STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. BUILDING 00 B. WING	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	745 N SWOPE ST GREENFIELD, IN 46140

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00435433, IN00435871, IN00436334, IN00437004 and IN00437810. Complaint IN00435433 -- No deficiencies related to the complaint are cited. Complaint IN00435871 -- No deficiencies related to the complaint are cited. Complaint IN00436334 -- No deficiencies related to the complaint are cited. Complaint IN00437004 -- No deficiencies related to the complaint are cited. Complaint IN00437810 -- Federal/state deficiency related to the allegations are cited at F580. Survey dates: July 12, 15 and 16, 2024 Facility number: 000050 Provider number: 155120 AIM number: 100266170 Census Bed Type: SNF/NF: 95 Total: 95 Census Payor Type: Medicare: 2 Medicaid: 73 Other: 20 Total: 95 This deficiency reflects State Findings cited in	F 0000	/p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandy Coomer	RN-RDCO	08/02/2024

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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	accordance with 410 IAC 16.2-3.1. Quality review completed on July 18, 2024.			
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- (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			

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	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 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 promptly notify the resident's representative following a fall with injury for 2 of 4 residents reviewed for falls. (Residents E and G) Findings include: 1. The clinical record of Resident E was reviewed on 7-16-24 at 11:52 a.m. Her diagnoses included, but were not limited to, a neurocognitive disorder with Lewey Body and unspecified dementia. She was admitted to the facility in, June 2024, for a short-term respite stay of less than 2 weeks, into the facility's secured dementia care unit. Her admission Minimum Data Set assessment, dated 6-25-24, indicated she was severely cognitively impaired, was ambulatory and had a history of falls in the previous one to six months, prior to admission to the facility. A progress note, dated 6-25-24 at 2:00 p.m., indicated Resident E had been "agitated and she was taking her clothes off." It indicated a nurse	F 0580	The facility does promptly notify the resident's representative when a fall with injury has occurred. Resident representative was notified for Resident E. Resident representative was notified for Resident G. Licensed staff educated Notification of Change policy. A look back was completed to ensure all resident representatives were notified of falls with injury. DNS or designee will audit all falls with injuries to ensure prompt family notification. These audits will occur daily x5 days for , then daily x3 days for 6 weeks.	08/09/2024

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	assessed the resident and "found [a] bump on her left forehead." A notation, dated 6/25/2024 at 2:21 p.m., indicated the Nurse Practitioner "assessed the resident," and initiated serial neurological assessments. An interdisciplinary note, dated 6-26-24 at 5:26 p.m., in the review of the fall, indicated the sister of Resident E was "contacted about fall," and listed the sister's personal telephone number. It did not identify the time, date or method of notification to the sister of the unwitnessed fall. In an interview, on 7-16-24 at 9:56 a.m., with a family member of Resident E, she indicated she was notified by the Director of Nursing (DON) that a fall had occurred, on 6-25-24, around noon, but did not learn of the fall until she went to visit Resident E, around dinner time the same day. The family member indicated the DON told her that she should have contacted her earlier and might have sent her out to the hospital to be checked. In an interview, on 7-16-24 at 1:06 p.m., with the DON, she indicated she needed to accept responsibility for the late notification to the family of Resident E of the unwitnessed fall. "I had told someone that I would call the family and I didn't get around to it. When the family came in later that evening, they were made aware of it." At 1:50 p.m., the DON indicated the approximate time of notification was 6-25-24 at 5:00 p.m. 2. The clinical record of Resident G was reviewed on 7-16-24 at 12:55 p.m. It indicated her diagnoses included, but were not limited to, Alzheimer's disease, diabetes, depression, and anxiety. It indicated she had lived on the secured dementia care unit for over 2 years. Her most recent Minimum Data Set assessment, dated 6-21-24, indicated she was severely cognitively impaired,			

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	was ambulatory, and had no recent falls. A progress note, dated 7-6-24 at 10:00 a.m., indicated an unnamed staff person had notified the nurse the resident was "found on floor by writer lying on right side sitting up on right arm. Res [resident] was visibly upset and is yelling out in pain. Res left arm sore to touch. Arm removed from sleeve and res left wrist is reddened and swollen." A second progress note, dated 7-6-24 at 10:06 a.m., and identified as a "Fall Risk Evaluation," indicated Resident G had "1-2 falls" in past 3 months, had "Intermittent confusion" and was ambulatory. She was identified by the facility as a fall risk. Additional details included, "Fall occurred in the hallway. Resident was reaching for item(s) at time of the fall. The reason for the fall was not evident." It indicated the fall resulted in the left wrist being swollen and painful and she was sent to a local emergency room for evaluation and treatment. The facility was later informed Resident G had sustained a fractured left wrist. The progress notes reflected the facility had notified the physician and/or nurse practitioner of the fall but did not indicate the time or method of notification. The progress notes did not reflect the date, time, method of notification or which family representative had been notified of the fall and injury. A progress note, dated 7-6-24 at 9:15 p.m., indicated the resident had returned to the facility and the family was at the bedside at that time. In an interview with the daughter and healthcare representative of Resident G, on 7-15-24 at 3:50 p.m., indicated she was known to the facility as her mother's healthcare representative. She indicated on the date of her mother's fall and			

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	fracture; she had not received any contact from the facility regarding the fall and fracture. "I visit her very frequently and mom has been on the memory care unit since she came here. It was a Saturday and I was home all day. From what I was told, she had the fall around 9:00 or 10:00 a.m., and they sent her out almost immediately. They did not call me. Instead, they called my brother around 5:00 or 6:00 p.m. He didn't call me for several hours after that and he just assumed that I already knew what was going on. So, that ended up causing mom to lay in the emergency room for nearly 10 hours by herself. You have to understand she has advanced dementia. That had to be very upsetting for her and probably [for] the staff in the emergency room, too, because she couldn't give them any details of what happened or her medical history. I would like you to check into this to see what happened. I don't want this to happen to anyone else." In an interview, on 7-16-24 at 1:06 p.m., with the Director of Nursing (DON), she indicated when she looked into the concerns of Resident G's family, she learned the nurse on duty had called the first person on the contact list, at the time of the fall, in the computer. "I have since fixed the ordering of the contacts in the computer. That is why the son was called and not the daughter." The DON indicated she and Resident G's daughter had discussed this concern previously and "that's what prompted me to check the contact list and talk to the nurse." On 7-16-24 at 2:18 p.m., the DON provided a copy of a policy entitled, "Notification of Changes," with a copyright date of 2023. This policy indicated, "The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent			

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	with his or her authority, the resident's representative when there is a change requiring notification...Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring notification. Circumstances requiring notification include: Accidents [such as] resulting in injury; potential to require physician intervention...Circumstances that require a need to alter treatment. This may include: a new treatment...Residents incapable of making decisions: the representative would make any decisions that have to be made..." This citation relates to Complaint IN00437810. 3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)			