STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155390	A. BUILDING 00 B. WING	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - WOODBRIDGE CARE CENTER	816 N FIRST AVE EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00411219. Complaint IN00411219 - Federal/state deficiencies related to the allegations are cited at F580. Unrelated deficiencies. Survey dates: June 28 & 29, 2023 Facility number: 000438 Provider number: 155390 AIM number: 100274170 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 3 Medicaid: 44 Other: 7 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 5, 2023.	F 0000	PLAN OF CORRECTION FOR WOODBRIDGE CARE CENTER F000 INITIAL COMMENTS . The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after July 22, 2023.	
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-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lana Ballard	Area Vice President/HFA	07/21/2023

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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	(A) An accident involving the resident which 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			

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	that comprise the composite distinct part, 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 provide notification of change for 1 of 3 residents reviewed for notification. A resident's representative was not notified of an incident with another resident. (Resident P) Finding includes: On 6/28/23 at 11:00 A.M., Resident P's clinical record was reviewed. Resident P was admitted on 5/25/23. Diagnosis included, but were not limited to, dementia. The most recent quarterly MDS (minimum data set) Assessment, dated 6/9/23, indicated no cognitive impairment. Resident P required extensive assistance of one staff with bed mobility, transfers, and toileting, had behaviors of rejection of care, but no other behaviors. Progress notes included, but were not limited to, the following: 6/18/23 Resident in the Dining Room with a female resident, he had her shirt pulled up and was having inappropriate conduct with (her). Female resident was allowing this to occur. One on one given to resident and educated on inappropriateness of sexual behavior in common areas and behavior improved. MD (Medical Director) aware. Will continue to monitor. Documented by LPN (Licensed Practical Nurse) 9. 6/22/23 IDT (Interdisciplinary Team) Note: Behavior, inappropriate touching. Seen by (psych services). Will be seen next week, 6/26/23. MD and family notified. Has brother in (city) that is active in his care. No visitation noted. Friends	F 0580	F580 Notification of Changes What correction action(s) will be accomplished for those residents found to have been affected by the deficient practice? · After assessment, Resident P had no negative outcome due to this alleged deficient practice. Resident P's responsible party/ brother was notified of alleged incident, and this was documented in the resident's clinical record. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · IDT will review all future incidents and ensure all family notifications were completed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · All licensed nursing staff and IDT will be re-educated and in-serviced on resident notification change. · Daily audits will be completed by the DNS/designee to ensure notifications are being	07/22/2023

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	visit. Phone conversations frequently. Documented by RN (Registered Nurse) 5. On 6/28/23 at 11:34 A.M., Resident P's brother indicated via phone call that he was listed as the resident's only contact, and the only person that should have been notified of any change of condition or incidents that may have happened with the resident. He indicated he had not received any phone calls from the facility since admission related to any behaviors or otherwise. He indicated that, to his knowledge, there had not been any incidents that have happened since his admission, and indicated Resident P had not had any behaviors of sexual inappropriateness prior to admission, or since admission. On 6/29/23 at 6:30 A.M., LPN 9 indicated she was the nurse on the unit at the time of the incident involving Resident P on 6/18/23, but did not witness it directly. She indicated she reported the incident to the Administrator, the MD, and the family. She indicated the family was concerned about the incident because "this type of behavior had happened before". On 6/29/23 at 9:45 A.M., RN 5 indicated the nurse that was on the unit during the incident with Resident P on 6/18/23 did not notify the resident's family. She indicated that she did not notify the family either, but would take a look at the progress notes and see if she remembered anything. RN 5 did not indicate remembering anything after that time. On 6/29/23 at 11:42 A.M., a current non-dated Notification of Changes policy was provided, and indicated "The purpose of this policy is to ensure the facility promptly informs the resident consults with resident's physician; and notifies, consistent		completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · To ensure compliance, the ED or designee will be responsible for the completion of notification to responsible party/family member tool to include documentation in the Residents clinical record weekly times 4 weeks, monthly times 6 months and then quarterly until continued compliance is maintained. If a threshold of 100% is not achieved an Action Plan will be developed to ensure compliance. Date of Compliance: July 22, 2023.	

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	with his or her authority, the resident's representative when there is a change requiring notification ... Circumstances requiring notification include: ... Accidents ... Potential to require physician intervention". This Federal tag relates to Complaint IN00411219. 3.1-5(a)			
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview, and record review, the facility failed to ensure behavioral health services were provided to a resident with a history of trauma to obtain the highest practicable well-being for 1 of 4 residents reviewed for behaviors. (Resident D) Finding includes: On 6/28/23 at 9:50 A.M., Resident D indicated he was having trouble sleeping at night due to nightmares related to childhood trauma. He indicated during the day, he could not stop thinking about the trauma he had endured in his past. He indicated he had notified the Social	F 0742	F742 Treatment/Services Mental/Psychosocial Concerns What correction action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident D had no negative outcome due to this alleged deficient practice. Resident D has received mental health services and continues with regular visits. How will you identify other residents having the potential to	07/22/2023

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	Services Director (SSD) that there was some trauma in his past, but had not shared details. He indicated he wished to share the concern in detail with a doctor, but had not had the opportunity to do so yet. At that time, Resident D was visibly upset, and pausing several times during the interview when remembering details of the trauma that was being relayed. On 6/28/23 at 10:00 A.M., the SSD indicated she was aware that Resident D had some sort of childhood trauma, but did not know the details. She indicated any time a resident shared with her that they had a history of trauma, she would sign them up for psychiatric services, and had done so with Resident D. She indicated she had spoken with Resident D about any possible triggers he had related to his past trauma, and none were identified, so a care plan was not developed. On 6/28/23 at 10:05 A.M., QMA (Qualified Medication Aide) 17 indicated she was unaware of Resident D's inability to sleep at night, but would pass that information along to a nurse so the doctor could be notified. On 6/28/23 at 1:27 P.M., Resident D's clinical record was reviewed. Resident D was admitted on 4/26/23 from the hospital. Diagnosis included, but were not limited to, dementia, epilepsy, anxiety depression, and psychotic disorder. The most recent admission MDS (minimum data set) Assessment, dated 5/13/23, indicated no cognitive impairment. Resident D required supervision of one staff with bed mobility, transferring, and eating, and limited assistance of one staff with toileting. The MDS indicated no behaviors. Resident D had indicated little interest or pleasure in doing things, feeling down, depressed, or hopeless, trouble falling or staying asleep, or		be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · 100% audit completed of residents who have signed up for mental health services to ensure all are receiving those services. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · SSD/designee will assess new admissions for mental health service requests and add them to the list to treated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · To ensure compliance, the ED or designee will be responsible for the completion of Mental Health/Psych services tool weekly times 4 weeks, monthly times 6 months and then quarterly until continued compliance is maintained. If a threshold of 100% is not achieved an Action Plan will be developed to ensure compliance. Date of Compliance: July 22, 2023.	

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	sleeping too much, feeling tired or having little energy, and feeling bad about self. Current physician orders included, but were not limited to: Psych services may evaluate and treat, dated 5/6/23. A current psychotropic medication use care plan, initiated 5/15/23, indicated an intervention that included, but was not limited to, refer to mental health services for medication and behavior intervention recommendations, dated 5/15/23. A current at risk for sleep pattern disturbance care plan indicated resident had a diagnosis of sleep disturbance. A current mental health needs care plan, initiated 5/17/23, included interventions to provide the resident with opportunity to express mental health needs to staff, dated 5/17/23, and skilled nursing staff will provide routine opportunities to identify mental health needs of resident, dated 5/17/23. Hospital notes, dated 4/24/23, indicated Resident D had been admitted to the hospital on 4/18/23 after living in a homeless shelter. The notes indicated on 4/23/23, the resident indicated he was not sleeping well at night, and during an interview he was "appropriate but depressed and flat mood and affect". On 6/29/23 at 9:23 A.M., all behaviors listed in Resident D's progress notes were provided, and indicated the following: 4/30/23 "Resident became anxious this morning, stating that he is too young to be in a nursing facility and that this is not where he is supposed to be. This nurse spoke 1 on 1 with resident,			

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	resident is upset r/t (related to) not having clothes at the facility. CNA (Certified Nurse Aide) found some clean [sic] clothes for resident and assisted him to shower, this was effective in improving behaviors at this time". 6/22/23 "On 6/21 @ approx 12:00 Pt (patient) and another pt had verbal altercation regarding remote control and the channel being turned. A Pt had gone out to garden on patio and when he returned the show he had been watching was changed by gentlemen playing cards. Verbal obscenities were yelled between two pts (patients)". 6/22/23 IDT Note: "6/21 was in 300 dr (dining room) and when verbal altercation with two other male residents happened [sic]. Administration was involved. Pt's separated. SS (Social Services) talked with all parties. All followed by (psych services) and will be seen on next visit, 6/26 and/or 6/30. Family and MD notified." All behavior monitoring since admission was requested and provided on 6/29/23 at 12:48 P.M. Resident D's behaviors included the following: 6/5/23 (repeats movements, resident has had the behavior before) Behaviors listed in the progress notes on 4/30/23 and 6/21/23 were not listed on the behavior monitoring documentation provided. On 6/28/23 at 2:15 P.M., the SSD indicated she had been mistaken thinking that Resident D had been seen by psych services, as he was not on the list for them to see this month. She indicated she had to put him on the list to be seen at the next visit. On 6/29/23 at 9:00 A.M., the SSD indicated psych services came to see residents 2 times a week (Monday and Friday) every other week. She			

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	indicated they had their own list of residents to see, and that she could add to the list as needed for new admissions, behaviors, or medication change requirements. She indicated if the resident's MDS mood assessment triggered depression, she would ask them if they wanted psych services. She then indicated Resident D's mood assessment did trigger depression upon admission, and he did not decline services. On 6/29/23 at 11:42 A.M., a current non-dated Behavioral Health Services policy was provided, and indicated "It is the policy of this facility to ensure all residents's receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning ... The facility will consider the acuity of the resident population. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment". 3.1-43(a)(1)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring;			

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	or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to ensure a resident received the appropriate dosage of a medication for 1 of 4 residents reviewed for medications. A resident received 4 times the ordered dose of cimetidine for more than 6 weeks. (Resident S) Finding includes: On 6/28/23 at 11:15 A.M., Resident S's clinical record was reviewed. Resident S was admitted on 5/20/19. His diagnoses included, but were not limited to, vascular dementia with agitation and schizoaffective disorder. The most current annual MDS (Minimum Data Set) assessment, dated 5/6/23, indicated Resident S was moderately cognitively impaired and had physical behaviors directed towards others for 1 to 3 days and verbal behaviors directed towards others for 4 to 6 days during the look back period. Current physician orders included, but were not limited to, the following: Cimetidine (antihistamine medication), 200 MG (milligrams) by mouth at bedtime for sexual inappropriate behaviors, dated 3/20/23. Discontinued physician orders included, but were	F 0757	F757 Unnecessary Drugs What correction action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident S had no negative outcome due to this alleged deficient practice. Resident S's order was corrected and updated to the appropriate dose in his medical record. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · IDT to review all new orders/changed orders to ensure they are inputted correctly. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	07/22/2023

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	not limited to, the following: Cimetidine, 200 MG by mouth four times a day for sexual inappropriate behaviors, dated 2/2/23, and was discontinued on 3/20/23. A GDR (gradual dose reduction), dated 1/31/23, recommended "please consider a trial dose reduction to 200mg QD (every day)". The physician approved and signed the GDR on 2/1/23. A progress note, dated 2/2/23, indicated "MRR (medication regimen review) received from pharmacy. Recommended to GDR cimetidine from 300mg q (every) daily from [sic] 200mg q daily. eMAR (electronic medication administration record) updated to reflect change. [Name] notified. Signed MRR faxed to pharmacy." A progress note, dated 2/26/23, indicated "Resident seen by MD (medical doctor) for routine visit. Medications reviewed, order summary signed. No changes made." A pharmacy note, dated 2/28/23, indicated an MRR was completed with no irregularities found. A progress note, dated 3/20/23, indicated "Medications reviewed related to loose stools. It was noted that he is on cimetidine QID (4 times a day). Cimetidine can cause diarrhea. Noted that order was changed on 2/2. Pharmacist had requested a GDR from 300 mg to 200 mg daily. Order was inadvertently written as 200 mg QID. [Name of Doctor] notified. New order received to dc (discontinue) cimetidine 200 mg QID and change to cimetidine 200 mg daily. [POA] notified." The progress notes indicated that Resident S had		· Daily audits to be completed by DNS/designee to ensure new and updated orders are reviewed for accuracy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · To ensure compliance, the ED or designee will be responsible for the completion of unnecessary medication usage tool weekly times 4 weeks, monthly times 6 months and then quarterly until continued compliance is maintained. If a threshold of 100% is not achieved an Action Plan will be developed to ensure compliance. Date of Compliance: July 22, 2023.	

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	loose stools on 3/6, 3/12, 3/13, 3/18, 3/19, 3/20, and 3/26. The MAR (medication administration record) indicated that Resident S had received 200 mg of cimetidine four times daily from 2/2/23 to 3/20/23. On 6/29/23 at 9:23 A.M., RN (Registered Nurse) 5 indicated medications are reviewed for each resident daily and contraindications or irregularities should be caught by staff at that time. She further indicated that Resident S's medication error should have been identified by staff earlier than it was. A policy on the MRR process was requested and not provided. On 6/29/23 at 11:49 A.M., the Regional Consultant indicated there was no policy related to the MRR process. 3.1-48(a)(6)			