				PRINTED:	00/21/2023
DEPARTMENT OF HEALTH AND HUM	FORM APPI	ROVED			
CENTERS FOR MEDICARE & MEDICA	OMB NO. 09	938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY	?
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	TILDING <u>00</u>	COMPLETED	
	155120	B. WING		06/01/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 745 N SWOPE ST		
BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			GREENFIELD, IN 46140		

BRICKY	ARD HEALTHCARE - BRANDYWINE CARE CENTEI		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	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for the Investigation of Complaint IN00408932. Complaint IN00408932. Federal/state deficiencies related to the allegations are cited at F607, F609 and F610 Unrelated deficiency is cited. Survey dates: May 31 and June 1, 2023 Facility number: 000050 Provider number: 155120 AIM number: 100266170 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 5 Medicarid: 70 Other: 27 Total: 102	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
F 0607 SS=D Bldg. 00	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 2, 2023 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,				

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

TITLE (X6) DATE

Rena Whichard DNS 06/17/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) E			(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLET			ETED	
		155120	B. W	NG		06/01/2023	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			SWOPE ST		
BRICKY	ARD HEALTHCARE	E - BRANDYWINE CARE CENTER			IFIELD, IN 46140		
	T		1				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCT		DATE
		oitation of residents and					
	misappropriation (of resident property,					
	8/83 12/h)/2) Fet	ablish policies and					
	procedures to inve						
	allegations, and	estigate any saon					
	anogationo, and						
	§483.12(b)(3) Incl	lude training as required at					
	paragraph §483.9						
		,					
	§483.12(b)(4) Est	ablish coordination with the					
	QAPI program red	quired under §483.75.					
	- , , , ,	sure reporting of crimes					
		ally-funded long-term care					
		lance with section 1150B of					
		cies and procedures must					
		t limited to the following					
	elements.						
	\$492.42/b\/E\/ii\	Docting a conceiquous					
	- , , , , , ,	Posting a conspicuous e rights, as defined at					
	section 1150B(d)(_					
	Section 1130b(d)(3) of the Act.					
	8483 12(h)(5)(iii)	Prohibiting and preventing					
	- , , , , , ,	ned at section 1150B(d)(1)					
	and (2) of the Act.						
		and record review, the facility	F 06	507	p paraid="1128052048"		06/30/2023
		ir polices and procedures		,	paraeid="{ff7f33ed-33a9-4ebf-	9e3d-	00/20/2020
		re followed for an allegation of			df8baab4912c}{168}" >What		
	physical and verbal	abuse for 1 of 3 residents			corrective actions will be		
	reviewed for abuse.	. (Resident D)			accomplished for those reside	nts	
					found to have been affected b	y the	
	Findings include:				deficient practice?		
	On 6-1-23 at 11:30	a.m., the Administrator					
		an abuse allegation for			The DCE is no longer with the		
		g CNA 4 and CNA 5 had			company.		
		er cream to his sacral and			Company.		
		d a burning sensation to him	1		Resident D had no negative		
	I	Č	1		l		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155120	B. Wl	ING	_	06/01/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			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	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nembers spoke to Resident D			outcomes related to the allege	ed	
	rudely and used profanity during the time of				deficient practice.		
		The abuse allegation copies					
		the report the facility sent to			How be identified and what		
		eport indicated the incident			corrective action will be put int	:0	
		and the two CNA's occurred			place?		
		d 6:30 a.m. The report				,	
		nistrator was not made aware			All residents have the potentia	ıı tor	
	_	ions until 5-11-23 at/around			being affected by the same		
		mpanying fax cover sheet			alleged deficient practice.		
		allegation notification was not			\^/	_	
	sent to IDOH-LTC until 5-11-23 at 4:45 p.m.				What measures will be put into		
	In an interview with the Administrator on 6-1-23 at				place and what systemic chan will be made to ensure that the	~	
		rated she did not receive the					
	-	d abuse until the next morning			deficient practice does not rec	ui !	
		meeting on 5-11-23.			Staff will be in serviced on the		
		ped the morning meeting and			policies and procedures on Ab		
		taff members to different tasks			Neglect, and Exploitation that		
	-	uch done as possible towards			prohibit and prevent abuse to		
	-	Our DCE (Director of Clinical			include reporting to the		
	_	mewas aware of the situation			Administrator and responding		
	· ·	I was very disappointed she			within specific timeframes per	the	
	•	e immediately. It ended up that			guidelines.		
	•	rt sent to state until later in the			94.4555.		
		licated the DCE was relatively					
		and was very concerned as to			How the corrective action will	be I	
		nappen to her. "I explained the			monitored to ensure the defici		
		ed to do was resident safety			practice will not recur, ., What		
	-	allegation." She indicated two			quality assurance program wil		
	days later on 5-13-2	23 at approximately 3:00 a.m.,			put into place?		
	she received a text i	message from the DCE that she			DNS/designee to randomly		
	was ill and would n	ot be into work that day. On			interview 5 residents and 5 sta	aff	
	the following Mond	lay, 5-15-23, when the			members per week for 4 week	(S	
		ned to work, she indicated had			then 3 residents and 3 staff		
	received a letter of	resignation from the DCE,			members per week for 2 mont	hs	
	effective immediate	ely.			then 1 resident and 1 staff		
					member weekly for 3 months	to	
	A review of the emp	ployee record of the DCE,			determine if a violation was		
	indicated she began	employment with the facility			reported or suspected to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155120		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/01/2023	
	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	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 3-28-23. It indices and neglect training training on the same of the same o	ated she had completed abuse, including abuse reporting		determine if the reported viola was reported immediately to the Administrator. Any deficiencing identified will be corrected immediately. The results of the audits will be reviewed by the QAPI committee to determine need for further monitoring.	tion ne es e

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STATEMENT OF DI AND PLAN OF COR		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155120	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/01/2023
NAME OF PROVIDE		- BRANDYWINE CARE CENTER	745 N S	ADDRESS, CITY, STATE, ZIP COD SWOPE ST NFIELD, IN 46140	
TAG R	EACH DEFICIEN EGULATORY 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
had s as we and t cussi burni botto rinse next the o scare years abusi imme done resid peop there dress In an p.m., last f "over anyo speal ago," the n admi A rev cond Minii 4-3-2 of his has n some	some barrier cree put the cream hey were red-long at us that wing. So, I went om and privates d and dried it g day, me and [n ffice by [name and never had ing them. We rediately, until t and was able t ent has a long I le that aren't true with two of us and interview with the indicated he had a mistrative team view of the clin ucted on 6-1-2 mum Data Set 23, indicated he is current, but unade false accustimes yells at set Administrator p	a Resident D on 5-31-23 at 2:05 he has been at the facility since dindicated he is treated, l. I can't say I have ever had by be rude or treat me bad or lythe situation a few weeks herstanding between him and di was dealt "fine" by the hical record of Resident D was at 9:59 a.m. His most recent (MDS) assessment, dated his cognitively intact. A review hadded care plans indicated he sations about staff and he			

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

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155120	· ′	LDING	NSTRUCTION 00	(X3) DATE : COMPL 06/01/	ETED
	ROVIDER OR SUPPLIER	- BRANDYWINE CARE CENTER		745 N S	DDRESS, CITY, STATE, ZIP COD WOPE ST FIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	date of 2023 and was policy utilized by the indicated, "It is the provide protections rights of each reside implementing written prohibit and prevent exploitation and miss propertyThe facility written policies and prevent abuse, negle residents and misapproperty; Establish property;	sappropriation of resident ty will develop and implement procedures that: Prohibit and ect and exploitation of propriation of resident policies and procedures to a allegationsThe acility abuse prohibition plans at I. ScreeningII. Employee ntion of Abuse, Neglect and dentification of Abuse, Neglect Y. Investigation of Alleged ExploitationVI. Protection of orting/ResponseVIII.					
F 0609 SS=D Bldg. 00	- , , .	, , , , , ,					
	violations involving exploitation or mis injuries of unknow misappropriation o	treatment, including					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED		
		155120	B. WING		06/01/2023	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD SWOPE ST		
BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER			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 APPROPRIATE			
TAG		LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
TAG	hours after the alle events that cause or result in serious than 24 hours if the allegation do not in result in serious be administrator of the officials (including Agency and adult state law provides care facilities) in a through established \$483.12(c)(4) Reginivestigations to the her designated reposition of the designated reposition of the St. 5 working days of alleged violation is corrective action in Based on interview failed to ensure an aphysical and verbal Administrator within aware of the allegate as well as the facility abuse to the Indianal Term Care Division being made aware of (Resident D.)	egation is made, if the the allegation involve abuse s bodily injury, or not later ee events that cause the nvolve abuse and do not odily injury, to the e facility and to other to the State Survey protective services where for jurisdiction in long-term ecordance with State law ed procedures. For the results of all the administrator or his or presentative and to other ance with State law, ate Survey Agency, within the incident, and if the es verified appropriate	F 0609	p paraid="919960926" paraeid="{89e7f3e3-77fa-460 a-592b8f317c77}{63}" >What corrective actions will be accomplished for those reside found to be affected by the deficient practices? Resident D had no negative outcomes related to the allege	8-952 ents	
	provided a copy of Resident D, alleging applied a skin barrio	a.m., the Administrator an abuse allegation for g CNA 4 and CNA 5 had er cream to his sacral and I a burning sensation to him		deficient practice. How be identified and what corrective action will be taken All residents have the potential being affected.		
		nembers spoke to Resident D		boiling allected.		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155120	B. W	ING		06/01/2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			SWOPE ST		
BRICKYA	ARD HEALTHCARE	- BRANDYWINE CARE CENTER			NFIELD, IN 46140		
	<u> </u>		1		<u> </u>		OVE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
	`	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION fanity during the time of		TAG			DATE
		The abuse allegation copies			What measures will be put into place and what systemic chan		
		the report the facility sent to			will be made to ensure the	iges	
		eport indicated the incident			deficient practice does not rec	ur?	
		and the two CNA's occurred			delicient practice does not rec	ui :	
		ad 6:30 a.m. The report			Staff will be in serviced on Abo	use.	
		nistrator was not made aware			Neglect, Exploitation, injuries		
		ions until 5-11-23 at/around			unknown source and		
		impanying fax cover sheet			misappropriation of resident		
		allegation notification was not			property to report immediately	. but	
		until 5-11-23 at 4:45 p.m.			not later than 2 hours after the		
		•			allegation is made, if the even		
	In an interview with the Administrator on 6-1-23 at				that caused the allegation invo		
	1:00 p.m., she indicated she did not receive the				abuse or result in serious bod		
	report of the alleged	d abuse until the next morning			injury, or not later than 24 hou	•	
	during the morning	meeting on 5-11-23.			events that caused the allegat		
	"I immediately stop	ped the morning meeting and			do not involve abuse and do n		
	assigned different s	taff members to different tasks			result in serious bodily injury,	to	
	in order to get as m	uch done as possible towards			the Executive Director and to		
	the investigation. C	Our DCE (Director of Clinical			State Survey Agency.		
	Education) at the ting	mewas aware of the situation					
	the day before and l	I was very disappointed she			The VP of Regulatory Complia	ance	
	did not report to me	immediately. It ended up that			re-educated the ED and the		
		rt sent to state until later in the			Director of Nursing Services (I	DNS)	
		licated the DCE was relatively			regarding the		
	_	and was very concerned as to			"Abuse/Neglect/Exploitation"		
		nappen to her. "I explained the			policy guidelines, The		
	_	ed to do was resident safety					
	"	allegation." She indicated two					
	1 .	23 at approximately 3:00 a.m.,			How be monitored to ensure t		
		message from the DCE that she			deficient practice will not recui	r, .	
		ot be into work that day and			e., What quality assurance	_	
		onday, 5-15-23, when the			program will be put into praction	ce?	
		ned to work, she had received			DNS/designee to randomly		
	_	on from the DCE, effective			interview 5 residents and 5 sta		
	immediately.				members per week for 4 week	(S	
		1 01 555			then 3 residents and 3 staff		
		ployee record of the DCE,			members per week for 2 mont	hs	
	I -	employment with the facility			then 1 resident and 1 staff		
	L on 3-28-23. It indic	cated she had completed abuse	1		member weekly for 3 months	to	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155120	B. WING			06/01/2023	
				CTREET A	DDBECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
DDIOI()(A					SWOPE ST		
BRICKY	ARD HEALTHCARE	- BRANDYWINE CARE CENTER		GREEN	FIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and neglect training	, including abuse reporting			determine if a violation was		
	training on the same	e date.			reported or suspected to		
					determine if the reported viola	tion	
	In an interview on 6	5-1-23 at 1:23 p.m., with CNA 4,			was reported immediately to the	ne	
	she indicated she an	nd a co-worker went into			Administrator. The Area Vice		
	Resident D's room o	on 5-10-23 before breakfast to			President or designee will aud	it all	
	get him cleaned up	for the morning. She indicated			reportable events x 4 weeks th	nen	
	-	ed a specific cream to be			4 a month x 5 months to		
	-	ates" area, as he "had some			determine if the Administrator	or	
	•	a long time. We didn't have it,			designee reported per the req	uired	
		ple tube of a barrier cream and			time frame to the IDOH. Any		
		n't the right one, then the			deficiencies identified will be		
		t off. The nurse, when we			corrected immediately. The		
		ut the cream, she said he had a			results of the audits will be		
		adn't come in yet." CNA 4			reviewed by the QAPI commit	tee	
		ot recall any inappropriate			to determine the need for furth	ier	
		oice tones being used by she			monitoring		
		uring this time, but did recall					
	-	ling and cursing at she and the					
		recalled Resident D later					
		he really appreciated					
		"He has a history of telling					
		ue, he even was moved from					
		r because of stuff like this. He					
		pairs" person for a long time. I					
	don't take care of hi	m anymore because of this."					
	In an inter	6 1 22 at 2:17 m mith CNIA 5					
		5-1-23 at 2:17 p.m., with CNA 5,					
		e morning of 5-10-23, she and one into Resident D's room to					
		the day. "He was yelling and					
		nole time. "He [later]went					
		one he could find in the					
		t some cream on him that was					
		e hadn't cleaned it off. That					
	_	When we got him cleaned up,					
		e incontinence problems and					
		as to his bottom, and he					
		own during the day, we tried					
		ortant it was to make sure he					
	l w wii iiiiii iiow iiiip	oram it was to make suit lie	l				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155120	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 1/2023
	ROVIDER OR SUPPLIER	- BRANDYWINE CARE CENTER	745 N S	ADDRESS, CITY, STATE, ZIP CO SWOPE ST IFIELD, IN 46140	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	as we put the cream and they were red-lecussing at us that we burning. So, I went bottom and privates rinsed and dried it genext day, me and In the office by Iname scared me to death. years and never had abusing them. We immediately, until the done and was able to resident has a long people that aren't there with two of us dressed for the day. In an interview with p.m., he indicated he last fall. Resident In "overall pretty good anyone intentionally speak to me hateful ago," was a misund the nursing staff and administrative team. A review of the clin conducted on 6-1-2 Minimum Data Set 4-3-23, indicated he of his current, but us has made false accurs sometimes yells at some times and the nursing staff and administrator processes.	n Resident D on 5-31-23 at 2:05 he has been at the facility since D indicated he is treated, I. I can't say I have ever had by be rude or treat me bad or lythe situation a few weeks herstanding between him and d was dealt "fine" by the dical record of Resident D was at 9:59 a.m. His most recent (MDS) assessment, dated he is cognitively intact. A review hadated care plans indicated he herstaff. brovided a copy of a policy				
	entitled, "Abuse, No	eglect and Exploitation," on n. This policy had a copyright				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155120		(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	COM	(X3) DATE SURVEY COMPLETED 06/01/2023	
	PROVIDER OR SUPPLIER	E - BRANDYWINE CARE CENTER	745 N	T ADDRESS, CITY, STATE, ZIP COI I SWOPE ST ENFIELD, IN 46140)	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.	JLD BE	(X5) COMPLETION
F 0610 SS=D Bldg. 00	date of 2023 and wa policy utilized by the indicated, "It is the provide protections rights of each reside implementing writte prohibit and prevent exploitation and mister propertyThe facility written policies and policies and procedures that inclusivolations to the Ad all other required againer than 2 hours afthe events that cause or result in serious by This Federal tag reliable. This Federal tag reliable. 3.1-28(c) 483.12(c)(2)-(4) Investigate/Prever §483.12(c) In respanse, neglect, exthe facility must:	sappropriation of resident ity will develop and implement procedures thatEstablish ures to investigate any such cility will have written ude: Reporting of all alleged ministrator, state agencyand genciesImmediately, but not fiter the allegation is made, if the the allegation involve abuse codily injury" attention to Complaint IN00408932. Int/Correct Alleged Violation conse to allegations of exploitation, or mistreatment, we evidence that all alleged coughly investigated.	TAG	DEFICIENCY)		DATE
	\ , , , ,	vent further potential abuse, on, or mistreatment while s in progress.				
	investigations to the her designated rep	oort the results of all ne administrator or his or presentative and to other ance with State law,				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/01/2023	
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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		λΤΕ	(X5) COMPLETION DATE
TAG	including to the St 5 working days of alleged violation is corrective action in Based on interview failed to ensure an aphysical and verbal Administrator within aware of the allegat which in turn result institute safeguards during the 27 hours being potentially propertators. (Resident D, alleging applied a skin barries scrotal area that had and the same staff in rudely and used propertion incontinence care. Included a copy of IDOH-LTC. The result between Resident D on 5-10-23 at/aroun indicated the Admin of the abuse allegat 9:35 a.m. The accondicated the abuse sent to IDOH-LTC. In an interview with 1:00 p.m., she indicated the morning the mornin	ate Survey Agency, within the incident, and if the severified appropriate must be taken. and record review, the facility allegation of staff to resident abuse was reported to the n 2 (two) hours of becoming ion by a facility staff member, ed in the facility failing to for the resident's safety in which the resident was not otected from the alleged	F 061			c6-afc s he ed into ages cur? use, of ately, r the	DATE 06/30/2023
l	i miniculately stop	ped the morning meeting and	1		LACCULIVE DIRECTOR. II AII AIIEQ	ลแบบ	I .

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COM			COMPL	COMPLETED	
155120		B. WING 06/01/2023			/2023			
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	₹			SWOPE ST			
BRICK∨/	ARD HEALTHOADE	E - BRANDYWINE CARE CENTER			IFIELD, IN 46140			
		DIVINE OAKE OLIVER		O'CLLIN				
(X4) ID		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 APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	•	taff members to different tasks			of abuse is involved safeguard			
		uch done as possible towards		be put into place to protect the		;		
	_	Our DCE (Director of Clinical			resident.			
	· ·	mewas aware of the situation						
		I was very disappointed she						
	-	e immediately. It ended up that			How be monitored to ensure the			
		rt sent to state until later in the			deficient practice will not , wha			
		licated the DCE was relatively			quality assurance program wil	ı be		
	•	and was very concerned as to			put into place?			
		nappen to her. "I explained the ed to do was resident safety			DNS/designee to randomly	æ		
	_	allegation." She indicated two			interview 5 residents and 5 sta			
	_	23 at approximately 3:00 a.m.,			members per week for 4 week then 3 residents and 3 staff	S		
		message from the DCE that she			members per week for 2 mont	he		
		ot be into work that day. On			then 1 resident and 1 staff	115		
		day, 5-15-23, when the			member weekly for 3 months t	to		
	_	ned to work, she indicated had			determine if a violation was	10		
		resignation from the DCE,			reported or suspected to			
	effective immediate	-			determine if the reported viola	tion		
		9			was reported immediately and			
	A review of the em	ployee record of the DCE,			were put in place to maintain	triat		
		employment with the facility			resident safety. Any deficienci	es		
		cated she had completed abuse			identified will be corrected			
		g, including abuse reporting			immediately. The results of th	е		
	training on the same				audits will be reviewed by the			
	-				QAPI committee to determine	the		
	In an interview on 6	5-1-23 at 1:23 p.m., with CNA 4,			need for further monitoring			
		nd a co-worker went into						
	Resident D's room	on 5-10-23 before breakfast to						
	get him cleaned up	for the morning. She indicated						
	Resident D requeste	ed a specific cream to be						
	placed on his "priva	ntes" area, as he "had some						
	raw places there for	a long time. We didn't have it,						
		ple tube of a barrier cream and						
	when he said it wasn't the right one, then the							
		t off. The nurse, when we						
		ut the cream, she said he had a						
		adn't come in yet." CNA 4						
		ot recall any inappropriate						
words or elevated voice tones being used by she		l				ĺ		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED		
155120		B. WING 06/01/2023				
			STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	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	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		uring this time, but did recall				
	-	ling and cursing at she and the				
		Frecalled Resident D later				
		l he really appreciated "He has a history of telling				
		ue, he even was moved from				
		r because of stuff like this. He				
		pairs" person for a long time. I				
		m anymore because of this."				
	aon i aine eare of m	in anymore occase of time.				
	In an interview on 6	5-1-23 at 2:17 p.m., with CNA 5,				
		e morning of 5-10-23, she and				
		one into Resident D's room to				
	-	e day. "He was yelling and				
	-	nole time. "He [later]went				
	around telling every	one he could find in the				
	building that we put	t some cream on him that was				
	burning him and we	hadn't cleaned it off. That				
	was not true at all.	When we got him cleaned up,				
	because he has som	e incontinence problems and				
		s to his bottom, and he				
		own during the day, we tried				
	-	ortant it was to make sure he				
		eam on his bottom. As soon				
	•	on his bottom and privates,				
		ooking, he started yelling and				
	-	e did it wrong and it was				
	_	and got the stuff to wash his				
	_	s with soap and water and				
	_	good." CNA 5 indicated, "The				
	-	ame of CNA 4] got called into				
		of the Administrator] and it				
		I've been doing this for 20 lanybody accuse me of				
		were put on suspension				
	_	hey got their investigation				
		to come back to work. That				
		history of saying things about				
	_	ue. That's why we went in				
	there with two of us to get him cleaned up and				1	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155120	B. WING			06/01/2023	
				_	_		-
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					SWOPE ST		
BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER				GREEN	IFIELD, IN 46140		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DECLIDED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		IE	DATE
		" She indicated she could not					
		ted with Resident D at any					
		ate of 5-10-23, but she recalled					
	_	e and CNA 4 were not					
		on Resident D's hallway and					
		h him prior to being removed					
	from her work assig	-					
							
	In an interview with	h Resident D on 5-31-23 at 2:05					
		he has been at the facility since					
	_	D indicated he is treated,					
		d. I can't say I have ever had					
		y be rude or treat me bad or					
		lythe situation a few weeks					
	*	erstanding between him and					
	-	d was dealt "fine" by the					
	administrative team	_					
	administrative team						
	A review of the clir	nical record of Resident D was					
		3 at 9:59 a.m. His most recent					
		(MDS) assessment, dated					
		e is cognitively intact. A review					
		indated care plans indicated he					
		sations about staff and he					
	sometimes yells at						
	The Administrator	provided a copy of a policy					
		eglect and Exploitation," on					
		m. This policy had a copyright					
		as indicated to be the current					
		ne facility. This policy					
		policy of this facility to					
	provide protections for the health, welfare and rights of each resident by developing and						
	implementing written policies and procedures that prohibit and prevent abuse, neglect and exploitation and misappropriation of resident						
	_	ity will develop and implement					
		I procedures that: Prohibit and					
	_	-					
prevent abuse, neglect and exploitation and			1				İ

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	COMPLETED 06/01/2023					
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 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F 0755 SS=D Bldg. 00	any such allegations to ensure all residen and psychosocial has abuse, during and af Examples include, be Responding immedivictim and integrity Examining the allegincluding physical estates assessment if needed the alleged victim and changes, if necessar from the perpetrator Providing emotional the resident during an needed; Revision of resident's medical, result of the inciden. This Federal tag relates as 1.28(a) 3.1-28(d) 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/§483.45 Pharmacy The facility must pemergency drugs are sidents, or obtain described in §483.	and procedures to investigateThe facility will make efforts ts are protected from physical rm, as well as additional fier the investigation. but are not limited to: ately to protect the alleged of the investigation; ed victim for any sign of injury, xamination or psychosocial d; Increased supervision of and residents; Room or staffing y, to protect the resident(s) r; Protection from retaliation; I support and counseling to and after the investigation, as the resident's care plan if the aursing, physical, mental or for preferences change as a t of abuse" Pharmacist/Records y Services						
	general supervisio	permits, but only under the n of a licensed nurse. Jures. A facility must						

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LENTERS FOR	R MEDICARE & MEDIC			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDI	NG <u>00</u>	COMPI	LETED	
		155120	B. WING		06/01	
			<u> </u>		-	
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CO)D	
				5 N SWOPE ST		
BRICKY	ARD HEALTHCARE	E - BRANDYWINE CARE CENTE	R ∣ GF	REENFIELD, IN 46140		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE					(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	`	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE AF	PROPRIATE	COMPLETION DATE
TAU			IA			DATE
		utical services (including				
	•	ssure the accurate				
		g, dispensing, and				
	_	ll drugs and biologicals) to				
	meet the needs of	each resident.				
	- ' '	e Consultation. The facility				
	must employ or ob	otain the services of a				
	licensed pharmac	ist who-				
	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.					
	§483.45(b)(2) Esta	ablishes a system of				
	records of receipt	and disposition of all				
	-	sufficient detail to enable				
	an accurate recon					
	8483 45(b)(3) Det	ermines that drug records				
	. , , , ,	nat an account of all				
	controlled drugs is					
	periodically recond					
		on, interview and record	F 0755	What corrective action(s) will bo	06/30/2023
		failed to ensure a staff member	1 0/33	What corrective action(s	•	00/30/2023
	-	dent's medication to come in		accomplished for those		
				found to have been affe	cled by the	
		are hands during the		deficient practice?		
	* *	cation for administration for 1		RN2 was counseled, re		
	of 1 resident's revie			and verbalized understa	-	
	preparation. (Resid	ent C)		the importance not med	lications to	
				touch their bare hands.		
	Findings include:					
		facility on 5-31-23 at 10:25				
		erved to prepare medications		How be identified and w	/hat	
		o Resident C. RN 2 was		corrective action(s be ta	aken?	
		nedication cards for				
	simethicone and did	cyclomine (medications used		All residents that receiv	е	
for gastric discomfort) and pop those medications				medication administration	on have the	

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directly into his bare hand and then into the

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potential to be affected by the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/01/2023 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE medication cup. RN 2 was interviewed at this deficient practice. time, regarding the practice of placing the medication into his bare hand, prior to placing the medication directly into the medication cup. RN 2 reiterated multiple times that it was an acceptable What measure will be put into practice to place the medications into his bare place and what systemic changes hands, "because they [his hands] are sanitized." will be made to ensure that deficient practice does not recur? In an interview with the Director of Nursing on 5-31-23 at 10:45 a.m., she indicated staff should Nursing staff will be educated on not place medications into their bare hands. the importance of not allowing medications to touch bare hands A review of Resident C's clinical record was and the importance of infection conducted on 5-31-23 at 1:03 p.m. Her diagnoses control when administering included, but were not limited to, multiple medications. sclerosis and GERD (gastroesophageal reflux disease). A review of her current medications included, but were not limited to, dicyclomine 20 mg (milligrams) four times daily and simethicone How be monitored to ensure the 250 mg, 2 capsules every 8 hours. deficient practice will not recur, I.e., what quality assurance On 6-1-23 at 8:55 a.m., the Administrator provided program will be put into place? a copy of a policy entitled, "Medication Administration." This policy had a copyright date Medication Administration of 2023, and was indicated to be the policy Observations to ensure that currently in use by the facility. This policy medications are not touched with indicated, "Medications are administered by bare hands will be completed on licensed nurses, or other staff who are legally various shifts on 4 Random authorized to do in this state, as ordered by the residents weekly x 4 weeks, then physician and in accordance with professional 3 residents weekly x 4 weeks then standards of practice, in a manner to prevent 2 resident weekly x 4 months. contamination or infection...Remove medication from source, taking care not to touch medication All deficient practices will be with bare hand." reported to the DNS/designee immediately and deficiencies will On 6-1-23 at 8:55 a.m., the Administrator provided be corrected immediately. Results a copy of a policy entitled, "Infection Prevention of all audits will be reviewed by the and Control Program." This policy had a QAPI committee to determine the copyright date of 2023, and was indicated to be need for further monitoring. the policy currently in use by the facility. This

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			X3) DATE SURVEY COMPLETED 06/01/2023		
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 DEFICIEN	CY 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)			DATE
	policy indicated, "The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelinesLicensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies." 3.1-25(b) 3.1-25(e)(1) 3.1-18(a)						

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