STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Brandywine Care Center	745 N Swope St Greenfield, IN 46140

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to timely notify the attending physician, hospice provider, and the resident's representative of a lack of pain medication and continued status of the medication's unavailability for 1 of 3 residents reviewed for pain medication receipt. (Resident B) Findings include: The clinical record of Resident B was reviewed on 6-26-25 at 12:24 p.m. The diagnoses included, but were not limited to, polyosteoarthritis, unspecified severe dementia and late onset Alzheimer's disease. His most recent Minimum Data Set assessment, dated 6-12-25, indicated his cognition was severely impaired, he received routine or scheduled pain medication and received hospice services. An observation of Resident B, on 6-26-25 at 10:16 a.m., revealed his speech was unclear, not in response to situation and with no discernable speech pattern. A review of his May 2025 Medication Administration Record (MAR) denoted he did not receive his physician-ordered medication of Norco (an opioid combination product of hydrocodone and acetaminophen) 5-325 milligrams (mg) four times daily for pain and discomfort of left ankle fracture from the morning dose of 5-21-25, through the evening/bedtime dose on 5-26-25. It did indicate Resident B received the third dose of the day on 5-26-25. The corresponding nurse's notes for this time period indicated the following: 5-21-25 at 8:24 a.m., and 11:58 a.m. - med not available. 5-21-25 at 3:09 p.m. - med not available; talk to hospice for refill. 5-22-25 at 7:27 a.m. and 11:28 a.m. - reordered. 5-22-25 at 5:12 p.m. and 9:31 p.m. - on order. 5-23-25 at 11:13 a.m., 11:16 a.m., 4:39 p.m., and 9:23 p.m. - on order. 5-24-25 at 10:05 a.m., and 12:03 p.m. - drug item unavailable. 5-24-25 at 4:42 p.m., and 7:22 p.m. - on order. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5-25-25 at 7:50 a.m., and 12:18 p.m. - no information documented. 5-25-25 at 9:02 p.m. - on order. 5-26-25 at 12:16 p.m., and 3:52 p.m. - no information documented. 5-26-25 at 10:26 p.m. - on order. The associated narcotic record for Resident B's Norco 5/325 mg four times daily for pain and discomfort of left ankle fracture indicated there were no doses signed out by the facility's nursing staff after 5-20-25 at 12:00 p.m. (noon) until the next dose signed out on 5-27-25 at 12:00 p.m. The narcotic record indicated fifty-six (56) tablets of this medication were received from the contracted pharmacy on 5-26-25, with no time indicated of the medication's receipt. The nursing progress notes, during the time period of 5-21-25 to 5-27-25, did not reflect any notifications of Resident B's responsible party being made aware of the lack of scheduled pain medication. The only notation of communication to the medical provider of the lack of the scheduled pain medication was as indicated above on 5-21-25, nor was the status of obtaining the medication indicated during the same time period. During an interview with the Corporate Nurse on 6-26-25 at 1:05 p.m., she indicated she was unable to locate any of the documentation from May 21st to May 26, 2025, that addresses anything about letting hospice or the attending physician know this resident was out of his Norco but will keep looking. In talking with the attending physician and pharmacy, I discovered some of the staff had reached out to them for a new script, but since he was a hospice resident, they [hospice] were responsible for the order. The staff did reach out to hospice for the new script. I did not see any documentation that addressed the resident's responsible party was made aware of the situation. On 6-26-25 at 1:22 p.m., the Corporate Nurse provided a copy of a policy entitled, Notification of Changes, with a copyright date of 2024. This policy indicated, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification .Circumstances requiring notification include .Circumstances that require a need to alter treatment. This may include: New treatment. Discontinuation of a current treatment due to: Adverse consequences. Acute condition. Exacerbation of a chronic condition . On 6-26-25 at 1:30 p.m., the Corporate Nurse provided a copy of a policy entitled, Unavailable Medications, with a copyright date of 2025. This policy indicated, The facility shall use uniform guidelines for unavailable medications . Staff shall take immediate action when it is known that the medication is unavailable: Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication; Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold .If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification . This citation relates to Complaint IN00462164. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-5(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently document the pain status of 1 of 3 residents revived for receipt of pain medications during a time period of five days when the resident was without their physician ordered and routinely scheduled opioid pain medication. (Resident B) Findings include: The clinical record of Resident B was reviewed on 6-26-25 at 12:24 p.m. The diagnoses included, but were not limited to, polyosteoarthritis, unspecified severe dementia and late onset Alzheimer's disease. His most recent Minimum Data Set assessment, dated 6-12-25, indicated his cognition was severely impaired, he received routine or scheduled pain medication and received hospice services. An observation of Resident B on 6-26-25 at 10:16 a.m., revealed his speech was unclear, not in response to situation and with no discernable speech pattern. Resident B did not display any signs of pain or discomfort at that time. During the entrance conference with the Executive Director on 6-25-25, she indicated she was unaware of any medication errors since she arrived to the facility in early [DATE]. On 6-25-25 at 2:50 p.m., the Executive Director provided a written statement which indicated, No med error from [DATE] to current 6-25-25. In an interview on 6-25-25 at 3:30 p.m., with the Director of Nursing and the Assistant Director of Nursing, each indicated they were unaware of any issues with any residents not having their scheduled pain medication for several days last month. A review of Resident B's [DATE] Medication Administration Record (MAR) denoted he did not receive his physician-ordered medication of Norco (an opioid combination product of hydrocodone and acetaminophen) 5-325 milligrams (mg) four times daily for pain and discomfort of left ankle fracture from the morning dose of 5-21-25, through the evening/bedtime dose on 5-26-25. The order for this medication also included an entry to include an assessment for the resident's pain level, at the time of the medication's administration. During the time period of 5-21-25 through 5-26-25 when the medication was not available for administration, the entry box for the pain assessment was blocked out with a computer-generated x, which did not allow an assessment to be entered into the MAR. During this same time period, Resident B did receive two doses of morphine sulfate concentrate of 20 mg/milliliter (ml) with instructions to administer 0.25 ml (or 5 mg) by mouth every two hours as needed for pain and shortness of breath. The doses were administered, on 5-21-25 at 8:58 a.m. and 5-24-25 at 10:05 a.m., with the pain level indicated to be at a level of 4 out of 10, with follow-up documentation the medication had been effective. A review of the nursing progress notes, during the time period of 5-21-25 through 5-26-25, reflected the administration of the above mentioned morphine sulfate, and indicated both doses were effective. No other notations regarding Resident B's pain status were located in the nursing progress notes. In an interview with the Corporate Nurse, on 6-26-25 at 2:25 p.m., she indicated the facility nursing staff, charts by exception, so there wouldn't be a note unless there was an issue about his pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6-26-25 at 3:01 p.m., the Corporate Nurse provided a copy of a policy entitled, Pain Management, with a copyright date of 2025. This policy indicated, 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 resident's goals and preferences .The facility will utilize a systemic approach for recognition, assessment, treatment and monitoring of pain .The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain . This citation relates to Complaint IN00462164. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for receipt of pain medications received their medications as ordered by the physician and failed to ensure an investigation was conducted into the issue of the lack of receipt of scheduled pain medication for five days. (Resident B) Findings include: The clinical record of Resident B was reviewed on 6-26-25 at 12:24 p.m. The diagnoses included, but were not limited to, polyosteoarthritis, unspecified severe dementia and late onset Alzheimer's disease. His most recent Minimum Data Set assessment, dated 6-12-25, indicated his cognition was severely impaired, he received routine or scheduled pain medication and received hospice services. An observation of Resident B, on 6-26-25 at 10:16 a.m., revealed his speech was unclear, not in response to situation and with no discernable speech pattern. During the entrance conference with the Executive Director on 6-25-25, she indicated she was unaware of any medication errors since she arrived to the facility in early May 2025. On 6-25-25 at 2:50 p.m., the Executive Director provided a written statement which indicated, No med error from May 1, 2025 to current 6-25-25. In an interview on 6-25-25 at 3:30 p.m., with the Director of Nursing and the Assistant Director of Nursing, each indicated they were unaware of any issues with any residents not having their scheduled pain medication for several days last month. A review of Resident B's May 2025 Medication Administration Record (MAR) denoted he did not receive his physician-ordered medication of Norco (an opioid combination product of hydrocodone and acetaminophen) 5-325 milligrams (mg) four times daily for pain and discomfort of left ankle fracture from the morning dose of 5-21-25, through the evening/bedtime dose on 5-26-25. It did indicate Resident B did receive the third dose of the day on 5-26-25. The corresponding nurse's notes for this time period indicated the following: 5-21-25 at 8:24 a.m., and 11:58 a.m., med not available. 5-21-25 at 3:09 p.m. med not available; talk to hospice for refill. 5-22-25 at 7:27 a.m. and 11:28 a.m., reordered. 5-22-25 at 5:12 p.m. and 9:31 p.m., on order. 5-23-25 at 11:13 a.m., 11:16 a.m., 4:39 p.m. and 9:23 p.m., on order. 5-24-25 at 10:05 a.m., and 12:03 p.m., drug item unavailable. 5-24-25 at 4:42 p.m., and 7:22 p.m., on order. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5-25-25 at 7:50 a.m., and 12:18 p.m., no information documented. 5-25-25 at 9:02 p.m., on order. 5-26-25 at 12:16 p.m., and 3:52 p.m., no information documented. 5-26-25 at 10:26 p.m. on order. The associated narcotic record for Resident B's Norco 5-325 mg four times daily for pain and discomfort of left ankle fracture indicated there were no doses signed out by the facility's nursing staff after 5-20-25 at 12:00 p.m. (noon) until the next dose signed out on 5-27-25 at 12:00 p.m. The narcotic record indicated fifty-six (56) tablets of this medication were received from the contracted pharmacy, on 5-26-25, with no time indicated of the medication's receipt. The nursing progress notes during the time period of 5-21-25 to 5-27-25 did not reflect any notifications of Resident B's responsible party being made aware of the lack of scheduled pain medication. The only notation of communication to the medical provider of the lack of the scheduled pain medication was as indicated above on 5-21-25, nor was the status of obtaining the medication indicated during the same time period. In an interview with the Corporate Nurse, on 6-26-25 at 1:05 p.m., she indicated she was unable to locate any of the documentation from May 21st to May 26, 2025, that addresses anything about letting hospice or the attending physician know this resident was out of his Norco but will keep looking. In talking with the attending physician and pharmacy, I discovered some of the staff had reached out to them for a new script, but since he was a hospice resident, they [hospice] were responsible for the order. The staff did reach out to hospice for the new script. On 6-26-25 at 1:22 p.m., the Corporate Nurse provided a copy of a policy entitled, Medication Errors, with a copyright date of 2025. This policy indicated, It is the policy of this facility to provide protections for the health, wealth, and rights of each resident by ensuring residents receive care and services in an environment free of significant medication errors. 'Medication error' means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order .or accepted professional standards and principles which apply to professionals providing services .The facility shall ensure medications will be administered as follows: According to physician's orders .Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines: Resident's Condition .Drug Category .Frequency of Error .The facility will consider factors indicating errors in medication administration, including, but not limited to the following: Medication administered not in accordance with the prescriber's order .If a medication error occurs, the following procedures will be initiated .Monitor and document the resident's condition .Document actions taken in the medical record. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6-26-25 at 1:30 p.m., the Corporate Nurse provided a copy of a policy entitled, Unavailable Medications, with a copyright date of 2025. This policy indicated, The facility shall use uniform guidelines for unavailable medications. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn [as needed or requested], and emergency medications. A STAT [immediate or emergent] supply of commonly used medications is maintained in-house for timely initiation of medications. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication; Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold . If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification . This citation relates to Complaint IN00462164. 3.1-25(a) 3.1-25(b)(3) 3.1-25(b)(9)