STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155076	A. BUILDING 00 B. WING	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BROOKVIEW CARE CENTER	7145 E 21ST STREET INDIANAPOLIS, IN 46219

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00451414 and Complaint IN00451475. Complaint IN00451414 - Federal/state deficiencies related to the allegations are cited at F0610 and F0755. Complaint IN00451475 - No deficiencies related to the allegations are cited. Survey dates: January 21, 2025 Facility number: 000031 Provider number: 155076 AIM number: 100266150 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 3 Medicaid: 53 Other: 14 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 22, 2025.	F 0000		
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based on interview and record review, the facility	F 0610	Preparation, submission and implementation of this Plan of	02/07/2025

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

Breque Norris | Area Vice President | 02/07/2025

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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	failed to thoroughly investigate an allegation of misappropriation of property for 1 of 3 residents reviewed for abuse. (Resident D) Findings include: The clinical record for Resident D was reviewed on 1/21/25 at 1:00 p.m. The diagnoses included, but were not limited to, dementia. A "Facility Reported Incident [FRI]" was reported to the Indiana Department of Health, dated 12/30/24, indicating an incident had occurred, on 12/30/24, with Resident D. A brief description of the allegation indicated Resident D reported his wallet, credit card, and insurance card was taken. The follow up to the incident indicated "Staff and resident interviews completed with no concerns. Credit card has been canceled and new [insurance] card ordered. Facility to replace wallet..." The investigation to the reported incident was provided by the Administrator on 1/21/25 at 2:00 p.m. The investigation included resident interviews that were conducted during the investigation. The resident interview questions were the following: "1. Has staff, a resident, or anyone else here, abused you - this includes verbal, physical, or sexual abuse? If yes ask who the abuser was, what happened, when it occurred, where it happened, and how often...Did you tell staff? If yes, ask who the resident told. Report immediately to the administrator..." "2. Have you seen any resident here being abused? If yes ask who the abuser was, what happened, when it occurred, where it happened,		Correction does not constitute an admission or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction was prepared and executed to continuously improve care quality and comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to this survey. F 610 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident and staff interviews were completed to include questions. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken All residents have the potential to be affected. All interview able residents interviewed to ensure no misappropriation has occurred. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with ED on thorough investigations to include appropriate questions when	

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	and how often...a. Did you tell staff? If yes, ask who the resident told. Report immediately to the administrator..." The investigation did not include interviews that were conducted with the residents related to misappropriation of property. An interview was conducted with the Administrator on 1/21/25 at 3:08 p.m. She indicated the investigation for Resident D was completed. There were two allegations reported on 12/30/24. An allegation of abuse and an allegation of misappropriation of property. The staff that conducted interviews with the residents must have been asking only the abuse questions. An abuse policy was provided by the Executive Director on 1/21/25 at 11:40 a.m. It indicated the following, "...Policy: It is the 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, exploitation and misappropriation of resident property...V. Investigation of alleged abuse, neglect and exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation... 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough		interviewing staff and residents. All Staff education on abuse including misappropriation. On-going review of investigations to be completed by Regional Field team to ensure complete investigation. 2 investigation audits to be completed monthly X 3 months and 1 monthly thereafter to complete 6 months. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place -by what date the systemic changes for each deficiency will be completed Feb 7, 2025	

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	documentation of the investigation..." This citation is related to Complaint IN00451414. 3.1-28(d)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to ensure that a narcotic pain medication was placed in a controlled substance lock box upon being delivered to the facility and to ensure the oncoming and off going licensed personnel signed the controlled drug shift audit form when completing the controlled drug audit each shift for 1 of 3 residents reviewed for pain medications (Resident E). Findings include: The clinical record for Resident E was reviewed on 1/21/25 at 11:15 a.m. The diagnoses included, but were not limited to, diabetes and chronic non-pressure skin ulcers of the left leg. An Admission Minimum Data Set (MDS) assessment, completed 10/14/24, indicated she was cognitively intact and received scheduled pain medications. A care plan, last revised on 11/1/24, indicated Resident E was at risk for pain related to wounds on legs and toes and diabetes. The goal was for her to not have interruptions in normal activities due to pain. The interventions included, but were not limited to, administer analgesics (pain medication) as ordered by the physician.	F 0755	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction was prepared and executed to continuously improve care quality and comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to this survey. F755 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Medications for Resident E were replaced by facility. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken All have the potential to be	02/07/2025

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	A physician's order, dated 1/14/25, indicated she was to receive fentanyl (narcotic pain medication) transdermal patch 25 micrograms (mcg) per hour. One patch was to be applied transdermal (on the skin) every three days. This order was discontinued on 1/16/25. A physician's order, dated 1/16/25, indicated she was to receive fentanyl transdermal patch 25 micrograms (mcg) per hour. One patch was to be applied transdermal every three days. An electronic medication administration record (EMAR) note, dated 1/15/25 at 12:56 p.m., indicated the fentanyl transdermal patch was not administered due to it being on order from the pharmacy. A Physician's Assistant Follow Up Visit note, dated 1/15/25, indicated resident E was evaluated for follow up of pain management. Fentanyl patches were not yet available from pharmacy, so she would continue the previous regimen until fentanyl patches are obtained. Resident E had no acute complaints at that time. Staff reported no other acute care concerns. Resident E appeared comfortable and in no acute distress. On 1/21/25 at 1:25 p.m., the Administrator provided the investigation file for Indiana State Reportable, dated 1/15/25, which indicated while counting narcotics during shift change, it was noted there were four fentanyl patches 25 mcg missing for one resident. The count was re-conducted with no change in the outcome. The Director of Nursing Services and the Administrator were notified of the missing medication. The investigation file contained a packing slip		affected. Audit completed of all narcotics to ensure no other narcotics missing -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with all nurses on appropriate medication storage to include newly delivered narcotics from pharmacy and shift to shift count of narcotics which include signing controlled drug form shift to shift. On- going monitoring to be completed to ensure proper compliance of controlled substance procedure. DNS or to review narcotic sheets to ensure shift to shift count being completed. Review to be completed 5X weekly X 4 weeks, 3X weekly X4 weeks, and weekly thereafter to complete 6 months. DNS or designee to monitor narcotic sheets to ensure all narcotics are signed in with 2 nurses. Monitoring to be completed 3X weekly X 8 weeks, weekly X 8 weeks, and monthly there after to complete 6 months. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what	

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	from the facility pharmacy, dated 1/14/25, which indicated that four fentanyl transdermal patches, 25 mcg, were sent to the facility from the pharmacy. During an interview on 1/21/25 at 1:50 p.m., the Administrator indicated Resident E's fentanyl patches, and the narcotic count sheet were missing. The fentanyl patches were left on the nursing station unattended. The facility was investigating to determine what happened to the fentanyl patches. The nurses' who had access to the medications when they were delivered had been drug tested with negative results. During an interview on 1/21/25 at 2:03 p.m., Pharmacy Technician 10 indicated that four fentanyl 25 mcg patches were sent to the facility and signed for by Registered Nurse (RN) 2. On 1/21/25 at 2:35 p.m., the West Hall narcotic book was observed with RN 3. The Emergency Kit and Controlled Drug- Shift Audit form for January 2025 was observed. There were no signatures present for the oncoming nurse, on 1/14/25 night shift, the oncoming nurse on 1/15/25 day shift, the oncoming nurse on 1/16/24 day shift, and 1/16/25 off going nurse on evening shift. During an interview on 1/21/25 at 2:35 p.m., RN 3 indicated the blanks on the Emergency Kit and Controlled Drug- Shift Audit form was because the staff had not signed the form. During an interview on 1/21/25 at 2:41 p.m., RN 2 indicated she had received the pharmacy delivery on the night shift of 1/14/25. The delivery was very large that night because there had been a new admission on the West Hall. RN 2 could not		quality assurance program will be put into place -by what date the systemic changes for each deficiency will be completed Feb 7, 2025	

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	specifically recall if she had received Resident E's fentanyl patches due to the amount of medication she had received that night. RN 2 had left all the delivered medication on the nurses' station so that the other nurses could come pick up the medications for their halls. Since there were so many medications delivered for the West Hall, RN 2 had placed all the West Hall medications in a bag and taken them to the West Hall nurses' station. There had not been anyone at the West Hall nurses' station when she dropped off the bag of medications. RN 2 had told the West Hall nurse she put the medications that had been delivered at the West nurses' station when they passed in the hallway. RN 2 was not sure what happened to Resident E's fentanyl patches after she took them to the West Hall nurses' station. The controlled medications were counted between each shift. After the controlled medication count, the oncoming and off going nurse should sign the Emergency Kit and Controlled Drug Shift Audit form at the front the narcotic book. During an interview on 1/21/25 at 3:15 p.m., Unit Manager (UM) 4 indicated the facility staff had searched the facility thoroughly and had not been able to find Resident E's fentanyl patches. There had been a lot of medications delivered on the night shift, of 1/14/25, including multiple other narcotics. All the other narcotics were accounted for. UM 4 was unsure where the fentanyl patches could have gone. She questioned if they may have been thrown away because the fentanyl patches are normally delivered in a small plastic sleeve, which may have gotten stuck on something. UM 4 had educated the nursing staff about double checking and ensuring that all medications they sign for are present prior to signing the delivery forms.			

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	On 1/21/25 at 11:40 a.m., the Corporate Support Health Care Administrator provided the Narcotic Pain Patch Policy, last revised February 2023, which read "...It is the policy of this facility to maintain records of all Narcotic patches at the time of receiving in the facility until destruction...Narcotic patches will be kept in a controlled substance lock box and reconciled at the end of each shift between the charge nurse responsible and the charge nurse taking responsibility of the medications... Both nurses will sign the shift change log verifying the count is accurate at the time of the reconciliation..." This citation is related to Complaint IN00451414. 3.1-25(e)(2) 3.1-25(e)(3)			