

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2024
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00446256 and IN00445740.</p> <p>Complaint IN00445740 -- Federal/state deficiency related to the allegations are cited at F604.</p> <p>Complaint IN00446256 -- No deficiencies related to the allegations are cited.</p> <p>Survey date: November 12, 2024</p> <p>Facility number: 000050 Provider number: 155120 AIM number: 100266170</p> <p>Census Bed Type: SNF/NF: 100 Total: 100</p> <p>Census Payor Type: Medicare: 3 Medicaid: 76 Other: 21 Total: 100</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000			
F 604 SS=D	<p>Quality review completed on November 14, 2024.</p> <p>Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)</p> <p>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p>	F 604			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2024
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 604	<p>Continued From page 1</p> <p>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12 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.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was free from a physical restraint during a blood sugar check for 1 of 3 residents reviewed for abuse. The deficient practice was corrected on 10/23/24, prior to the start of the survey, and was therefore past noncompliance. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed</p>	F 604	<p>Past noncompliance: no plan of correction required.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2024
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 604	<p>Continued From page 2</p> <p>on 11/12/24 at 12:30 p.m. Her diagnoses included, but were not limited to, dementia, mood disorder, and diabetes. She was admitted to the facility on 8/20/24 and resided on the memory care unit of the facility.</p> <p>The 8/26/24 dementia care plan indicated the goal was for her to be able to communicate basic needs on a daily basis. Interventions were to explain all procedures and reason before performing, initiated 8/26/24, and pleasant interaction, which reassures patient when confused, initiated 8/26/24.</p> <p>The 10/17/24 psychiatry progress note indicated, "Assessment and Plan: 1. Mood disorder: No recent behavioral issues per staff report. Patient denies feeling depressed or anxious. She does not appear manic...2. Dementia: CT (computed tomography) showed small vessel ischemic disease, indicating vascular component. History and interview would suggest a severe stage of impairment. BIMS [Brief Interview for Mental Status] = 9, indicating moderate impairment Progressive illness. Continue supportive care and environment. f/u [follow up] 4 weeks and prn [as needed]...."</p> <p>On 11/12/24 at 12:30 p.m., the Executive Director (ED) provided the investigative file into an incident involving Resident B, Registered Nurse (RN) 2, Qualified Medication Aide (QMA) 3, and Certified Nursing Assistant (CNA) 4. The file included the, 10/23/24, statement from RN 2, the, 10/23/24, statement from CNA 4, and the, 10/21/24, statement from QMA 3.</p> <p>The 10/23/24 statement from RN 2 read, "In August, back in the AACU [Advanced Alzheimer's</p>	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2024
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 604	<p>Continued From page 3</p> <p>Care Unit], I went into residents room to obtain a blood sugar on [name of Resident B]. The resident was not cooperating so I left the room. I reported to [name of QMA 3] that I was unable to get the blood sugar because the resident did not want to be poked. [Name of QMA 3] said 'I will take care of her.' [Name of QMA 3] went to get [name of Resident B] out of her room and brought her outside of the nursing station, in the hallway. [Name of QMA 3] asked another CNA by the name of [name of CNA 4], to hold the resident. [Name of QMA 3] then held [Name of Resident B's] hand and looked at me and said poke it. I did as she said. [Names of CNA 4 and QMA 3] then let go of [name of Resident B]. At the time, I had only been at my job for a few days and was still learning the concept of abuse as I was new to the United States."</p> <p>An interview was conducted with RN 2 via telephone on 11/12/24 at 2:57 p.m. She indicated back in August 2024, she was a new nurse in training, and QMA 3 was her preceptor. QMA 3 asked her to "prick" the patients that were diabetic, and one of them was Resident B. RN 2 informed Resident B that she would be obtaining her blood sugar, and Resident B informed her that she did not want it checked. RN 2 then left Resident B's room and informed QMA 3 that Resident B did not want her blood sugar checked. QMA 3 informed RN 2 that she (QMA 3) would take care of it. RN 2 and QMA 3 went back to Resident B's room. QMA 3 assisted Resident B in her wheelchair into the hallway. QMA 3 tried to get a hold of Resident B's hand. Resident B tried to stand, so QMA 3 "was trying to hold her down, had her arms around her." Resident B was "too strong," so QMA 3 asked for help from one of the CNAs. One of the CNAs helped QMA 3 hold</p>	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2024
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 604	<p>Continued From page 4</p> <p>Resident B down, grabbed Resident B's hand, and QMA 3 told her (RN 2) to "poke her." RN 2 "poked her" on her pointy finger or thumb. RN 2 did not have access to the MAR (medication administration record) at that time, so she did not document the blood sugar check. At the time this happened, she did not report it to anyone, because "I didn't know what they were doing." RN 2 did not take part in holding her back and was trying to calm her. Eventually, RN 2 reported the incident to someone from corporate office.</p> <p>The 10/23/24 CNA 4 statement indicated, "I was sitting at the dining room table before dinner in AACU, [name of QMA 3] asked me to help her hold [name of Resident B] down because [name of Resident B] would not let [name of QMA 3] get her blood sugar. [Name of QMA 3] went and got the nurse. We went down by the nurses station in the hallway. [Name of QMA 3] kept telling the resident [name of Resident B] that she needed to get her blood sugar and the resident continued to refuse. I tried to tell [name of Resident B] she needed to let us so that we did not send her to the hospital. [Name of Resident B] tried to get out of her wheelchair and the nurse was trying to direct [name of Resident B] to sit back in her wheel chair. Once [name of Resident B] sat back in her wheel chair [name of QMA 3] said I need to get your blood sugar. [Name of Resident B] stood up again and was holding onto the rail trying to get away. The nurse pushed the wheel chair behind [name of Resident B] and was able to get her to sit back in her wheel chair. I rubbed the top of her hands to try and sooth [sic] her. The nurse was trying to console the resident as well. [Name of QMA 3] was standing and waiting. I turned [name of Resident B's] hand around and told her we were going to get her blood sugar. She was</p>	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2024
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 604	<p>Continued From page 5</p> <p>crying and said just get it over with. [Name of QMA 3] poked her. I brought [name of Resident B] to the dining room and got her water. [Name of Resident B] then said she wanted to go to her room so I took her back to her room."</p> <p>CNA 4 was unavailable for interview.</p> <p>The 10/21/24 QMA 3 statement, signed by QMA 3, indicated, "[Name and title of QMA 3] denies administering insulin as she is not currently insulin certified. Denies claim of holding resident down to administer insulin or oral medications. QMA states she does not have any coworkers or knowledge of someone having concerns or issues with [name of QMA 3.] Reports having signed off on insulins at times by accident, then reported to nurse for correction."</p> <p>An interview was conducted with QMA 3 via telephone on 11/12/24 at 2:49 p.m. She indicated she no longer worked at the facility, but remembered Resident B. Resident B refused insulin, so the nurse called her family to come in, as only family could get her to do it. QMA 3 never held Resident B still to have her blood sugar checked or insulin administered, and never saw anyone else hold her either. QMA 3 was terminated from employment with the facility for holding down a resident and administering insulin. "They said two people confirmed it. That never happened, never held down any patient." She was just terminated a few weeks ago, so if it happened in August, she was unsure why she was just recently terminated. If she ever witnessed something like that, she'd go to the Assistant Director of Nursing or ED and inform them.</p>	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2024
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 604	<p>Continued From page 6</p> <p>An interview was conducted with the ED on 11/12/24 at 12:45 p.m. She indicated she received a call from corporate that they received a call about a resident who was restrained, in August 2024, during a blood sugar check involving QMA 3. The ED began an investigation. During interviews, RN 2 answered yes to the abuse questions asked. RN 2 informed her that QMA 3 came from behind Resident B and wrapped her arms around her while CNA 4 held Resident B's arm. The ED interviewed CNA 4, who at first answered no to all of the abuse questions. CNA 4 then answered yes to the abuse questions but gave her a slightly different story about how Resident B was held during the blood sugar check. The ED questioned CNA 4 as to whether she considered the occurrence to be abusive, and CNA 4 informed her she was told to come help, but thought afterwards it may not have been the best situation. The ED informed CNA 4 she should have reported it, and explained to RN 2 that they cannot hold a resident down in long term care.</p> <p>On 11/12/24 at 3:15 p.m., the ED provided the Restraint Free Environment policy. It indicated, "It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Definitions: Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but</p>	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2024
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 604	<p>Continued From page 7</p> <p>are not limited to ...Holding down a resident in response to a behavioral symptom, or during the provision of care if the resident is resistive or refusing the care....Compliance Guidelines: 1. The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms."</p> <p>This deficient practice was corrected, on 10/23/24, after the facility implemented a systemic plan that included the following actions: assessment or interview of all residents regarding safety and abuse; corrective action for the staff involved in physically restraining a resident; in-servicing education to staff related to care of residents with resistive behaviors and/or dementia; provision of oversight, audits, and additional training as needed by regional/corporate/hired consultant team visits at least weekly; and daily clinical review by Director of Nursing Services or Designee for behaviors or injury that may need further investigation or intervention with findings presented to the Quality Assessment and Assurance (QAA) Committee for review.</p> <p>This citation relates to Complaint IN00445740.</p> <p>3.1-3(w)</p>	F 604			