PRINTED: 05/16/2022 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155120	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/11/2022	
	PROVIDER OR SUPPLIEF	E - BRANDYWINE CARE CENTER	745 N	ADDRESS, CITY, STATE, ZIP COD SWOPE ST NFIELD, IN 46140		
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	N (X5) BE COMPLETION DATE	
Bldg. 00	IN00374467, IN003 and IN00376792. Complaint IN00374 Federal/State defici allegations are cited Complaint IN00375 Federal/State defici allegations are cited Complaint IN00375 deficiencies related Complaint IN00376 Federal/State defici allegations are cited Complaint IN00376 Federal/State defici allegations are cited Complaint IN00376 Federal/State defici is cited at F580.	5612 - Substantiated. encies related to the flat F580, F689, F690 and F760. 5691 - Substantiated. No to the allegations are cited. 5702 - Substantiated. encies related to the flat F557 and F690. 5792 - Substantiated. ency related to the allegations 16, 7, 8 and 11, 2022 55120 000050 266170	F 0000	Preparation, submission and implementation of this Plan Correction does not constitute admission or agreement with facts and conclusions set for the survey report. Our Plan Correction was prepared an executed as a means to continuously improve the queare and comply with all applicable federal and state requirements. The facility respectfully requested this survey.	of ute an h the rth on of id uality of	

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

Other: 25

(X6) DATE

TITLE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete RJJY11 Facility ID: 000050 If continuation sheet Page 1 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155120		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/11/2022			
	PROVIDER OR SUPPLIER	- BRANDYWINE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 745 N SWOPE ST GREENFIELD, IN 46140			
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F 0557 SS=D Bldg. 00	Total: 92 These deficiencies is accordance with 41st accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1. pleted on April 20, 2022 Right to have Prsnl Property ct and Dignity. a right to be treated with y, including: right to retain and use ons, including furnishings, pace permits, unless to do upon the rights or health r residents. and record review, the facility sident requiring toileting this service in a timely a the resident feel embarrassed tinent episode and feeling she exceed by a staff member for 1 wed for neglect and/or respect.	F 0557	F 557 Respect and Dignity What corrective actions will accomplished for those residents found to have bee affected by the deficient practice? Resident E: Medical record w reviewed and plan of care upon appropriately to include needs toileting and transfer assistant How other residents having potential to be affected by the same deficient practice will lidentified and what corrective action will be taken All residents that require assistance with toileting/incontinence needs a transfers have the potential to affected by the same deficient	05/17/2022 be n vas dated s for ce the ne be ve	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 2 of 27

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. RULLIDING B. WING STRIFET ADDRESS, CITY, STATE, ZIP COD 745 N SWOOPE ST GREENFIELD. IN 46140 SUMMARY STATIMENT OF DEFICIENCE: PREFIX TAG CALIFER PROPERTY MUST BE PRECEDED BY FULL TAG EXERNIVE assistance of five or more persons for tolleting 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 reall" want to get me up with the hoyer [mechanical lift], but I missisted. 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 whechelmar and take me to the bathroom wholes who wholes be about to take me to the bathroom and never did. So, I ended up werting 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 Enclity 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 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 brough the bank to be the root to check on her. "She told me earlier that day, an agency aide had either brough her has even the bathroom and had responded the agency aide told her she would be back to take her to the bathroom and had responded the agency aide told her she would be back to take her to the bathroom and had responded the agency aide told her she would be back to take her to the bathroom and had responded to the recombination and the providing	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
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						to intonviousble of	. d	
			e ,			to interviewable ar	ıu	
never returned. "So, I helped her to get cleaned non-interviewable						non-interviewable		
up, because by that time, she had been			-					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 3 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/11/2022 155120 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 745 N SWOPE ST BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE incontinent of urine and had soaked through her residents to ensure panties and pants, requiring a complete change of staff are promoting clothing. [Name of Resident E] is a very intelligent woman and is not a complainer. She is dignity and respect normally continent of bowel and bladder. She during care services does not wear an adult brief or even a sanitary pad." QMA 6 indicated Resident E did not have in a timely manner. an adult brief in place at that time. These reviews are to In an interview on 4-6-22 at 1:32 p.m., with the be conducted 5 Social Services Designee (SSD), she indicated she had recently spoken with the family member of times weekly x 4 Resident E, regarding care issues from the weeks, then 3 times weekend of 3-26-22. She indicated the family member informed her an agency aide did not want weekly x 4 weeks, to use the hoyer on the resident and left her wet then weekly x 4 after an incident in which the resident had her morning diuretic. The SSD indicated this resident months. 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 How the corrective lunch and not cleaned up until after the next shift arrived, several hours later. The SSD indicated action will be this incident left the resident feeling like the staff monitored to ensure member had been uncaring and had upset the resident quite a bit. the deficient practice will not recur, i.e., This Federal tag relates to Complaint IN00376702. what quality 3.1-3(t)assurance program will be put into place Results of these audits will be brought to QAPI

PRINTED: 05/16/2022

	Γ OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED 1B NO. 0938-039
	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155120	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/11/2022	
	PROVIDER OR SUPPLIER	E - BRANDYWINE CARE CENTE	R	745 N S	ADDRESS, CITY, STATE, ZIP COD SWOPE ST NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(i Notify of Changes §483.10(g)(14) No (i) A facility must i resident; consult v physician; and no	v)(15) (Injury/Decline/Room, etc.) otification of Changes. mmediately inform the		TAG	monthly x 6 month to identify trends and to make recommendations issues/trends are identified, then will continue audits based on QAPI recommendation. none noted, then work complete audits based on a prn basis.	. If II	DATE
	when there is- (A) An accident in results in injury ar requiring physicia (B) A significant cl	volving the resident which and has the potential for					

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(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

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 5 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155120			(X2) MULTIPLE CO A. BUILDING B. WING	URVEY TED 2022		
	F PROVIDER OR SUPPLIEI YARD HEALTHCARI	RE - BRANDYWINE CARE CENTE	745 N	ADDRESS, CITY, STATE, ZIP COD SWOPE ST NFIELD, IN 46140		
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	consequences, or of treatment); or (D) A decision to resident from the §483.15(c)(1)(ii). (ii) When making (g)(14)(i) of this sensure that all pe in §483.15(c)(2) is upon request to the (iii) The facility more resident and the resident and resident	transfer or discharge the facility as specified in notification under paragraph ection, the facility must rtinent information specified available and provided ne physician. Ist also promptly notify the esident representative, if second or roommate ecified in §483.10(e)(6); or esident rights under Federal gulations as specified in of this section. Ist record and periodically as (mailing and email) and the resident must disclose in its nent its physical uding the various locations composite distinct part, the policies that apply to tween its different locations				
	Based on interview failed to promptly a responsible party a residen'ts change o resident's death, an	and record review, the facility notify the family and/or and Hospice regarding a f condition, related to a d for elopement for 2 of 3 for notification. (Residents F	F 0580	F 580 Notify of Changes What corrective actions will accomplished for those residents found to have been affected by the deficient	be	05/17/2022

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and C)

Event ID:

RJJY11

Facility ID: 000050

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If continuation sheet

Page 6 of 27

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155120	B. WI	NG		04/11/	2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			SWOPE ST		
BRICKY#	ARD HEALTHCARE	- BRANDYWINE CARE CENTER			IFIELD, IN 46140		
DINONIA	WO HEALTHOANE	- DIVARD I WINE CARE CENTER		OKLLIN	III ILLD, III TO ITO		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				Resident F: No longer resides	at	
					the facility		
		rd of Resident F was reviewed			Resident C: Medical record w		
		a.m. Her diagnoses included,			reviewed and updated to refle	ct	
		d to Rheumatoid arthritis,			Physician and Family notificat	ion	
		cognitive impairment,			of change regarding fall and		
		foot and ankle, a history of			elopement.		
		and embolism (blood clots),					
	_	cation defict and general			How other residents having t		
		It indicated she had been			potential to be affected by th		
	~ .	ervices for one year for severe			same deficient practice will b	e	
	*	nutrition. The hospice			identified and what correctiv	е	
		ected she experienced a			action will be taken		
	significant decline i	in the days prior to passing.					
					All residents with a change in		
		n a family member on 4-7-22 at			condition have the potential to		
		cated, " [I] cannot express the			affected by the same deficient		
		not being called about my			practice.		
		ne nursing home not even					
		tell you the absolute pain and			Initial audit		
		walked in around 9:15 [a.m.]			DNS or Designee completed a		
		empty. Of course, the nursing			day look back of all residents	to	
		nd apologized, but that's not			ensure that the physician and		
		ation. I just do not want this			family/responsible party have		
		er family. They hadn't even			notified of any change in cond		
	_	bout her death until after I			and notification is documented	d in	
	left."				the medical record.		
	-	w on 4-11-22 at 1:31 p.m., with			What measures will be put in	ito	
	-	e service, the staff member			place and what systemic		
		yed a phone call on the			changes will be made to		
		, from the nursing facility			ensure that the deficient		
		to notify their hospice agency			practice does not recur		
		esident F. She indicated the			Education		
		lained they were late in letting			Licensed clinical staff were		
		e nurse for the patient			educated on the guideline for		
	-	vas in the building around the			Notification of change in condi	tion	
	-	patient had passed. She [the			to include but not limited to		
	facility staff explai	ned it was actually a different	I		decline in health/death or risk		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155120	B. WI	NG		04/11/	2022
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
DDIOI()/A					SWOPE ST		
BRICKY	ARD HEALTHCARE	- BRANDYWINE CARE CENTER		GREEN	IFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	hospice company [t	hat was in the facility at that			event such as elopement or fa	lls	
	time.] This was def	finitely not the norm for any of			and notification is documented	l in	
	our hospice patients	s. Most facilities are really			the clinical record.		
	good to let us know	when things are looking					
	bad." During the in	itial portion of the phone			On-going monitoring		
	-	ent's name had not been			The DNS or Designee will revi	ew	
		pice agency, but the hospice			residents daily during morning		
		iately knew of whom was being			clinical review and/or rounding		
	-	rovision of the name of the			ensure changes in condition w		
		nt's name was verified to			identified and interventions		
		he hospice staff indicated the			implemented timely.		
	· ·	enced a significant decline in			These reviews to be conducte	d 5	
		to her death and her passing			times weekly x 4 weeks, then		
	was expected.	1 0			times weekly x 4 weeks, then		
	•				weekly x 4 months.		
	In an interview with	n the Director of Nursing					
		at 2:05 p.m., she indicated			How the corrective action wi	II .	
		morning meeting on 3-25-22,			be monitored to ensure the		
	-	told the group Resident F's son			deficient practice will not		
		I not been notified of his			recur, i.e., what quality		
		d "he had come to the facility			assurance program will be p	ut	
		ound her empty bed." The			into place		
		ready come and taken the			•		
		ral home. "The agency nurse			Results of these audits will be		
		he called [name of the funeral			brought to QAPI monthly x 6		
	home]. The funeral	home said they would call the			months to identify trends and t	io	
	_	outer, the way the funeral home			make recommendations. If		
		numbers were listed, it was			issues/trends are identified, th	en	
		ducated the agency nurse we			will continue audits based on		
		otify the family upon			QAPI recommendation. If nor	ie	
	-	ot the funeral home or the			noted, then will complete audi		
	Hospice. They [Ho	spice or funeral home] might			based on a prn basis.		
		nould be doing that."			,		
		_					
	2. The clinical reco	ord of Resident C was reviewed					
	on 4-7-22 at 10:55 a	a.m. Her diagnoses included,					
		l to, late onset Alzheimer's					
		on, diabetes, atherosclerotic					
		pacemaker and unsteadiness					
		ost recent Minimum Data Set					
			1		İ		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet Page 8 of 27

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155120		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/11/2022	
	PROVIDER OR SUPPLIER	- BRANDYWINE CARE CENTER	745 N S	ADDRESS, CITY, STATE, ZIP COD SWOPE ST IFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	has severely impaired limited assistance of any equipment for reassessments were conscored of 0.0, indicated 3-9-22 with a score risk of elopement at 5.0, indicating she will be sufficient to the facility of the facility facility. She indicated elopement, the reside wanderguard [device approaching areas the boundaries], as "I has a shower a day or so one." She indicated eloped from the builtime, but I was never find anything docur she had a wanderguard A written note, date Wound Nurse had president C's right a central supply. This the initial attempted Resident C eloping her moving to the sepecific information Resident C's clinical On 4-11-22 at 3:10 provided a copy of the second	e to audibly alarm when one is hat are not within acceptable ad given [name of Resident C] to before that and never saw Resident C, "apparently had Iding a few days before this er notified of it. I could not mented in her chart about it. If ard on, why didn't it alarm?" d 3-15-22, indicated the blaced the wanderguard to mkle, after receiving it from a would have occurred after a elopement and prior to from the facility and prior to becured memory care unit. This is was not documented in I record. p.m., the Executive Director a policy entitled, "Notification			
	or changes . Tills	policy had a copyright date of			1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet Page 9 of 27

PRINTED: 05/16/2022

DEPARTMENT CENTERS FOR		RM APPROVED IB NO. 0938-039					
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155120	A. BUILDING <u>00</u> B. WING			COMPLETED 04/11/2022	
	PROVIDER OR SUPPLIER		_	745 N S	ADDRESS, CITY, STATE, ZIP COD SWOPE ST		
BRICKYA	ARD HEALTHCARE	E - BRANDYWINE CARE CENTE	.K	GREEN	NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		ated to be the current policy					
	I -	ity. This policy indicated, "The					
		cy is to ensure the facility					
		ne resident, consults the					
		, consistent with his or her					
	1	ent's representative when there					
		g notificationthe facility ident, consult with the					
		and/or notify the resident's					
		egal representative when there					
	1	g notification. Circumstances					
		on include: Accidents resulting					
		tial to require physician					
		ficant change in the resident's					
		psychosocial condition such					
		health, mental or psychosocial					
		clude: Life-threatening					
	· ·	cal implicationsDeath of a					
	resident"	1					
	3.1-5(a)(1)						
	3.1-5(a)(2)						
	_	ates to Complaints IN00375612					
	and IN00376792.						
F 0686	483.25(b)(1)(i)(ii)						
SS=D		Prevent/Heal Pressure					
Bldg. 00	Ulcer						
=	§483.25(b) Skin Ir	ntegrity					
	§483.25(b)(1) Pre	• •					
		prehensive assessment of					
		ility must ensure that-					

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unavoidable; and

(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

(ii) A resident with pressure ulcers receives

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 10 of 27

STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155120	B. WI	NG		04/11/	/2022
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			SWOPE ST		
BRICKY	ARD HEALTHCARE	- BRANDYWINE CARE CENTER			NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	CF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	ent and services, consistent					
	1	standards of practice, to prevent infection and prevent					
	new ulcers from d						
		on, interview and record	F 06	586			05/17/2022
		failed to assess and treat an	1 00	700	F 686: Treatment/Services to		03/1//2022
	I -	re ulcer (full thickness tissue			Prevent/Heal Pressure Ulcer		
		dents reviewed for pressure			What corrective actions will	be	
	ulcers (Resident G)				accomplished for those		
					residents found to have been	n	
					affected by the deficient		
	Finding include:				practice?		
	Review of the recor	rd of Resident G on 4/11/22 at			Resident G: Medical record wa	as	
	12:00 p.m., indicate	ed the resident's diagnoses			reviewed for timely assessme	nt,	
	included, but were	not limited to, anxiety, acquired			treatment and updated plan of	f	
		right leg above the knee,			care regarding treatment and		
		eripheral vascular disease. The			services for wound care.		
	resident was admitt	ed to the facility on 4/1/22.					
		1 1			How other residents having		
		rge orders and report for			potential to be affected by th		
		1/1/22 at 12:22 p.m., indicated dered to cleanse the left			same deficient practice will be identified and what corrective		
		n with normal saline and pat			action will be taken	е	
		re to the peri wound skin.			action will be taken		
		0.125% dakin's moistened gauze			All residents that require treat	ment	
		reat tissue infection of a			of wounds have the potential t		
	`	cover with a dressing twice a			affected by the same deficient		
	1 -	s infected and worsening on			practice.		
		ection had spread to the pelvic					
		lood stream. The resident			Initial audit		
		d to the facility with hospice			DNS or Designee completed a		
	end of life comfort	and care.			audit of all resident with wound	ds	
	TEN	B 11 (C 1) 14/1/22			that require treatment and		
	1	or Resident G, dated 4/1/22 at			observation to ensure treatme		
	_	I the resident was admitted to			are completed as ordered and		
	pressure ulcer to sag	e hospital with an unstageable			assessments are done timely.		
	pressure urcer to sa	Ciuii.			What measures will be put in	nto	
	The skin evaluation	for Resident G, dated 4/1/22 at			place and what systemic	110	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet Page 11 of 27

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155120	B. W	ING		04/11	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	3			SWOPE ST		
BRICKY	ARD HEALTHCARE	- BRANDYWINE CARE CENTER			NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	the resident unstageable			changes will be made to		
	pressure ulcer on the sacrum that measured 9				ensure that the deficient		
	centimeters (cm) by 9 cm by 0.4 cm. The wound				practice does not recur		
		erosanguineous (thin, watery,			Education		
		nage. There were no further			Licensed Clinical staff were		
		in the resident's electronic			education on the guidelines fo		
	health record.				Wound Treatment Manageme	ent to	
					include but not limited to,		
	* *	r for Resident G, dated 4/4/22,			completion of treatments as		
	indicated the resident was ordered wound care to				ordered and timely assessme	nt of	
	the sacrum, irrigate and pat dry. Apply Dakins				wounds.		
	soaked kerlix to wound bed and cover with a						
	dressing every 12 hours. This indicated the				On-going monitoring		
		dered a treatment for the			The DNS or Designee will aud		
	unstageable pressur	e ulcer for 4 days.			residents with actual wounds	for	
					timely completion of weekly		
		ministration Record for			assessment. Reviews will be		
		April 2022, indicated the			completed 2 times a week x 4		
		eive a treatment to the			weeks then weekly x5 months	3.	
		re ulcer 11 times since			The DNS or Designee will		
	admitted to the faci	lity.			complete a random observation		
					residents with wounds to ensu		
	_	v and observation with			treatments are completed time	-	
		/22 at 1:40 p.m., indicated his			and per physician orders. The		
	_	s hurting him "so bad" he			reviews to be conducted 5 tim		
	_	on the 1 to 10 pain scale. The			weekly x 4 weeks, then 3 time		
		he staff told him to roll side to			weekly x 4 weeks, then weekl	y x	
		n, but it did not help. The			4 months.		
		when he was admitted to the]., ,, ,, ,, ,,		
	•	ne facility did not provide a			How the corrective action wi	II	
	_	essure ulcer and "from time to			be monitored to ensure the		
		nys" completing his pressure			deficient practice will not		
		e resident was rolling side to			recur, i.e., what quality	4	
	side in his bed moa	ning and groaning in pain.			assurance program will be p	ut	
	During an interview	w with the Wound Nurse on			into place		
		, indicated the admitting nurse			Results of these audits will be		
		t G's unstageable pressure					
	1 ^	the orders was why the			brought to QAPI monthly x 6	to	
		the orders was why the			months to identify trends and	i.U	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155120		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/11/2022	
	PROVIDER OR SUPPLIER	- BRANDYWINE CARE CENTER	745 N S	ADDRESS, CITY, STATE, ZIP COD SWOPE ST NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	twice a day. The W no assessments com since 4/1/22. The W the responsibility of	ole to complete the treatment ound Nurse verified there were appleted of the pressure ulcer Yound Nurse indicated it was f the Unit Manager to are ulcer assessments.		issues/trends are identified, the will continue audits based on QAPI recommendation. If nor noted, then will complete audit based on a prn basis.	ne
	Wound Nurse on 4/ had a large bandage The dressing was da Nurse indicated she	on and interview with the 11/22 at 2:30 p.m., Resident G on his sacrum from hip to hip. ated 4/10/22. The Wound would complete an round and provide his			
	4/11/22 at 3:56 p.m new pressure ulcer assessment on the le	with the Wound Nurse on ., indicated Resident G had a when she completed the eft ishium. The Wound Nurse re ulcer's assessment.			
	at 3:28 p.m., indicat unstageable pressur measured 11 cm by tissue and serous (the The tissue was pain unstageable pressur	for Resident G, dated 4/11/22 ted the resident had an e ulcer on the sacrum that 11 cm by 0.3 cm, with necrotic nin, watery, clear) drainage. ful. The resident had another e ulcer to the left ischium, ous drainage that measured			
	provided by the Dir 3:55 p.m., indicated promote healing of implement interven implemented in acc orders. For resident present: treatment in	prevention guidelines ector Of Nursing on 4/11/22 at I the facilities policy was to pressure ulcers and to tions. Interventions would be ordance with the physician s who have a pressure injury nedication administration wound summary charting was			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 13 of 27

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155120	B. WI	NG		04/11/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				SWOPE ST		
BRICKYA	ARD HEALTHCARE	- BRANDYWINE CARE CENTER			IFIELD, IN 46140		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ace with interventions					
	documented.						
	This F. Jamel 44 - 11-1	-t t- C1-int D100274467					
	This Federal tag rela	ates to Complaint IN00374467.					
	3.1-40						
	3.1 10						
F 0689	483.25(d)(1)(2)						
SS=D	Free of Accident						
Bldg. 00	Hazards/Supervisi	ion/Devices					
	§483.25(d) Accide	ents.					
	The facility must e						
	- ' ' ' '	resident environment					
		accident hazards as is					
	possible; and						
	\$402 0E/d\/0\Eack	a regident regelyes					
	- , , , ,	n resident receives sion and assistance devices					
	to prevent acciden						
	•	and record review, the facility	F 06	89			05/17/2022
		equate supervision to prevent	1 00	,0)	F 689 Free of Accident		03/1//2022
		the premises for 1 of 3			Hazards/Supervision		
	resident reviewed for	or elopements for a resident			What corrective actions will	be	
	with previous attem	pts of exit seeking and for			accomplished for those		
		nitor and document a fall for 1			residents found to have beer	า	
	of 3 residents review	wed for falls. (Resident C)			affected by the deficient		
					practice?		
	Findings include:				Desident Me P. J.D.	_	
	A The eliminal	ord of Resident C was reviewed			Resident : Medical Record wa		
		n.m. Her diagnoses included,			reviewed and updated to reflect family notification of risk event		
		to, late onset Alzheimer's			current assessment for fall and		
		on, diabetes, atherosclerotic			elopement risk and care plan	-	
		pacemaker and unsteadiness			updated with appropriate		
		ost recent Minimum Data Set			interventions		
	(MDS) assessment,	dated 2-22-22, indicated she					
	has severely impaire	ed cognition, ambulates with			How other residents having t	the	
		f one person and does not use			potential to be affected by th	е	
	any equipment for n	nobility. Elopement risk			same deficient practice will b	е	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet Page 14 of 27

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	.ETED
		155120	B. WI	NG		04/11/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		l	SWOPE ST		
BRICKY	ARD HEALTHCARE	E - BRANDYWINE CARE CENTER			NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	assessments were c	onducted on 2-21-22 with a			identified and what correctiv	е	
	score of 0.0, indicar	ting she was not at risk; on			action will be taken		
	3-9-22 with a score of 3.0, indicating she was at						
	risk of elopement a	nd on 3-13-22 with a score of			All residents at risk for falls or		
	5.0, indicating she	was at high risk of elopement.			elopement are at risk for the s	ame	
					deficient practice.		
	A care plan, develo	ped on 3-9-22, for "At risk for					
	elopement related to	o: Attempts to leave Living			Initial audit		
	Center wanders [sid	c]." The interventions			DNS or Designee completed a	a 30	
	identified for this c	oncern were listed as the			day look back of all risk events	s to	
	placement of a wan	derguard, initiated on 3-9-22			ensure there is documentation	ı of	
	and revised on 3-14	1-22; admission to the secured			notification, risk assessment a	ınd	
	memory care unit o	n 3-13-22; evaluation of the			plan of care updated with		
	resident's cognitive	impairment on the resident's			appropriate interventions		
	ability to understan	d initiated on 3-9-22 and on					
	3-14-22 to redirect	the resident away from doors.			What measures will be put ir	ito	
					place and what systemic		
	In an interview with	n a family member on 4-7-22 at			changes will be made to		
	9:35 a.m., she indic	eated she had been notified of			ensure that the deficient		
	Resident C eloping	from the facility on the			practice does not recur		
		2 to the building immediately					
		and asked to come into the			Education		
		ted at the time of the			Licensed staff were educated		
	elopement, the resid				the guideline for Fall Prevention	on	
		ce to audibly alarm when one is			Program and Elopement and		
		hat are not within acceptable			Wandering Resident. To inclu	ıde	
	_	ad given [name of Resident C]			but not limited to Risk		
		o before that and never saw			assessment, post risk event		
		d Resident C, "apparently had			follow-up and interventions wi	th	
	-	ilding a few days before this			documented notification.		
		er notified of it. I could not					
		mented in her chart about it. If			On-going monitoring		
	she had a wandergu	ard on, why didn't it alarm?"			DNS or Designee will review r		
					events daily to ensure there is		
		4-11-22 at 10:02 a.m., with LPN			appropriate follow up to includ	e but	
	_	or to Resident C being			not limited to documented		
		ared memory care unit, she had			notification, risk assessment a	nd	
		nt ambulate to the end of the			updated plan of care. These		
		he resided and would pull on			reviews to be conducted 5 tim	es	
	I the exit doors and v	yould say she was looking for	1		weekly x 4 weeks, then 3 time	·s	1

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

PRINTED: 05/16/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155120	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/11/2022
	ROVIDER OR SUPPLIER	- BRANDYWINE CARE CENTER	745 N S	ADDRESS, CITY, STATE, ZIP COD SWOPE ST IFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION 3 indicated Resident C was	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Weekly x 4 weeks, then weekl	DATE
	easy to redirect awa indicated she "could but the resident did	y from the doors. LPN 3 In't provide a specific date, have a wanderguard placed		4 months. How the corrective action wi	
	moving to the secur indicated, after the p Resident C would a	next door and prior to her ed dementia unit." LPN 3 placement of the wanderguard, sk LPN 3 if she had any		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be p	ut
	called "the watch or around mid-afternood door, the wandergua	o cut off what the resident her ankle." LPN 3 indicated on of the day she eloped next and strap was not located, but		Results of these audits will be brought to QAPI monthly x 6	
	the hall she resided station. "The agenc know what it was; s	and was found on the floor of on, closer to the nurse's y aide who found it did not he thought it was part of		months to identify trends and make recommendations. If issues/trends are identified, the will continue audits based on	en
	aware with the residunknown date, that	LPN 3 indicated she was lent's initial elopement attempt, the resident did not have a tempted to elope by following		QAPI recommendation. If nor noted, then will complete audi based on a prn basis.	
	someone out the ent the entry door parki it is assumed she we	trance and was in sight and in ng lot. "The second attempt, ent out the door when			
	indicated after the s made to move Resid	ng into the building." LPN 3 econd attempt, a decision was dent C to the secured memory ntation of Resident C exit			
	elopement attempt i	f her hallway and the initial nto the front parking area were sident's clinical record.			
	Wound Nurse had p	d 3-15-22, indicated the blaced the wanderguard to nkle, after receiving it from			
	the initial attempted Resident C eloping her moving to the so specific information	s would have occurred after l elopement and prior to from the facility and prior to ecured memory care unit. This n was not documented in			
	Resident C's clinica	l record.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 16 of 27

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155120	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/11/2022
	ROVIDER OR SUPPLIER	- BRANDYWINE CARE CENTER	745 N S	ADDRESS, CITY, STATE, ZIP COD SWOPE ST IFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	on 4-7-22 at 10:55 a but were not limited disease, hypertensic heart disease with a on her feet. Her mo (MDS) assessment, has severely impaire limited assistance of any equipment for moteral had any falls simperiod. A Fall Risk indicated she was at in the last 3 months. In an interview with on 4-7-22 at 9:35 a. recently informed his previous evening (dindicated she had be documentation in the regarding any falls of care unit (MCU). In an interview on 4 she indicated on/arcof Resident C having began. She indicated QMA 7, had been to Resident C had a fall had not been injured shift nurse had check it up in the morning heads and the sched locate her to come it that has not happend being a new employ facility's documentation.	and of Resident C was reviewed a.m. Her diagnoses included, I to, late onset Alzheimer's on, diabetes, atherosclerotic pacemaker and unsteadiness est recent Minimum Data Set dated 2-22-22, indicated she ed cognition, ambulates with fone person and does not use mobility. It indicated she had use the last certification time. Assessment, dated 2-21-22, trisk of falls and had no falls are family member of Resident C m., she indicated a staff member er Resident C had a fall the ate unspecified). She seen unable to locate any eresident's clinical record while on the secured memory 1-8-22 at 11:40 a.m., with LPN 4, and 3-29-22, she was notified g a fall after the morning shift and an agency staff member, old in the shift hand-off, Il during the night shift and I. "I don't know if the night ked her out or not. I did bring meeting with the department uler was supposed to try to an and document this. So far, ed." LPN 4 indicated, with her tree, she was unfamiliar with the tion and post-fall care process II. She indicated that she did			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 17 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155120	B. WING		04/11/2022
NAME OF T	DOLUDED OF CURRY TO		STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	ROVIDER OR SUPPLIER		745 N S	SWOPE ST	
BRICKYA	ARD HEALTHCARE	- BRANDYWINE CARE CENTER	GREEN	NFIELD, IN 46140	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		essments of the resident after			
		sure if anyone else might have			
		ated the resident's daughter Il, but was unsure if the			
		or nurse practitioner was			
	made aware of the f	-			
	made aware or the r				
	The facility provide	ed documentation for a post-fall			
		, dated 3-27-22. It indicated on			
		Manager was made aware that			
	resident had a fall w	vith no injury on 3-29-22." It			
	indicated Resident (C was unable to describe any			
		e fall. It indicated Resident C			
		te independently, was alert to			
		osing factors of poor lighting,			
		aired memory, confusion,			
		recent room change. Her care			
	_	vas a fall risk. There was not			
	-	ation of a physical assessment			
		ne of the fall. A note, dated			
		"UM [unit manager], ACD and DNS [director of nursing			
		fall [sic] CP [care plan] for this			
	_	ecently moved back to the unit			
		ering. Family was very			
		ED and DNS were concerned	1		
		ppears to be adapting well to			
		Staff were made aware by an			
		er that a fall had occurred in the			
		y were notified. No injuries	1		
	were noted. Reside	nt is unable to recall falling.	1		
		ntions were in place. Agency	1		
		sked not to the facility due to			
		on. Resident appears to be			
		ew environment and shows no			
		ial distress There is no	1		
		fall. Resident just appears to			
		s were assessed to ensure	1		
	soles still have grip	and were still dependable."			
			1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 18 of 27

PRINTED: 05/16/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155120	r í	JILDING	ONSTRUCTION 00	(X3) DATE COMPI 04/11	LETED
	PROVIDER OR SUPPLIEF	RE - BRANDYWINE CARE CENTE	:R	745 N S	ADDRESS, CITY, STATE, ZIP COD SWOPE ST IFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 0690 SS=D Bldg. 00	Prevention Program policy was indicate utilized by the facil resident experience the resident; Complete an incide family; Review the as indicated; Docur actions; Obtain with injury." This Federal deficient IN00375612. 3.1-45(a)(2) 483.25(e)(1)-(3) Bowel/Bladder Inc §483.25(e) (ncont §483.25(e) (ncont §483.25(e) (ncont §483.25(e)(1)) The resident who is composed by the composition of the clinical contract continence is \$483.25(e)(2)For incontinence, bas comprehensive as ensure that- (i) A resident who an indwelling cath unless the resider demonstrates that necessary;	copy of a policy entitled, "Fall n," on 4-6-22 at 1:55 p.m. This d to be the current policy ity. It indicated, "When any s a fall, the facility will: Assess lete a post-fall assessment; int report; Notify physician and resident's care plan and update ment all assessments and mess statements in the case of ency relates to Complaint continence, Catheter, UTI inence. If facility must ensure that continent of bladder and on receives services and intain continence unless his dition is or becomes such not possible to maintain. a resident with urinary ed on the resident's essessment, the facility must enters the facility without the enters the facility without enters the facility without enters the facility with an or enters the facility with an or enters the facility with an ent					

FORM CMS-2567(02-99) Previous Versions Obsolete

indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 19 of 27

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155120	(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG <u>00</u>	(X3) DATE SURVEY COMPLETED 04/11/2022
	PROVIDER OR SUPPLIER	- BRANDYWINE CARE CENTER	745	REET ADDRESS, CITY, STATE, ZIP COD 5 N SWOPE ST REENFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO THE APPR	D BE COMPLETION
	receives appropriate to prevent urinary restore continence. \$483.25(e)(3) For incontinence, base comprehensive as ensure that a reside bowel receives appropriate to provide the mechanical lift to the reviewed for activities bathroom, resulting a resident who is type. Findings include: The clinical recorded 4-6-22 at 11:50 a.m. were not limited to chronic pain, generate obesity, restless leg depression, hyperter weakness. Her most (MDS) assessment, cognitively intact, is from one surface to ambulate, requires a requires extensive a persons for toileting incontinent of bladd. In an interview with	necessary; and of is incontinent of bladder ate treatment and services tract infections and to be to the extent possible. a resident with fecal and on the resident's assessment, the facility must dent who is incontinent of propriate treatment and as much normal bowel as much normal bowel are and services of a ansfer 1 of 3 residents as of daily (ADL) care to the in an incontinent episode for pically continent. (Resident E) of Resident E was reviewed on an incontinent episode for pically continent. (Resident E) of Resident E was reviewed on a territorial and generalized muscle at recent Minimum Data Set dated 3-25-22, indicated she is a fully dependent for transfers another, is unable to a wheelchair for mobility, ssistance of two or more a services and is occasionally	F 0690	F 690 Bowel/Bladder Inco What corrective actions accomplished for those residents found to have affected by the deficient practice? Resident E: Medical recorreviewed and plan of care appropriately to include not toileting and transfer assist How other residents have potential to be affected be same deficient practice identified and what correction will be taken All residents that require assistance with toileting/incontinence need transfers have the potential affected by the same deficient practice. Initial audit	been d was updated eeds for stance ing the by the will be ective ds and al to be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 20 of 27

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155120	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/11/2022	
	PROVIDER OR SUPPLIER	I : : - BRANDYWINE CARE CENTER	745 N	SWOPE ST		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE	
	the aide "did not rea	with an agency aide in which ally want to get me up with the		DNS or Designee completed review of all residents that red		
	hoyer [mechanical lift], but I insisted. She made it clear it took her too long to have to use the hoyer.			assistance with toileting/incontinence and		
	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			transfers to ensure plan or ca reflects needed assistance ar		
				care is provided in a profession	onal	
	to put me in the who	eelchair and take me to the		What measures will be put i	nto	
	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			place and what systemic		
	bathroom and never did. So, I ended up wetting			changes will be made to ensure that the deficient		
	myself and had to sit through lunch wet and did not get cleaned up until the afternoon aide came			practice does not recur Education		
	on duty. It was very embarrassing." Res	y upsetting and sident E indicated she did not		Clinical staff (Nurses/QMA/C. were educated on the guideling)	•	
	-	cility about this situation, but nation with her daughter, who		for providing Incontinence cal utilizing assistive devices	re,	
		the facility management team.		(mechanical lifts) and guidelir promoting/maintaining reside		
		n QMA 6 on 4-8-22 at 2:42 p.m., called Resident E "being very		dignity		
	teary-eyed the after She recalled beginn	noon of Saturday, 3-26-22." ing her shift around 2:00 p.m.,		On-going monitoring DNS or Designee will observe		
	had entered the room	to Resident E's "call light or m to check on her. She told		providing toileting/incontinent care and transfers to ensure	staff	
	brought her lunch to	an agency aide had either her or was picking up her		are promoting dignity and res during care services.		
	Resident E indicate	ent asked to be toileted." d the agency aide told her she		DNS or Designee will intervie residents regarding needs be	ing	
		ke her to the bathroom and b, I helped her to get cleaned		met in a timely manner and to promote dignity and respect.		
	up, because by that incontinent of urine	time, she had been and had soaked through her		These reviews are to be cond 5 times weekly x 4 weeks, the		
	panties and pants, re	equiring a complete change of Resident E] is a very		times weekly x 4 weeks, then weekly x 4 months.	I	
	intelligent woman a	and is not a complainer. She is of bowel and bladder. She			:11	
	-	ult brief or even a sanitary		How the corrective action w be monitored to ensure the	""	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet Page 21 of 27

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155120
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREGULATORY OR LSC IDENTIFYING INFORMATION 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 STREET ADDRESS, CITY, STATE, ZIP COD 745 N SWOPE ST GREENFIELD, IN 46140 (X5) CMPLETION DATE deficient practice will not recur, i.e., what quality assurance program will be put into place 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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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 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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morning diuretic. The SSD indicated this resident is normally continent, but due to the staff member not complying with the resident's request for QAPI recommendation. If none noted, then will complete audits based on a prn basis.
is normally continent, but due to the staff member not complying with the resident's request for noted, then will complete audits based on a prn basis.
not complying with the resident's request for based on a prn basis.
tonome, one was mediument and left wet unough
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)
F 0007
F 0697
SS=D Pain Management
Bldg. 00 §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 F 0697 05/17/2022
review the facility failed to adequately assess and F 697 Pain Management
treat a resident's pain for 1 of 3 residents reviewed What corrective actions will be
for end of life care (Resident G). accomplished for those
residents found to have been

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet Page 22 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/11/2022 155120 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 745 N SWOPE ST BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE affected by the deficient Finding include: practice? Resident G: Medical Record was Review of the record of Resident G on 4/11/22 at reviewed and appropriately reflects 12:00 p.m., indicated the resident's diagnoses pain assessment, management included, but were not limited to, anxiety, acquired and plan of care for pain absence of left and right leg above the knee, management. osteomyelitis and peripheral vascular disease. The resident was admitted to the facility on 4/1/22. How other residents having the potential to be affected by the The hospital discharge orders and report for same deficient practice will be Resident G, dated 4/1/22 at 12:22 p.m., indicated identified and what corrective the resident was ordered to cleanse the left action will be taken ischium and sacrum with normal saline and pat dry. Apply sensicare to the peri wound skin. All residents that are currently on Lightly pack with 0.125% dakin's moistened gauze pain management have the (treatment used to treat tissue infection of a potential to be affected by the pressure ulcer) and cover with a dressing twice a same deficient practice day. The wound was infected and worsening on the sacrum. The infection had spread to the pelvic Initial audit bone and into the blood stream. The resident DNS or Designee completed an would be discharged to the facility with hospice audit of all residents on pain end of life comfort and care. management to ensure pain goals are being met and plan of care The pain evaluation for Resident G, dated 4/3/22 reflects resident pain management at 5:40 p.m., indicated the resident was needs. experiencing a current pain level of 8 on the 1-10 pain scale. The evaluation did not have any What measures will be put into further documentation such as location, place and what systemic frequency, current pain treatment plan and if it changes will be made to was effective, goals for treatment management, ensure that the deficient characteristics of the pain, impact of quality of life, practice does not recur what made the pain worse, strategies that reduced Education the pain or possible causal factors. Licensed Clinical staff were educated on the guideline for Pain During an interview and observation with Management to include but not Resident G on 4/11/22 at 1:40 p.m., indicated his limited to adequately assessing hips and wound was hurting him "so bad" he and treating a resident's pain.

FORM CMS-2567(02-99) Previous Versions Obsolete

rated his pain as a 7 on the 1 to 10 pain scale. The

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 23 of 27

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155120	B. W	ING		04/11/	2022	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	3			SWOPE ST			
BRICKY	ARD HEALTHCARE	E - BRANDYWINE CARE CENTER	₹		IFIELD, IN 46140			
	T		1		· 		(VE)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG	·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION he staff told him to roll side to	+	TAG			DATE	
		n, but it did not help. The			On-going monitoring	d		
		-			DNS or Designee will audit ar			
	resident indicated the facility had not been				interview residents to ensure			
	managing his pain. The resident's family member present also indicated the facility had not been				management needs are being			
	_	ent's pain. The resident was			per the residents plan of care. These reviews to be conducted			
		in his bed moaning and			times weekly x 4 weeks, then			
	groaning in pain.	in ms ocu moaning and			times weekly x 4 weeks, then	J		
	groaning in pain.							
	During an interview	v with the Wound Nurse on			weekly x 4 months.			
	-				How the corrective action wi			
4/11/22 at 2:15 p.m., Resident G reported that his				be monitored to ensure the	11			
	pain level was a 7 today and there was not a completed pain assessment done on 4/3/22. The				deficient practice will not			
		ied there had not been a			recur, i.e., what quality			
		essment on the resident and it			assurance program will be p			
		ity of the Unit Manager to			into place	uı		
	complete one.	ity of the offit Manager to			Into place			
	complete one.				Results of these audits will be			
	During an observat	ion and interview with the			brought to QAPI monthly x 6			
	-	/11/22 at 2:30 p.m., Resident G			months to identify trends and	to		
		e on his sacrum from hip to hip.			make recommendations. If	io .		
		ated 4/10/22. The Wound			issues/trends are identified, th	ıen		
		e would complete an			will continue audits based on			
		yound and provide his			QAPI recommendation. If no	ne		
		dent expressed he was having			noted, then will complete audi			
	pain.	active empression for their flut flut			based on a prn basis.			
	1				23304 on a pin baolo.			
	The skin evaluation	n for Resident G, dated 4/11/22						
		ted the resident had an						
	_	re ulcer on the sacrum that						
		11 cm by 0.3 cm, with necrotic						
		hin, watery, clear) drainage.						
		iful. The resident had another						
		re ulcer to the left ischium,						
		ous drainage that measured						
		so painful. The resident was						
		the treatment and anxiety						
	related to the pain.	•						
	The pain managem	ent policy provided by the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet Page 24 of 27

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í				DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155120	B. WI		00	04/11/		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
BRICKYA	ARD HEALTHCARE	- BRANDYWINE CARE CENTER		GREEN	IFIELD, IN 46140			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
F 0760 SS=D Bldg. 00	indicated the facility management was prequire such service for pain upon admis characteristics of the frequency, location, descriptors of the particular of life and resident accontrol. This Federal tag relations as 1.3.1-37(a) 483.45(f)(2) Residents are Free The facility must endicated to ensure medical based on interview failed to ensure medications as a commended in the company of the physician, in for medications as a commended in the company of the physician and the company of the physician and the company of the comp	dents are free of any	F 07	760	F 760 Residents are free of significant med errors What corrective actions will accomplished for those residents found to have been affected by the deficient practice? Resident C: Medical Record wareviewed for documentation the medications are given as order those the medications are given as order to the medication of the medication of the medication of the medication are given as order to the medication of the medication are given as order than the medication of the medication are given as order to the medication are giv	vas nat nred. the e	05/17/2022	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet Page 25 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155120	B. WI	ING		04/11/	2022
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIE	R			SWOPE ST		
BRICKY	ARD HEALTHCAR	E - BRANDYWINE CARE CENTER			IFIELD, IN 46140		
						1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	any equipment for	mobility.			medication administration have		
	In an interview	h a family mambar as 4.7.22 at			potential to be affected by the	!	
		h a family member on 4-7-22 at cated there was a medication			same deficient practice.		
	· ·	nich a QMA had signed off on			Initial audit		
		ent C's medications were given			DNS or Designee completed a	a 7	
		up of pills with her name was			day look back of residents to	a <i>1</i>	
	later found on the u				ensure medications are		
	inter reality on the t				documented and administered	d as	
	On 4-8-22 at 3:50 r	o.m., the Director of Nursing			ordered.	_ 40	
		copy of a review of an incident,					
		r." This document indicated,			What measures will be put in	nto	
		arted meds were given,			place and what systemic		
		re prepped and left in the top of			changes will be made to		
		ed there were no injuries			ensure that the deficient		
	associated with this	s incident. Progress notes			practice does not recur		
	reflected on 3-31-2	2 at 12:51 p.m., LPN 4 had "took			Education		
		eart for [an] Agency QMA and			Nurses and QMAs received		
		d documented that meds were			education on the Medication		
	-	ere still in the top of the cart in			Administration Guidelines to		
		ps. Family and NP [nurse			include but not limited to ensu	-	
	-	ed, ED [executive director]			medications are administered	as	
	notified as well."				ordered and documented.		
		4000 1050					
		4-8-22 at 3:50 p.m. with the			On-going monitoring		
		d she had spoken with LPN 4			DNC or Designate will word		
		Agency QMA 5 had admitted			DNS or Designee will review	1;4	
		medications as given on the administered Resident C her			medication administration aud		
	· ·	ndicated the 9:00 a.m.			tool and ensure medications a documented and not left in	ale	
		ven were as follows:			medication cart for interviewal	hle	
	_	lligrams (mg) one tablet by			and non-interviewable resider		
		lly at breakfast for type 2			These reviews to be conducted		
	diabetes.	if at orealist for type 2			times weekly x 4 weeks, then		
		ne generic) one tablet by mouth			times weekly x 4 weeks, then		
	daily for eye health	•			weekly x 4 months.		
		e tablet by mouth daily for heart					
	health.	,y			How the corrective action wi	ill	
		vo tablets by mouth twice daily			be monitored to ensure the		
	for back pain.	-			deficient practice will not		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJJY11

Facility ID: 000050

If continuation sheet

Page 26 of 27

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

PRINTED: 05/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155120	B. WING		04/11/2022		
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 745 N SWOPE ST GREENFIELD, IN 46140				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ACH CORRECTIVE ACTION SHOULD BE COMPLET OSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG			DATE
	-Fosamax 70 mg one tablet by mouth weekly on				recur, i.e., what quality		
	Thursday for osteoporosis.			assurance program will be		ut	
					into place		
	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				Results of these audits will be brought to QAPI monthly x 6 months to identify trends and make recommendations. If issues/trends are identified, the will continue audits based on QAPI recommendation. If nor noted, then will complete audit based on a prn basis.		
	licensed nurses, or of authorized to do so physician and in acc standards of practic contamination or in administered" This Federal tag relationships and the standards of practic contamination or in administered"	ions are administered by other staff who are legally in this state, as ordered by the cordance with professional e, in a manner to prevent fectionSign MAR after					
	3.1-48(c)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RJJY11 Facility ID: 000050 If continuation sheet Page 27 of 27