaving medications at the bedside and not communicating resident information with the other shift. She openly admitted she did not listen to the resident's lungs because she did not have a stethoscope to listen to them. The physician assessed Resident B, a code was called, 911 was called, and they coded the resident for 30 minutes until EMS got there and took over. The AED machine shocked the resident after the EMS got to the facility. EMS was coding her on the way to the hospital and her | | | |

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| | physician intubated her prior to leaving the facility and followed her to the hospital. After EMS left with the resident, the ADON went to her office and immediately started writing her statement of the account of what happened that day. She had a "sick feeling in the pit of her stomach" about LPN 1, so she looked up her Nursing license and discovered she had a probationary nursing license which she did not know about. She immediately went to the DON to inform him of LPN 1 having a probationary license since 2016, which he was not aware of either.<br><br>During an interview, on 6/8/23 at 2:59 p.m., the DON (Director of Nursing) and ED (Executive Director) were in attendance. The HR Manager was responsible for pulling the licenses and certificates and notifying the DON of any issues with those prior to hiring the individuals. The DON indicated he was not aware LPN 1 had a probationary license. The HR Manager never told him LPN 1 had a probationary license since 2016. When he asked the HR Manager why she did not tell him LPN 1 had a probationary license, she indicated she thought LPN 1 had told him. He should have been writing quarterly follow-ups on her to the Indiana State Board of Nursing. When he asked LPN 1 why she did not tell him she had a probationary Nursing license, she indicated she was going to tell him when he had to fill out her Quarterly probation performance report. At that time, the ED indicated she was not aware LPN 1 had a probationary license either. LPN 1 was terminated for using her personal cell phone in front of residents and attendance issues.<br><br>During an interview, on 6/8/23 at 3:20 p.m., with the DON and ED in attendance. The DON indicated LPN 1's duties included, but were not limited to, passing medications including | | | |

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| | controlled substances, completing assessments of residents such as skin and change of condition, documenting in the resident records, overseeing and supervising CNA's and QMA's, and calling the physician for orders.<br><br>During an interview, on 6/12/23 at 11:30 a.m., LPN 1 indicated she always took her residents' vital signs when she first came on duty. Resident B's blood pressure (BP) at 6:15 a.m., was 137/53, then at 8:00 a.m., her BP was 77/40 and her blood sugar was 147. Breakfast came, but the resident did not eat. When she administered the resident's medications to her at approximately 8:00 a.m., she was not responding, so she had to give her a "hard" sternal rub to get her to wake up and take her medications. When she went down to the resident's room at the time the ADON and the physician was in her room, she was snoring, then she started having agonal breathing. She did not know the UM gave the resident sugar water for a low blood sugar. She did not send her out to the hospital for a condition change because the nurses were not allowed to call 911 or send residents out to the hospital until they contacted the DON first, according to the "hidden policy." LPN 1 indicated a "hidden policy" was a policy which was not an official policy, but it was a note written by the DON for the staff to follow.<br><br>During an interview, on 6/12/23 at 3:01 p.m., CNA 2 indicated Resident B had an appointment the morning of 5/19/23, so she had to get her up and ready. She was not talking and would not wake up for her, which was unusual, so she went to get CNA 3 to ask her if she was able to wake the resident up. CNA 2 went to get LPN 1 to inform her Resident B did not look good and was not acting like herself and she was clammy. Between 8:00 a.m. and 11:00 a.m., CNA 2 tried to feed the | | | |

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| | resident, but she would not wake up to eat. She was able to hear her snoring while in another resident's room which was not normal for her. She went to LPN 1 again trying to get some help for the resident because she did not look good. LPN 1 indicated the resident's vital signs were good. CNA 2 had the UM go look at the resident and she gave her some sugar water because she had gotten information her blood sugar was low. She asked LPN 1 to assess Resident B once again, but LPN 1 never went into the resident's room to assess her. When the ADON got back into her office, from the morning meeting, CNA 2 and CNA 3 went to her office and asked her to go assess Resident B due to LPN 1 was not assessing her when she was told there was a change in her condition. The resident ended up being coded shortly thereafter.<br><br>LPN (Licensed Practical Nurse) 1's nursing license indicated, on 8/3/16, "Reinstatement of a Suspended License Once the Board Feels the Licensee is able to Practice with Reasonable Skill and Safety Probation."<br><br>A facility document indicated LPN 1 was terminated for Category I, which was gross misconduct due to her failing her 90-day probationary period related to not following up with a provider on a resident status decline and she had multiple verbal counseling moments/teachable moments to correct performance as evident by phone usage while on the floor and leaving medications at the bedside.<br><br>A current policy, titled "Notification of Changes," dated October 2022 and provided by the DON on 6/8/23 at 2:08 p.m., indicated "Policy: The purpose of this policy is to ensure the facility promptly...consults the resident's physician; and | | | |

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| | notifies, consistent with his or her authority...when there is a change requiring notification. Definitions: 'Life-Threatening conditions...Need to alter treatment significantly' means a need to stop a form of treatment because of adverse consequences (such as adverse drug reaction), or commence a new form of treatment to deal with a problem (for example the use of any medical procedure, or therapy that has not been used on that resident before)...Circumstances requiring notification include...Significant change in resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: Life-threatening conditions, or Clinical complications. Circumstances that require a need to alter treatment. This may include: New treatment. Discontinuation of current treatment due to: Adverse consequences. Acute condition. Exacerbation of a chronic condition. A transfer or discharge of the resident from the facility...Competent individuals: The facility must still contact the resident's physician and notify resident's representative, if known...."<br><br>A current policy, titled "Abuse, Neglect and Exploitation" dated October 2022 and provided by the ED on 6/10/23 at 4:16 p.m., indicated "Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property...'Neglect' means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress...IV. Identification of Abuse, Neglect and Exploitation...B. Possible indicators of abuse include, but are not limited | | | |

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| | to...8. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & [and] positioning...."<br><br>The Immediate Jeopardy that began on 5/19/23 was removed on 6/10/23 when all nursing staff were educated on what to do for a resident with a change of condition, educated on reporting accurate information about a resident's condition to the management staff, management staff were educated to verify the information given from nursing staff was accurate and staff were educated to notify the physician when a change a condition had occurred.<br><br>This Federal tag relates to Complaints IN00409512 and IN00409907.<br><br>3.1-27(a)(3) | | | |
| F 0839<br>SS=D<br>Bldg. 00 | 483.70(f)(1)(2)<br>Staff Qualifications<br>§483.70(f) Staff qualifications.<br>§483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.<br><br>§483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.<br>Based on interview and record review, the facility failed to ensure a staff member had the appropriate qualifications and current license to perform the duties of a Licensed Practical Nurse (LPN) during the 69 day time period she was hired at the facility and failed to ensure the management staff was aware a LPN was working with a probationary nursing license during the 51 day | F 0839 | 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.<br>- Both Nurses are no longer employed at the facility. | 06/26/2023 |

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| | time period she was hired at the facility for 2 of 2 staff reviewed for staff qualifications.(Employee 6 and LPN 1)<br><br>Findings include:<br><br>1. An anonymous complaint sent to the Indiana Department of Health indicated Employee 6 was the "nurse" who was arrested for not being a nurse, and who had stolen license numbers. She was reported on the news, on 5/31/23, for frequently working as a nurse.<br><br>During an interview, on 6/8/23 at 2:08 p.m., the ED (Executive Director) and the DON (Director of Nursing) was in attendance. The ED indicated Employee 6 was working at the facility as an LPN, but no one in the management staff had any idea she was working as an LPN without a valid Nursing license. The DON indicated he received a phone call from corporate the day he walked Employee 6 out (3/20/23). He walked the employee out of the facility immediately, but the corporate office did not explain to the ED or DON why until after she was terminated and walked out of the facility. She was hired on 1/10/23.<br><br>During an interview, on 6/8/23 at 2:27 p.m., the DON, ED, and Human Resource (HR) manager were in attendance. The HR manager indicated she could not remember what explanation Employee 6 told her for the reason there was a difference between her last name on her job application and her Nursing license. The HR manager did not verify Employee 6's name on her Nursing license she provided prior to her being hired. The ED indicated at that time, Employee 6 had three different Social Security numbers using three different peoples' names, five different drivers' licenses and one Nursing license, so she | | 2. 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 have the potential to be affected. HR will complete all documentation verification including social security numbers and licenses for all new hires prior to orientation.<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- An audit has been completed of all licensed employees to verify active licenses. HR manager will continue to audit and complete new hire verification which will be reviewed by the Executive Director monthly.<br><br>4. 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>- HR manager will track and audit all new hires monthly and present the audits at the montly Quality Assurance meeting. This will be ongoing.<br><br>5. Date of Compliance.<br>6-26-23 | |

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| | did not even know if her true name was the one, she had on her job application or not. At that time, the DON indicated he walked her out, on 3/20/23, without any knowledge as to why he was terminating her.<br><br>During an interview, on 6/8/23 at 2:59 p.m., the DON indicated the HR manager was waiting for Employee 6's fingerprint background check to come back, but she never received them. Employee 6 had an appointment to go get her fingerprint background check completed.<br><br>During an interview, on 6/8/23 at 3:20 p.m., the ED and DON were in attendance. The ED indicated Employee 6 was hired for employment in October 2022, but she never came to work for the facility, so she had to be terminated from their system. She was rehired in January 2023 as a LPN. The DON indicated she worked as an LPN completing LPN duties which included, but were not limited to, the following: passing medications including insulin and controlled substances, completing assessments of residents' skin and changes in condition, documenting in resident records', overseeing and supervising CNA's and QMA's, and calling physicians for orders.<br><br>A record review of Employee 6's employee file was completed on 6/8/23 at 3:15 p.m.<br><br>a. Employee 6's date of hire was 1/10/23 and her termination date was 3/20/23.<br><br>b. Employee 6 indicated on her job application she attended a Community College in Knoxville, Tennessee for 1 year to earn her LPN degree. She had worked at another facility from 2018 to that present time frame. | | | |

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| | c. She had two Indiana State Police background checks indicating they were "Inconclusive Results-Fingerprint Recommended" dated 10/26/22 and 1/10/23. The background check requesting fingerprints, dated 10/26/23, had a birthdate ending in 1975 and the background check requesting fingerprints, dated 1/10/23, had a birthdate ending in 1973. The month and day were the same, but the years were different on the two fingerprint background checks.<br><br>d. There was a registration appointment document indicating Employee 6 had an appointment, on 1/25/23 at 12:30 p.m., to get her fingerprint background check completed, but there were never any results from this background check given to the facility. There was a copy of a receipt from where the fingerprint background check was paid for on 3/8/23, so she could get the background check completed, but the facility never got the fingerprint results given to them.<br><br>e. The Licensed Practice Nurse license Employee 6 was using indicated a different last name from the name on her employment application with her name on her application in parenthesis next to the name on the license. The license indicated she had received the license on 4/10/1996, and she also had a compact license (a license in which she could go from state to state and work without retesting for a new license if that state was one of the compact licensing states).<br><br>f. Employee 6 had State of Indiana tax forms she had completed on 10/25/23 and 1/9/23. Both of those documents had different social security numbers on them.<br><br>g. On 3/1/23, she was given an educational moment for complaints from residents and | | | |

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| | residents' family members, the residents were given the wrong medication during medication pass, and she had left her medication cart unlocked.<br><br>h. A document, titled "Job Description," for Nurse Staff LPN was signed by Employee 6 and the HR manager on 1/10/23. The "Job Description" indicated Employee 6 provided nursing care to residents under the direction of a supervisor and as prescribed by the residents' Physician and in accordance with the standards of nursing practices and regulations and directed by a supervisor. Essential Job duties included but were not limited to the following: supervise under the direction of a supervisor, other professional and non-professional staff in the day-to-day delivery of resident care. Monitor resident activity and provide nursing care directed by a supervisor and according to the Physician's order, care plans, established standards and facility policies. Communicate with residents, family members, other interdisciplinary team members and management. Prepare and administer medications under the direction of a supervisor and as ordered by the residents' Physician in accordance with nursing standards and facility policy. Signed, dated, and performed all charting and record keeping in accordance with established policies and procedures. Assisted the supervisor as directed and participated in developing and implementing a written care plan for individual residents that addressed the needs of the resident. She must have adhered to the company's Code of Conduct and Business Ethics policy including documentation and reporting responsibilities. The qualifications she had to meet were high school diploma or equivalent and she must have held and maintained a current license to practice as an LPN in the State of | | | |

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| | Indiana.<br><br>2. An anonymous complaint sent to the Indiana Department of Health indicated, on 5/19/23, it was reported to the nurse a female resident was not responding several times, the resident then coded and died from neglect. A CNA noticed Resident B was not responding as normal and went to the Assistant Director of Nursing (ADON) office for help after she had notified LPN 1 and did not feel LPN 1 took her seriously. LPN 1 indicated to the ADON she checked the resident, and her vitals were within normal limits and her blood sugar was low. At approximately 11:30 a.m., the CNA contacted the ADON for help a second time due to the resident was still declining and LPN 1 was not responding to the CNAs request to re-evaluate the resident, the resident then coded, was sent to the hospital, and later passed away.<br><br>During an interview, on 6/8/23 at 11:38 a.m., the Unit Manager indicated LPN 1 was terminated from the facility for "Neglect and Gross Misconduct" and the incident with Resident B played a part in her being terminated from the facility.<br><br>During an interview, on 6/8/23 at 12:21 p.m., the ADON indicated the incident with Resident B involving LPN 1 was "plain and simple neglect of a resident". LPN 1 had issues prior to the incident, she was given verbal counseling for issues such as leaving medications at the bedside and not communicating resident information with the other shift. After EMS left with Resident B, the ADON went to her office and immediately started writing her statement of the account of what happened that day. She had a "sick feeling in the pit of her stomach" about LPN 1, so she looked up her nursing license and discovered she had a | | | |

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| | probationary nursing license which she did not know about. She immediately went to the DON to inform him of LPN 1 having a probationary license since 2016, which he was not aware of either.<br><br>During an interview, on 6/8/23 at 2:59 p.m., the DON and ED were in attendance. The HR Manager was responsible for pulling the licenses and certificates and notifying the DON of any issues with those prior to hiring the individuals. The DON indicated he was not aware LPN 1 had a probationary license. The HR Manager never told him LPN 1 had a probationary license since 2016. When he asked the HR Manager why she did not tell him LPN 1 had a probationary license, she indicated she thought LPN 1 had told him. He should have been writing quarterly follow-ups on her to the Indiana State Board of Nursing. When he asked LPN 1 why she did not tell him she had a probationary Nursing license, she indicated she was going to tell him when he had to fill out her Quarterly probation performance report. At that time, the ED indicated she was not aware LPN 1 had a probationary license either. LPN 1 was terminated for using her personal cell phone in front of residents and attendance issues.<br><br>During an interview, on 6/8/23 at 3:20 p.m., with the DON and ED in attendance. The DON indicated her duties included, but were not limited to, passing medications including controlled substances, completing assessments of residents such as skin and change of condition, documenting in the resident records, overseeing and supervising CNA's and QMA's, and calling physicians for orders.<br><br>A record review of LPN 1's employee record was completed on 6/8/23 at 3:30 p.m.<br>a. LPN 1's start date was 4/4/23 and her | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155834 | A. BUILDING 00<br>B. WING | 06/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BRICKYARD HEALTHCARE - WILLOW SPRINGS CARE CENTEI | 2002 WEST 86TH STREET<br>INDIANAPOLIS, IN 46260 |

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| | termination date was 5/25/23.<br><br>b. LPN 1's nursing license indicated, on 8/3/16, "Reinstatement of a Suspended License Once the Board Feels the Licensee is able to Practice with Reasonable Skill and Safety Probation."<br><br>c. An education moment, dated 5/15/23, indicated LPN 1 was educated for not adhering to the policies and procedures when she did not chart all the necessary information as to the continuity of care and for a resident's safety when a resident had a fall while out for an appointment. She failed to document a progress report or a skin event for abrasions to the resident's knees in the resident's records in the computer.<br><br>d. A facility document indicated LPN 1 was terminated for Category I, which was gross misconduct due to her failing her 90-day probationary period related to not following up with a provider on a resident status decline and she had multiple verbal counseling moments/teachable moments to correct performance as evident by phone usage while on the floor and leaving medications at the bedside.<br><br>e. A document, titled "Job Description," for Nurse Staff LPN was signed by LPN 1 and the HR manager on 4/4/23. The "Job Description" indicated LPN 1 provided nursing care to residents under the direction of a supervisor and as prescribed by the residents' physician and in accordance with the standards of nursing practices and regulations and directed by a supervisor. Essential Job duties included but were not limited to the following: supervise under the direction of a supervisor, other professional and non-professional staff in the day-to-day delivery of resident care. Monitor resident activity and | | | |

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| | provide nursing care directed by a supervisor and according to the Physician's order, care plans, established standards and facility policies. Communicate with residents, family members, other interdisciplinary team members and management. Prepare and administer medications under the direction of a supervisor and as ordered by the residents' Physician in accordance with nursing standards and facility policy. Signed, dated, and performed all charting and record keeping in accordance with established policies and procedures. Assisted the Supervisor as directed and participated in developing and implementing a written care plan for individual residents that addressed the needs of the resident. She must have adhered to the company's Code of Conduct and Business Ethics policy including documentation and reporting responsibilities. The qualifications she had to meet were high school diploma or equivalent and she must have held and maintained a current license to practice as an LPN in the State of Indiana.<br><br>During an interview, on 6/12/23 at 11:30 a.m., LPN 1 indicated she was terminated from the facility because she did not tell the management staff, she was working with a probationary nursing license.<br><br>This Federal tag relates to Complaint IN00409907.<br><br>3.1-14(s) | | | |