STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	06/21/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00410284, IN00410288, and IN00410832. Complaint IN00410284 - No deficiencies related to the allegations are cited. Complaint IN00410288 - Federal/State deficiencies related to the allegation are cited at F659. Complaint IN00410832 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: June 20 and 21, 2023. Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census Bed Type: SNF/NF: 101 Total: 101 Census Payor Type: Medicare: 3 Medicaid: 85 Other: 13 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 27, 2023.	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements.¿¿ ¿ The facility respectfully requests a desk review of our responses to this survey.¿	
F 0659 SS=E	483.21(b)(3)(ii) Qualified Persons			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaushik Patel	Executive Director	07/10/2023

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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Bldg. 00	§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure QMAs who were not insulin-certified did not administer insulin for 6 of 23 residents receiving insulin or other injectable anti-diabetic medications. (Residents M, O, S, U, Z, and BB.) Findings include: Medication Administration Records from June 2023 for all residents receiving insulin and/or anti-diabetic injectable medications were reviewed, on 6/21/23 at 9:00 a.m., and indicated the following for 6 out of 23 residents reviewed: Resident M received Insulin Glargine 9 (long-acting) on 6/7/23 at 7:00 a.m. from QMA 52. Resident O received Basaglar (long-acting insulin) on 6/15/23 at 8:00 p.m. from QMA 52. Resident S received Insulin NPH (intermediate-acting) on 6/3/23 at 7:00 a.m. from QMA 53. Resident U received Insulin Glargine on 6/7/23 at 7:00 a.m. from QMA 52. Resident Z received Insulin Glargine on 6/3/23 at 7:00 a.m. from QMA 53. Resident BB received Insulin Lispro (rapid-acting) on 6/3/23 at 11:30 a.m. from QMA 53.	F 0659	F 659 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Follow up was completed on resident M, O, S, U, Z, and BB and assessment completed to ensure that no adverse reactions were noted following insulin administration. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit of all residents that received insulin injections in the last 2 reviewed to ensure all administered by an insulin certified QMA or nurse. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with all Nurses and QMAs regarding following scope of practice	07/11/2023

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	A list of Qualified Medication Aides provided by the DON, on 6/21/23 at 2:20 p.m., indicated QMA 52 and QMA 53 were not certified to administer insulins. During an interview, on 6/21/23 at 12:00 p.m., the DON indicated that QMAs must receive clinical experience in administering insulin and other injectable medications. It was her understanding that clinical training was provided by the QMA course providers, and any such clinical training happened outside of the facility. QMAs were not to administer insulin if they were not certified to do so. During an interview, on 6/21/23 at 2:20 p.m., the DON indicated QMA 53 had taken the injectable administration course, but had not completed the certification portion of the course. QMA 52 had not taken the injectable medication course and was not certified to administer injectable medications. Review of a current, 12/31/19, document titled "INDIANA STATE DEPARTMENT OF HEALTH QUALIFIED MEDICATION AIDE (QMA) - INSULIN ADMINISTRATION EDUCATION MODULE INSTRUCTOR MANUAL," retrieved from www.in.gov/health, indicated the following: "...Health Facility must: Verify on the Indiana Nurse Aide Registry that the QMA has had the appropriate training/testing with the QMA-Insulin Administration Certification sub-type...." This Federal tag relates to complaint IN00410288. 3.1-35(g)(1) 3.1-35(g)(2)		regarding medication administration to include but not limited to insulin administration and documentation only by qualified individuals. DNS or Designee: On- going audit to be completed to monitor Medication Administration Record to ensure insulins are being administered by qualified staff. Audit to be competed on random residents 5 times weekly X 2 weeks, 3 times weekly X 2 weeks, weekly X 2 weeks, and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to provide supervision and implement person-centered interventions to prevent residents from leaving the facility property without facility knowledge, for 2 of 2 residents reviewed for elopement (Residents H and CC). Findings include: 1. During an observation, on 6/21/23 at 10:36 a.m., Resident H was up in a wheel-chair, wheeling himself around the facility talking on a cell phone. Resident H's clinical record was reviewed on 6/21/23 at 10:47 a.m. Diagnoses included paraplegia, paralytic syndrome following cerebral infarction bilateral, cannabis abuse, stimulant abuse, opioid abuse, bipolar disorder current manic severe with psychotic features, and violent behavior. Current physician orders included the following: May go on pass with responsible party without medications (dated 5/8/23) and may go LOA (Leave of Absence) on property unsupervised (dated 6/9/23). A 6/15/23, quarterly, MDS (Minimum Data Set)	F 0689	F 689 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident CC and resident H to immediately following with no negative outcome. Education completed with both resident CC and Resident H on their current LOA orders and the LOA policy. Care plans for both resident H and CC reviewed and updated with person centered interventions. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed of all residents and LOA orders to ensure that care plan is in place and up to date with person centered interventions.	07/11/2023

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	assessment indicated he was cognitively intact. He required extensive assistance of two staff members with bed mobility, transfers, toilet use, and personal hygiene. He required extensive assistance of one staff member with dressing and required supervision with locomotion on and off the unit. A current care plan, dated 12/11/22, indicated he had an ADL (Activities of Daily Living) self-care deficit related to paralysis secondary to a stroke and he required limited to extensive assistance for bed mobility, transfers, eating and toileting. Interventions included transfers with extensive assistance of two staff members, revised date of 2/21/23, and mobility- non-ambulatory, independent when up in wheel-chair, with a revised date of 4/6/23. The clinical record did not include a care plan and/or person-centered interventions related to exiting the facility property without supervision. A progress note, dated 5/10/23 at 3:18 p.m., indicated he appeared to be under the influence while he wheeled himself down the hall. His eyes were bloodshot, pupils pinpoint, and he was giddy. He denied taking anything. The physician was notified and ordered a drug test. He refused to take a drug test, but did admit he ingested an edible his family member had brought him. He indicated he did not have any more edibles at the facility. He was educated on the negative effects of THC (the main psychoactive compound in cannabis that produces the high sensation) and the facility was a drug-free facility. The resident would be under supervised visits, and was able to go outside with supervision. The resident was made aware of the LOA order.		-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with facility staff on the guidelines for Leave of Absence to include but limited to following LOA orders, plan of care, and what to do in case of an elopement. DNS or will review during clinical review: Behavior notes and progress notes to identify any concerns regarding LOA process or elopement risk. Notes to be monitored 5 times weekly X 2 weeks, 3 times weekly X 2 weeks, weekly X 2 weeks, and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis.	

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	A Behavior Note, dated 5/17/23 at 8:17 p.m., indicated he had left the building with another resident, unaccompanied by staff. The intervention attempted was staff going to the gazebo to find the residents, and he returned to the facility without difficulty. A Behavior Note, dated 5/30/23 at 11:51 p.m., indicated Resident H had been found outside with another resident around 11:00 p.m. He did not re-enter the facility until 11:50 p.m., and had not alerted staff he was exiting the building. The intervention attempted was education, which was ineffective, as education had been provided many times on different shifts but the behavior continued. A Behavior Note, dated 6/5/23 at 11:13 p.m., indicated he reported to staff he was refusing his medication from third shift because he was angry at them for alerting management that he exited the building at night. A progress note, dated 6/10/23 at 10:39 a.m., indicated he was outside smoking and he was reminded it was a non-smoking facility. A Behavior Note, dated 6/19/23 at 12:30 p.m., indicated the resident had been seen wheeling himself on Lyn-Mar Drive (the road the facility was located on) in his wheel-chair, with another resident. The staff member turned their vehicle around and asked what the residents were doing. The resident indicated it was not their business. He was asked to return to the facility because it was dangerous. He refused to turn around to head back to the facility. He continued down Lyn-Mar Drive and reached Chadam Lane. The DON and ADON arrived and spoke with him. The intervention attempted was to encourage him to			

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	return to the facility and the event was reported to the DON. A review of Google Maps indicated the distance from the facility to Chadam Lane was 0.6 miles. An IDT (Interdisciplinary Team) Note, dated 6/19/23 at 12:51 p.m., indicated a discussion had taken place with the resident to discuss the facility's concerns. The resident indicated he was upset and wanted to get away for awhile, so he was headed to Walmart. He was calm, and was able to be re-directed back to the facility after their discussion. During an interview, on 6/21/23 at 11:04 a.m., Resident H indicated he was allowed to exit the facility unsupervised. During an interview, on 6/21/23 at 11:23 a.m., the DON indicated Resident H had exited the facility without staff's knowledge, and she had discussed it with the physician. The physician had written an order that he could go outside on the property unsupervised. During an interview, on 6/21/23 at 3:32 p.m., LPN 7 indicated Resident H had exited the facility, and would not be able to get himself up if he fell because he was paralyzed from the waist down. Residents had the door code to exit the facility because the Administrator had given it to them. 2. Resident CC's clinical record was reviewed on 6/21/23 at 3:47 p.m. Diagnoses included, but were not limited to, paraplegia and schizophrenia. Current physician orders included may go LOA on property unsupervised (dated 5/8/23) and may go on pass with responsible party without			

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	medications (dated 5/8/23). A 5/8/23 quarterly MDS assessment indicated he was cognitively intact. He required extensive assistance of two staff members for bed mobility, personal hygiene, toilet use, transfers, and dressing. He required extensive assistance of one for locomotion on and off the unit. A current care plan, dated 5/17/17, indicated he had a physical functioning deficit related to mobility impairment due to paraplegia, foot drop of bilateral feet, and relied on set-up/supervision to extensive assistance on staff for bed mobility, transfers and toileting. Interventions included mobility- non-ambulatory, wheel-chair was primary mode of transportation, revised date of 10/25/22, and transfers- extensive assistance of two staff members and mechanical lift for transfer assistance, revised date of 5/12/23. The clinical record did not include a care plan and/or person-centered interventions related to exiting the facility property without supervision. A progress note, dated 5/8/23 at 2:40 p.m., indicated he had been spoken to about outside time. He was allowed to sit in the gazebo area, but unable to go to the parking lot. He was reminded the facility was a non-smoking facility. A Behavior Note, dated 6/19/23 at 12:30 p.m., indicated the resident was seen by a staff member (who was driving to the facility) rolling down Lyn-Mar Drive in his chair, away from the campus with another resident. He had indicated he needed to get away but turned around and headed back to the facility. The intervention attempted included letting him know it wasn't safe to be going down the road.			

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	During an interview, on 6/21/23 at 3:37 p.m., CNA 9 indicated Residents H and CC had exited the facility on their own. Resident CC had loaned his electric chair to other residents in the past, so they had the ability to exit the facility as well. During an interview, on 6/21/23 at 3:43 p.m., the Administrator indicated there had not been a resident who had left the property unsupervised, and some residents did have the codes to exit the doors to outside on the property. Review of a current, undated facility policy, titled "Incidents and Accidents," provided by the DON on 6/21/23 at 4:50 p.m., indicated the following: "...An "incident" is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization...The purpose of incident reporting can include: * Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrence and improve the management of resident care...5. The following incidents/accidents require an incident/accident report but are not limited to:...* Elopement...." Review of the current "Long-Term Care Abuse and Incident Reporting Policy," dated 12/6/22, indicated the following: "...Elopement occurs when...a resident with decision making capacity leaves the premises or a safe area, without facility knowledge, and does not return as per the resident plan of care or service plan, related to leaving the facility...." 3.1-45(a)			