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

FORM APPROVED
OMB NO. 0938-039

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	04/11/2022

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 IN00374467, IN00375612, IN00375691, IN00376702 and IN00376792. Complaint IN00374467 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686 and F697. Complaint IN00375612 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F689, F690 and F760. Complaint IN00375691 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00376702 - Substantiated. Federal/State deficiencies related to the allegations are cited at F557 and F690. Complaint IN00376792 - Substantiated. Federal/State deficiency related to the allegations is cited at F580. Survey dates: April 6, 7, 8 and 11, 2022 Facility number: 155120 Provider number: 000050 AIM number: 100266170 Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 7 Medicaid: 60 Other: 25	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 on 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 20, 2022			
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on interview and record review, the facility failed to ensure a resident requiring toileting assistance received this service in a timely manner, resulting in the resident feel embarrassed for having an incontinent episode and feeling she was treated disrespected by a staff member for 1 of 3 residents reviewed for neglect and/or respect. (Resident E) Findings include: The clinical record of Resident E was reviewed on 4-6-22 at 11:50 a.m. Her diagnosis included, but were not limited to dorsalgia (severe back pain), chronic pain, generalize osteoarthritis, morbid obesity, restless leg syndrome, anxiety, depression, hypertension and generalized muscle weakness. Her most recent Minimum Data Set (MDS) assessment, dated 3-25-22, indicated she is cognitively intact, is fully dependent for transfers from one surface to another, is unable to ambulate and requires a wheelchair for mobility, requires	F 0557	F 557 Respect and Dignity **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident E : Medical record was reviewed and plan of care updated appropriately to include needs for toileting and transfer assistance **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that require assistance with toileting/incontinence needs and transfers have the potential to be affected by the same deficient	05/17/2022

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	extensive assistance of two or more persons for toileting services and is occasionally incontinent of bladder. In an interview with Resident E on 4-6-22 at 11:15 a.m., she indicated sometime in March, 2022, she had an interaction with an agency aide in which the aid "did not really want to get me up with the hoyer [mechanical lift], but I insisted. She made it clear it took her too long to have to use the hoyer. I take a water pill and it seems like everyday around lunchtime, I have to use the bathroom because of the water pill. Again, she [agency aide] was not happy about the thought of having to put me in the wheelchair and take me to the bathroom with the hoyer. She told me that somebody should have put a brief on me. She said she would be back to take me to the bathroom and never did. So, I ended up wetting myself and had to sit through lunch wet and did not get cleaned up until the afternoon aide came on duty. It was very upsetting and embarrassing." Resident E indicated she did not tell anyone at the facility about this situation, but did share this information with her daughter, who in turn, spoke with the facility management team. In an interview with QMA 6 on 4-8-22 at 2:42 p.m., she indicated she recalled Resident E "being very teary-eyed the afternoon of Saturday, 3-26-22." She recalled beginning her shift around 2:00 p.m., and had responded to Resident E's "call light or had entered the room to check on her. "She told me earlier that day, an agency aide had either brought her lunch to her or was picking up her tray when the resident asked to be toileted." Resident E indicated the agency aide told her she would be back to take her to the bathroom and never returned. "So, I helped her to get cleaned up, because by that time, she had been		practice. Initial audit DNS or Designee completed a review of all residents that require assistance with toileting/incontinence and transfers to ensure plan or care reflects needed assistance and care is provided in a professional manner. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education Clinical staff (Nurses/QMA/C.N.A.) were educated on the guidelines for providing Incontinence care, utilizing assistive devices (mechanical lifts) and guideline for promoting/maintaining resident dignity **On-going monitoring DNS or Designee will observe staff providing toileting/incontinence care and transfers to interviewable and non-interviewable**	

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	incontinent of urine and had soaked through her panties and pants, requiring a complete change of clothing. [Name of Resident E] is a very intelligent woman and is not a complainer. She is normally continent of bowel and bladder. She does not wear an adult brief or even a sanitary pad." QMA 6 indicated Resident E did not have an adult brief in place at that time. In an interview on 4-6-22 at 1:32 p.m., with the Social Services Designee (SSD), she indicated she had recently spoken with the family member of Resident E, regarding care issues from the weekend of 3-26-22. She indicated the family member informed her an agency aide did not want to use the hoyer on the resident and left her wet after an incident in which the resident had her morning diuretic. The SSD indicated this resident is normally continent, but due to the staff member not complying with the resident's request for toileting, she was incontinent and left wet through lunch and not cleaned up until after the next shift arrived, several hours later. The SSD indicated this incident left the resident feeling like the staff member had been uncaring and had upset the resident quite a bit. This Federal tag relates to Complaint IN00376702. 3.1-3(t)		**residents to ensure staff are promoting dignity and respect during care services in a timely manner. These reviews are to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.** **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** **Results of these audits will be brought to QAPI**	

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			monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
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			

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	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 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 family and/or responsible party and Hospice regarding a residen'ts change of condition, related to a resident's death, and for elopement for 2 of 3 resident's reviewed for notification. (Residents F and C)	F 0580	F 580 Notify of Changes **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	05/17/2022

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	Findings include: 1. The clinical record of Resident F was reviewed on 4-11-22 at 9:45 a.m. Her diagnoses included, but were not limited to Rheumatoid arthritis, hypertension, mild cognitive impairment, osteoarthritis of the foot and ankle, a history of venous thrombosis and embolism (blood clots), cognitive communication defict and general muscle weakness. It indicated she had been receiving hospice services for one year for severe protein-calorie malnutrition. The hospice documentation reflected she experienced a significant decline in the days prior to passing. In an interview with a family member on 4-7-22 at 10:23 a.m., he indicated, " [I] cannot express the sadness I feel about not being called about my mother dying and the nursing home not even calling me. Cannot tell you the absolute pain and shock I felt when I walked in around 9:15 [a.m.] and found her bed empty. Of course, the nursing home apologized and apologized, but that's not going to fix the situation. I just do not want this to happen to another family. They hadn't even called the hospice about her death until after I left." In a phone interview on 4-11-22 at 1:31 p.m., with Resident F's hospice service, the staff member indicated she received a phone call on the morning of 3-25-22, from the nursing facility at/around 9:45 a.m. to notify their hospice agency of the passing of Resident F. She indicated the person calling "explained they were late in letting us know because the nurse for the patient thought our nurse was in the building around the time and knew the patient had passed. She [the facility staff] explained it was actually a different		Resident F: No longer resides at the facility Resident C: Medical record was reviewed and updated to reflect Physician and Family notification of change regarding fall and elopement. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents with a change in condition have the potential to be affected by the same deficient practice. Initial audit DNS or Designee completed a 15 day look back of all residents to ensure that the physician and family/responsible party have been notified of any change in condition and notification is documented in the medical record. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education Licensed clinical staff were educated on the guideline for Notification of change in condition to include but not limited to decline in health/death or risk	

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	hospice company [that was in the facility at that time.] This was definitely not the norm for any of our hospice patients. Most facilities are really good to let us know when things are looking bad." During the initial portion of the phone interview, the resident's name had not been provided to the hospice agency, but the hospice staff person immediately knew of whom was being referenced by the provision of the name of the facility. The resident's name was verified to ensure accuracy. The hospice staff indicated the resident had experienced a significant decline in the week or so prior to her death and her passing was expected. In an interview with the Director of Nursing (DON) on 4-11-22 at 2:05 p.m., she indicated during the facilty's morning meeting on 3-25-22, LPN 3 came in and told the group Resident F's son had been in and had not been notified of his mother's passing and "he had come to the facility to visit her and he found her empty bed." The funeral home had already come and taken the resident to the funeral home. "The agency nurse was called. He said he called [name of the funeral home]. The funeral home said they would call the family. In the computer, the way the funeral home and hospice phone numbers were listed, it was very confusing. I educated the agency nurse we are responsible to notify the family upon someone's death, not the funeral home or the Hospice. They [Hospice or funeral home] might call them, but we should be doing that." 2. The clinical record of Resident C was reviewed on 4-7-22 at 10:55 a.m. Her diagnoses included, but were not limited to, late onset Alzheimer's disease, hypertension, diabetes, atherosclerotic heart disease with a pacemaker and unsteadiness on her feet. Her most recent Minimum Data Set		event such as elopement or falls and notification is documented in the clinical record. On-going monitoring The DNS or Designee will review residents daily during morning clinical review and/or rounding to ensure changes in condition were identified and interventions implemented timely. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **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** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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(MDS) assessment, dated 2-22-22 , indicated she has severely impaired cognitition, ambulates with limited assistance of one person and does not use any equipment for mobility. Elopement risk assessments were conducted on 2-21-22 with a score of 0.0, indicating she was not at risk; on 3-9-22 with a score of 3.0, indicating she was at risk of elopement and on 3-13-22 with a score of 5.0, indicating she was at high risk of elopement.

In an interview with a family member on 4-7-22 at 9:35 a.m., she indicated she had been notified of Resident C eloping from the facility on the afternoon of 3-13-22 to the building immediately north of the facility and asked to come into the facility. She indicated at the time of the elopement, the resident did not have a wanderguard [device to audibly alarm when one is approaching areas that are not within acceptable boundaries], as "I had given [name of Resident C] a shower a day or so before that and never saw one." She indicated Resident C, "apparently had eloped from the building a few days before this time, but I was never notified of it. I could not find anything documented in her chart about it. If she had a wanderguard on, why didn't it alarm?"

A written note, dated 3-15-22, indicated the Wound Nurse had placed the wanderguard to Resident C's right ankle, after receiving it from central supply. This would have occurred after the initial attempted elopement and prior to Resident C eloping from the facility and prior to her moving to the secured memory care unit. This specific information was not documented in Resident C's clinical record.

On 4-11-22 at 3:10 p.m., the Executive Director provided a copy of a policy entitled, "Notification of Changes". This policy had a copyright date of

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	2022 and was indicated to be the current policy utilized by the facility. This policy indicated, "The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, consistent with his or her authority, the resident's representative when there is a change requiring notification...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 resulting in injury [or] potential to require physician intervention. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: Life-threatening conditions, or Clinical implications...Death of a resident..." 3.1-5(a)(1) 3.1-5(a)(2) This Federal tag relates to Complaints IN00375612 and IN00376792.			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives			

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	necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to assess and treat an unstageable pressure ulcer (full thickness tissue loss) for 1 of 3 residents reviewed for pressure ulcers (Resident G). Finding include: Review of the record of Resident G on 4/11/22 at 12:00 p.m., indicated the resident's diagnoses included, but were not limited to, anxiety, acquired absence of left and right leg above the knee, osteomyelitis and peripheral vascular disease. The resident was admitted to the facility on 4/1/22. The hospital discharge orders and report for Resident G, dated 4/1/22 at 12:22 p.m., indicated the resident was ordered to cleanse the left ischium and sacrum with normal saline and pat dry. Apply sensicare to the peri wound skin. Lightly pack with 0.125% dakin's moistened gauze (treatment used to treat tissue infection of a pressure ulcer) and cover with a dressing twice a day. The wound was infected and worsening on the sacrum. The infection had spread to the pelvic bone and into the blood stream. The resident would be discharged to the facility with hospice end of life comfort and care. The nursing note for Resident G, dated 4/1/22 at 4:59 p.m., indicated the resident was admitted to the facility from the hospital with an unstageable pressure ulcer to sacrum. The skin evaluation for Resident G, dated 4/1/22 at	F 0686	F 686: Treatment/Services to Prevent/Heal Pressure Ulcer **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident G: Medical record was reviewed for timely assessment, treatment and updated plan of care regarding treatment and services for wound care. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that require treatment of wounds have the potential to be affected by the same deficient practice. Initial audit DNS or Designee completed an audit of all resident with wounds that require treatment and observation to ensure treatments are completed as ordered and assessments are done timely. **What measures will be put into place and what systemic**	05/17/2022

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	4:59 p.m., indicated the resident unstageable pressure ulcer on the sacrum that measured 9 centimeters (cm) by 9 cm by 0.4 cm. The wound was necrotic with serosanguineous (thin, watery, pale, red/pink) drainage. There were no further wound assessments in the resident's electronic health record. The physician order for Resident G, dated 4/4/22, indicated the resident was ordered wound care to the sacrum, irrigate and pat dry. Apply Dakins soaked kerlix to wound bed and cover with a dressing every 12 hours. This indicated the resident was not ordered a treatment for the unstageable pressure ulcer for 4 days. The Medication Administration Record for Resident G, dated April 2022, indicated the resident did not receive a treatment to the unstageable pressure ulcer 11 times since admitted to the facility. During an interview and observation with Resident G on 4/11/22 at 1:40 p.m., indicated his hips and wound was hurting him "so bad" he rated his pain as a 7 on the 1 to 10 pain scale. The resident indicated the staff told him to roll side to side to help the pain, but it did not help. The resident indicated when he was admitted to the facility on 4/1/22 the facility did not provide a treatment on his pressure ulcer and "from time to time they missed days" completing his pressure ulcer treatment. The resident was rolling side to side in his bed moaning and groaning in pain. During an interview with the Wound Nurse on 4/11/22 at 2:15 p.m., indicated the admitting nurse did not put Resident G's unstageable pressure ulcer treatments in the orders was why the resident had not received treatments. The floor		**changes will be made to ensure that the deficient practice does not recur** Education Licensed Clinical staff were education on the guidelines for Wound Treatment Management to include but not limited to, completion of treatments as ordered and timely assessment of wounds. On-going monitoring The DNS or Designee will audit residents with actual wounds for timely completion of weekly assessment. Reviews will be completed 2 times a week x 4 weeks then weekly x5 months. The DNS or Designee will complete a random observation of residents with wounds to ensure treatments are completed timely and per physician orders. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **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** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If	

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	155120	A. BUILDING 00 B. WING	04/11/2022

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	nurse was responsible to complete the treatment twice a day. The Wound Nurse verified there were no assessments completed of the pressure ulcer since 4/1/22. The Wound Nurse indicated it was the responsibility of the Unit Manager to complete the pressure ulcer assessments. During an observation and interview with the Wound Nurse on 4/11/22 at 2:30 p.m., Resident G had a large bandage on his sacrum from hip to hip. The dressing was dated 4/10/22. The Wound Nurse indicated she would complete an assessment of the wound and provide his treatment. During an interview with the Wound Nurse on 4/11/22 at 3:56 p.m., indicated Resident G had a new pressure ulcer when she completed the assessment on the left ishium. The Wound Nurse provided the pressure ulcer's assessment. The skin evaluation for Resident G, dated 4/11/22 at 3:28 p.m., indicated the resident had an unstageable pressure ulcer on the sacrum that measured 11 cm by 11 cm by 0.3 cm, with necrotic tissue and serous (thin, watery, clear) drainage. The tissue was painful. The resident had another unstageable pressure ulcer to the left ischium, with slough and serous drainage that measured 0.1 cm. The pressure injury prevention guidelines provided by the Director Of Nursing on 4/11/22 at 3:55 p.m., indicated the facilities policy was to promote healing of pressure ulcers and to implement interventions. Interventions would be implemented in accordance with the physician orders. For residents who have a pressure injury present: treatment medication administration records and weekly wound summary charting was		issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	part of the compliance with interventions documented. This Federal tag relates to Complaint IN00374467. 3.1-40			
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 interview and record review, the facility failed to provide adequate supervision to prevent an elopement off of the premises for 1 of 3 resident reviewed for elopements for a resident with previous attempts of exit seeking and for failed to assess, monitor and document a fall for 1 of 3 residents reviewed for falls. (Resident C) Findings include: A. The clinical record of Resident C was reviewed on 4-7-22 at 10:55 a.m. Her diagnoses included, but were not limited to, late onset Alzheimer's disease, hypertension, diabetes, atherosclerotic heart disease with a pacemaker and unsteadiness on her feet. Her most recent Minimum Data Set (MDS) assessment, dated 2-22-22 , indicated she has severely impaired cognition, ambulates with limited assistance of one person and does not use any equipment for mobility. Elopement risk	F 0689	F 689 Free of Accident Hazards/Supervision **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident : Medical Record was reviewed and updated to reflect family notification of risk events, current assessment for fall and elopement risk and care plan updated with appropriate interventions **How other residents having the potential to be affected by the same deficient practice will be**	05/17/2022

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	assessments were conducted on 2-21-22 with a score of 0.0, indicating she was not at risk; on 3-9-22 with a score of 3.0, indicating she was at risk of elopement and on 3-13-22 with a score of 5.0, indicating she was at high risk of elopement. A care plan, developed on 3-9-22, for "At risk for elopement related to: Attempts to leave Living Center wanders [sic]." The interventions identified for this concern were listed as the placement of a wanderguard, initiated on 3-9-22 and revised on 3-14-22; admission to the secured memory care unit on 3-13-22; evaluation of the resident's cognitive impairment on the resident's ability to understand initiated on 3-9-22 and on 3-14-22 to redirect the resident away from doors. In an interview with a family member on 4-7-22 at 9:35 a.m., she indicated she had been notified of Resident C eloping from the facility on the afternoon of 3-13-22 to the building immediately north of the facility and asked to come into the facility. She indicated at the time of the elopement, the resident did not have a wanderguard [device to audibly alarm when one is approaching areas that are not within acceptable boundaries], as "I had given [name of Resident C] a shower a day or so before that and never saw one." She indicated Resident C, "apparently had eloped from the building a few days before this time, but I was never notified of it. I could not find anything documented in her chart about it. If she had a wanderguard on, why didn't it alarm?" In an interview on 4-11-22 at 10:02 a.m., with LPN 3, she indicated prior to Resident C being admitted to the secured memory care unit, she had observed the resident ambulate to the end of the hallway on which she resided and would pull on the exit doors and would say she was looking for		**identified and what corrective action will be taken** All residents at risk for falls or elopement are at risk for the same deficient practice. Initial audit DNS or Designee completed a 30 day look back of all risk events to ensure there is documentation of notification, risk assessment and plan of care updated with appropriate interventions **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education Licensed staff were educated on the guideline for Fall Prevention Program and Elopement and Wandering Resident. To include but not limited to Risk assessment, post risk event follow-up and interventions with documented notification. On-going monitoring DNS or Designee will review risk events daily to ensure there is appropriate follow up to include but not limited to documented notification, risk assessment and updated plan of care. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times	

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	her children. LPN 3 indicated Resident C was easy to redirect away from the doors. LPN 3 indicated she "couldn't provide a specific date, but the resident did have a wanderguard placed prior to her eloping next door and prior to her moving to the secured dementia unit." LPN 3 indicated, after the placement of the wanderguard, Resident C would ask LPN 3 if she had any scissors or a knife to cut off what the resident called "the watch on her ankle." LPN 3 indicated around mid-afternoon of the day she eloped next door, the wanderguard strap was not located, but the actual wanderguard was found on the floor of the hall she resided on, closer to the nurse's station. "The agency aide who found it did not know what it was; she thought it was part of someone's watch." LPN 3 indicated she was aware with the resident's initial elopement attempt, unknown date, that the resident did not have a wanderguard and attempted to elope by following someone out the entrance and was in sight and in the entry door parking lot. "The second attempt, it is assumed she went out the door when someone was coming into the building." LPN 3 indicated after the second attempt, a decision was made to move Resident C to the secured memory care unit. Documentation of Resident C exit seeking at the end of her hallway and the initial elopement attempt into the front parking area were not located in the resident's clinical record. A written note, dated 3-15-22, indicated the Wound Nurse had placed the wanderguard to Resident C's right ankle, after receiving it from central supply. This would have occurred after the initial attempted elopement and prior to Resident C eloping from the facility and prior to her moving to the secured memory care unit. This specific information was not documented in Resident C's clinical record.		weekly x 4 weeks, then weekly x 4 months. **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** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	B. The clinical record of Resident C was reviewed on 4-7-22 at 10:55 a.m. Her diagnoses included, but were not limited to, late onset Alzheimer's disease, hypertension, diabetes, atherosclerotic heart disease with a pacemaker and unsteadiness on her feet. Her most recent Minimum Data Set (MDS) assessment, dated 2-22-22 , indicated she has severely impaired cognition, ambulates with limited assistance of one person and does not use any equipment for mobility. It indicated she had not had any falls since the last certification time period. A Fall Risk Assessment, dated 2-21-22, indicated she was at risk of falls and had no falls in the last 3 months. In an interview with a family member of Resident C on 4-7-22 at 9:35 a.m., she indicated a staff member recently informed her Resident C had a fall the previous evening (date unspecified). She indicated she had been unable to locate any documentation in the resident's clinical record regarding any falls while on the secured memory care unit (MCU). In an interview on 4-8-22 at 11:40 a.m., with LPN 4, she indicated on/around 3-29-22, she was notified of Resident C having a fall after the morning shift began. She indicated an agency staff member, QMA 7, had been told in the shift hand-off, Resident C had a fall during the night shift and had not been injured. "I don't know if the night shift nurse had checked her out or not. I did bring it up in the morning meeting with the department heads and the scheduler was supposed to try to locate her to come in and document this. So far, that has not happened." LPN 4 indicated, with her being a new employee, she was unfamiliar with the facility's documentation and post-fall care process at the time of the fall. She indicated that she did			

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	not conduct any assessments of the resident after her fall and was unsure if anyone else might have done so. She indicated the resident's daughter was aware of the fall, but was unsure if the resident's physician or nurse practitioner was made aware of the fall. The facility provided documentation for a post-fall without injury form, dated 3-27-22. It indicated on 3-29-22, the "Unit Manager was made aware that resident had a fall with no injury on 3-29-22." It indicated Resident C was unable to describe any details regarding the fall. It indicated Resident C was able to ambulate independently, was alert to person with predisposing factors of poor lighting, gait imbalance, impaired memory, confusion, dementia and had a recent room change. Her care plan reflected she was a fall risk. There was not any clear documentation of a physical assessment conducted at the time of the fall. A note, dated 3-30-22, indicated, "UM [unit manager], ACD [activities director] and DNS [director of nursing services] were over fall [sic] CP [care plan] for this resident. She was recently moved back to the unit for increased wandering. Family was very hesitant about this. ED and DNS were concerned about safety. She appears to be adapting well to her surroundings. Staff were made aware by an agency staff member that a fall had occurred in the unit. MD and family were notified. No injuries were noted. Resident is unable to recall falling. Current fall interventions were in place. Agency staff member was asked not to the facility due to lack of documentation. Resident appears to be acclimated to her new environment and shows no signs of psycho-social distress There is no evident cause of the fall. Resident just appears to have tripped. Shoes were assessed to ensure soles still have grip and were still dependable."			

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	The ED provided a copy of a policy entitled, "Fall Prevention Program," on 4-6-22 at 1:55 p.m. This policy was indicated to be the current policy utilized by the facility. It indicated, "When any resident experiences a fall, the facility will: Assess the resident; Complete a post-fall assessment; Complete an incident report; Notify physician and family; Review the resident's care plan and update as indicated; Document all assessments and actions; Obtain witness statements in the case of injury." This Federal deficiency relates to Complaint IN00375612. 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's			

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	clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on interview and record review, the facility failed to provide the care and services of a mechanical lift to transfer 1 of 3 residents reviewed for activites of daily (ADL) care to the bathroom, resulting in an incontinent episode for a resident who is typically continent. (Resident E) Findings include: The clinical record of Resident E was reviewed on 4-6-22 at 11:50 a.m. Her diagnosis included, but were not limited to dorsalgia (severe back pain), chronic pain, generalize osteoarthritis, morbid obesity, restless leg syndrome, anxiety, depression, hypertension and generalized muscle weakness. Her most recent Minimum Data Set (MDS) assessment, dated 3-25-22, indicated she is cognitively intact, is fully dependent for transfers from one surface to another, is unable to ambulate, requires a wheelchair for mobility, requires extensive assistance of two or more persons for toileting services and is occasionally incontinent of bladder. In an interview with Resident E on 4-6-22 at 11:15 a.m., she indicated sometime in March, 2022, she	F 0690	F 690 Bowel/Bladder Incontinence **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident E: Medical record was reviewed and plan of care updated appropriately to include needs for toileting and transfer assistance **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that require assistance with toileting/incontinence needs and transfers have the potential to be affected by the same deficient practice. Initial audit	05/17/2022

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	155120	A. BUILDING 00 B. WING	04/11/2022

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	had an interaction with an agency aide in which the aide "did not really want to get me up with the hoyer [mechanical lift], but I insisted. She made it clear it took her too long to have to use the hoyer. I take a water pill and it seems like everyday around lunchtime, I have to use the bathroom because of the water pill. Again, she [agency aide] was not happy about the thought of having to put me in the wheelchair and take me to the bathroom with the hoyer. She told me that somebody should have put a brief on me. She said she would be back to take me to the bathroom and never did. So, I ended up wetting myself and had to sit through lunch wet and did not get cleaned up until the afternoon aide came on duty. It was very upsetting and embarrassing." Resident E indicated she did not tell anyone at the facility about this situation, but did share this information with her daughter, who in turn, spoke with the facility management team. In an interview with QMA 6 on 4-8-22 at 2:42 p.m., she indicated she recalled Resident E "being very teary-eyed the afternoon of Saturday, 3-26-22." She recalled beginning her shift around 2:00 p.m., and had responded to Resident E's "call light or had entered the room to check on her. She told me earlier that day, an agency aide had either brought her lunch to her or was picking up her tray when the resident asked to be toileted." Resident E indicated the agency aide told her she would be back to take her to the bathroom and never returned. "So, I helped her to get cleaned up, because by that time, she had been incontinent of urine and had soaked through her panties and pants, requiring a complete change of clothing. [Name of Resident E] is a very intelligent woman and is not a complainer. She is normally continent of bowel and bladder. She does not wear an adult brief or even a sanitary		DNS or Designee completed a review of all residents that require assistance with toileting/incontinence and transfers to ensure plan or care reflects needed assistance and care is provided in a professional manner. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education Clinical staff (Nurses/QMA/C.N.A.) were educated on the guidelines for providing Incontinence care, utilizing assistive devices (mechanical lifts) and guideline for promoting/maintaining resident dignity On-going monitoring DNS or Designee will observe staff providing toileting/incontinence care and transfers to ensure staff are promoting dignity and respect during care services. DNS or Designee will interview residents regarding needs being met in a timely manner and to promote dignity and respect. These reviews are to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the**	

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	pad." QMA 6 indicated Resident E did not have an adult brief in place at that time. In an interview on 4-6-22 at 1:32 p.m., with the Social Services Designee (SSD), she indicated she had recently spoken with the family member of Resident E, regarding care issues from the weekend of 3-26-22. She indicated the family member informed her an agency aide did not want to use the hoyer on the resident and left her wet after an incident in which the resident had her morning diuretic. The SSD indicated this resident is normally continent, but due to the staff member not complying with the resident's request for toileting, she was incontinent and left wet through lunch and not cleaned up until after the next shift arrived, several hours later. The SSD indicated this incident left the resident feeling like the staff member had been uncaring and had upset the resident quite a bit. This Federal tag relates to Complaint IN00376702 and IN00375612. 3.1-3(t)		**deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review the facility failed to adequately assess and treat a resident's pain for 1 of 3 residents reviewed for end of life care (Resident G).	F 0697	F 697 Pain Management **What corrective actions will be accomplished for those residents found to have been**	05/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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Finding include:

Review of the record of Resident G on 4/11/22 at 12:00 p.m., indicated the resident's diagnoses included, but were not limited to, anxiety, acquired absence of left and right leg above the knee, osteomyelitis and peripheral vascular disease. The resident was admitted to the facility on 4/1/22.

The hospital discharge orders and report for Resident G, dated 4/1/22 at 12:22 p.m., indicated the resident was ordered to cleanse the left ischium and sacrum with normal saline and pat dry. Apply sensicare to the peri wound skin. Lightly pack with 0.125% dakin's moistened gauze (treatment used to treat tissue infection of a pressure ulcer) and cover with a dressing twice a day. The wound was infected and worsening on the sacrum. The infection had spread to the pelvic bone and into the blood stream. The resident would be discharged to the facility with hospice end of life comfort and care.

The pain evaluation for Resident G, dated 4/3/22 at 5:40 p.m., indicated the resident was experiencing a current pain level of 8 on the 1-10 pain scale. The evaluation did not have any further documentation such as location, frequency, current pain treatment plan and if it was effective, goals for treatment management, characteristics of the pain, impact of quality of life, what made the pain worse, strategies that reduced the pain or possible causal factors.

During an interview and observation with Resident G on 4/11/22 at 1:40 p.m., indicated his hips and wound was hurting him "so bad" he rated his pain as a 7 on the 1 to 10 pain scale. The

affected by the deficient practice?

Resident G: Medical Record was reviewed and appropriately reflects pain assessment, management and plan of care for pain management.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken

All residents that are currently on pain management have the potential to be affected by the same deficient practice

Initial audit
DNS or Designee completed an audit of all residents on pain management to ensure pain goals are being met and plan of care reflects resident pain management needs.

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur
Education
Licensed Clinical staff were educated on the guideline for Pain Management to include but not limited to adequately assessing and treating a resident's pain.

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	155120	A. BUILDING 00 B. WING	04/11/2022

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

(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
	resident indicated the staff told him to roll side to side to help the pain, but it did not help. The resident indicated the facility had not been managing his pain. The resident's family member present also indicated the facility had not been managing the resident's pain. The resident was rolling side to side in his bed moaning and groaning in pain. During an interview with the Wound Nurse on 4/11/22 at 2:15 p.m., Resident G reported that his pain level was a 7 today and there was not a completed pain assessment done on 4/3/22. The Wound Nurse verified there had not been a completed pain assessment on the resident and it was the responsibility of the Unit Manager to complete one. During an observation and interview with the Wound Nurse on 4/11/22 at 2:30 p.m., Resident G had a large bandage on his sacrum from hip to hip. The dressing was dated 4/10/22. The Wound Nurse indicated she would complete an assessment of the wound and provide his treatment. The resident expressed he was having pain. The skin evaluation for Resident G, dated 4/11/22 at 3:28 p.m., indicated the resident had an unstageable pressure ulcer on the sacrum that measured 11 cm by 11 cm by 0.3 cm, with necrotic tissue and serous (thin, watery, clear) drainage. The tissue was painful. The resident had another unstageable pressure ulcer to the left ischium, with slough and serous drainage that measured 0.1 cm. that was also painful. The resident was having pain during the treatment and anxiety related to the pain. The pain management policy provided by the		On-going monitoring DNS or Designee will audit and interview residents to ensure pain management needs are being met per the residents plan of care. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **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** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	Director Of Nursing on 4/11/22 at 3:55 p.m., indicated the facility must ensure that pain management was provided to residents who require such services. The facility would evaluate for pain upon admission. Identifying key characteristics of the pain: duration of the pain, frequency, location, pattern, radiation of the pain, descriptors of the pain, impact of pain on quality of life and resident goals for management of pain control. This Federal tag relates to Complaint IN00374467. 3.1-37(a)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure medications are given as ordered by the physician, in that 1 of 3 residents reviewed for medications as ordered had the medications documented in the computerized Medication Administration Record (MAR), but found to have not been given as ordered for the morning medication administration. (Resident C) Findings include: The clinical record of Resident C was reviewed on 4-7-22 at 10:55 a.m. Her diagnoses included, but were not limited to, late onset Alzheimer's disease, hypertension, diabetes, atherosclerotic heart disease with a pacemaker and unsteadiness on her feet. Her most recent Minimum Data Set (MDS) assessment, dated 2-22-22 , indicated she has severely impaired cognitition, ambulates with limited assistance of one person and does not use	F 0760	F 760 Residents are free of significant med errors **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident C: Medical Record was reviewed for documentation that medications are given as ordered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that receive	05/17/2022

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	any equipment for mobility. In an interview with a family member on 4-7-22 at 9:35 a.m., she indicated there was a medication error recently in which a QMA had signed off on the MAR for Resident C's medications were given as ordered, but a cup of pills with her name was later found on the unit. On 4-8-22 at 3:50 p.m., the Director of Nursing (DON) provided a copy of a review of an incident, entitled "Med Error." This document indicated, "Agency QMA charted meds were given, however, meds were prepped and left in the top of the cart. It indicated there were no injuries associated with this incident. Progress notes reflected on 3-31-22 at 12:51 p.m., LPN 4 had "took over [medication] cart for [an] Agency QMA and noted that QMA had documented that meds were given, but meds were still in the top of the cart in medication prep cups. Family and NP [nurse practitioner] notified, ED [executive director] notified as well." In an interview on 4-8-22 at 3:50 p.m. with the DON, she indicated she had spoken with LPN 4 and discovered the Agency QMA 5 had admitted to documenting the medications as given on the MAR, but had not administered Resident C her medications. She indicated the 9:00 a.m. medications not given were as follows: -Metformin 500 milligrams (mg) one tablet by mouth one time daily at breakfast for type 2 diabetes. -PreServision (or the generic) one tablet by mouth daily for eye health. -aspirin 325 mg one tablet by mouth daily for heart health. -Tylenol 650 mg two tablets by mouth twice daily for back pain.		medication administration have the potential to be affected by the same deficient practice. Initial audit DNS or Designee completed a 7 day look back of residents to ensure medications are documented and administered as ordered. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education Nurses and QMAs received education on the Medication Administration Guidelines to include but not limited to ensuring medications are administered as ordered and documented. On-going monitoring DNS or Designee will review medication administration audit tool and ensure medications are documented and not left in medication cart for interviewable and non-interviewable residents. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not**	

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	-Fosamax 70 mg one tablet by mouth weekly on Thursday for osteoporosis. In review of the MAR for March 31, 2022, it was noted the Fosamax was signed off as administered by a different staff member at 5:00 a.m. Additionally, Agency QMA 5 had signed off the following medications for 9:00 a.m., as administered: -Pamelor 10 mg one tablet by mouth daily for depression. -Antifungal Clotrimazole 1% cream to groin-periarea every shift for fungal rash. On 4-11-22 at 3:55 p.m., the DON provided a copy of a policy entitled, "Medication Administration, " with a copyright date of 2021 and identified as the policy utilized by the facility. This policy indicated, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection...Sign MAR after administered..." This Federal tag relates to Complaint IN00375612. 3.1-48(c)(2)		**recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	