

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/04/2023	
NAME OF PROVIDER OR SUPPLIER BROWNSBURG MEADOWS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7133 MEADOW TRAIL, BROWNSBURG, , 46112					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: January 3 and 4, 2023. Facility number: 013356 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 12, 2023.	R 0000					
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation,	R 0273	R273 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to have			02/01/2023	

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interview, and record review, the facility failed to ensure all foods were labeled for 1 of 1 observation. This deficiency had the potential to effect 80 of 80 residents who received food from the kitchen.

Findings include:

During a tour of the kitchen with the Culinary Manager (CM), from 10:25 a.m. to 10:55 a.m., the following was found.

1. The stand-alone freezer had no open or expiration dates on these foods: potato wedges, chicken patties, haddock, hamburger patties, and bags of meatballs, hash browns, and onion rings.
2. The stand-alone refrigerator had no open or expiration dates on the Swiss cheese.
3. The walk-in refrigerator had no open or expiration dates on the parmesan cheese.
4. On the bread shelves, 2 loaves of raisin bread had no dates on them. The CM indicated they should have been dated when they came in.

On 1/3/23 at 10:45 a.m., the CM indicated all foods should have been dated.

A current policy, titled, "Food Storage," dated 10/17, was provided by the Executive

been affected by the deficient practice. All items were discarded immediately upon findings.

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

An audit was conducted by Culinary Manager to ensure that all food had been properly labeled and dated. No other items were found to be affected by this deficient practice.

What measures will be put into place or what systemic changes has the facility will make to ensure that the deficient practice dose not recure:

All food items will continue to be labeled at time of receipt. Culinary staff will be in-serviced on the process of labeling food upon receipt and dating the food items when opened.

How the corrective action will be monitored to ensure the

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Director (ED), on 1/3/23 at 1:35 p.m. A review of the policy indicated, "...All foods should be covered or wrapped tightly, labeled and dated"

Based on observation, interview, and record review, the facility failed to ensure all foods were labeled for 1 of 1 observation. This deficiency had the potential to effect 80 of 80 residents who received food from the kitchen.

Findings include:

During a tour of the kitchen with the Culinary Manager (CM), from 10:25 a.m. to 10:55 a.m., the following was found.

1. The stand-alone freezer had no open or expiration dates on these foods: potato wedges, chicken patties, haddock, hamburger patties, and bags of meatballs, hash browns, and onion rings.
2. The stand-alone refrigerator had no open or expiration dates on the Swiss cheese.
3. The walk-in refrigerator had no open or expiration dates on the parmesan cheese.
4. On the bread shelves, 2 loaves of raisin bread had no dates on them. The CM indicated they should have been dated when they came in.

deficient practice will not recure, what quality assurance program will be put into place:

A QA tool has been developed and will be implemented to ensure correct food storage protocol for labeling and dating. The QA tool will be utilized 2 times a week x4 weeks, then weekly x4 weeks, then monthly for 3 months, then quarterly thereafter until a threshold of 100% is met.

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	On 1/3/23 at 10:45 a.m., the CM indicated all foods should have been dated. A current policy, titled, "Food Storage," dated 10/17, was provided by the Executive Director (ED), on 1/3/23 at 1:35 p.m. A review of the policy indicated, "...All foods should be covered or wrapped tightly, labeled and dated"			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation,	R 0301	R301 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: One resident was found to have been affected by the deficient practice. Medication was removed immediately, and a new bottle of medication was provided. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: An audit was conducted by	02/01/2023

interview, and record review, the facility failed to ensure all facility administered medications had complete pharmacy labels for 1 of 5 residents reviewed during medication administration (Resident 65)

Findings include:

On 1/3/23 at 2:22 p.m., Qualified Medication Aide (QMA) 9 provided magnesium oxide 400 milligrams (mg) to Resident 65. The prescription label was observed to be partially missing.

On 1/4/23 at 9:07 a.m., the Assistant Director of Nursing (ADON) indicated if you combined the half present pharmacy label and the label on the bottle itself, the labeling was complete.

On 1/4/23 at 9:12 a.m., a review of the pharmacy label indicated only the resident's first name was present and the rest of the physician's order was torn off. The label indicated, " ...Take one tablet" There was no pharmacy issue or expiration date, address or phone number. The resident's name was noted to be hand-written on the bottle. There was no change of order on the bottle.

On 1/4/23 at 2:30 p.m., the Director of Nursing (DON) provided a copy of Resident 65's January Medication

ADON to ensure that all medications had proper labeling identifications on them. No other items were found to be affected by this deficient practice.

What measures will be put into place or what systemic changes has the facility will make to ensure that the deficient practice dose not recure:

All medications will continue to be labeled upon receiving. Nursing staff will be in-serviced on the necessary labeling requirements.

How the corrective action will be monitored to ensure the deficient practice will not recure, what quality assurance program will be put into place:

A QA tool has been developed and will be implemented to ensure correct medication labeling protocols are being completed. The QA tool will be utilized 2 times a week x4 weeks, then weekly x4 weeks, then monthly for 3 months, then quarterly thereafter until a threshold of

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Administration Record (MAR). A review of the MAR indicated, " ...Magnesium oxide 400 mg tablet, give one table by mouth once a day" Hand written over this order was, " ...Order [triangle meaning changed] 12/13/22" Another medication order on the January MAR indicated, " ...Magnesium oxide 400 mg, three times q (every) day 12/23/22"

An admission document regarding residential medications was signed by Resident 65's guardian. It indicated, " ...In accordance with the Indian Health Facilities Rules for Residential Care Facilities, all medications (i.e. Over the counter and prescriptions) meet the following requirements ...Prescription: 1. The resident's full name ...5. The name and address of the pharmacy that filled the prescription ...6. Directions for use ...7. Date of issue"

Based on observation, interview, and record review, the facility failed to ensure all facility administered medications had complete pharmacy labels for 1 of 5 residents reviewed during medication administration (Resident 65)

Findings include:

On 1/3/23 at 2:22 p.m.,
Qualified Medication Aide

100% is met.

(QMA) 9 provided magnesium oxide 400 milligrams (mg) to Resident 65. The prescription label was observed to be partially missing.

On 1/4/23 at 9:07 a.m., the Assistant Director of Nursing (ADON) indicated if you combined the half present pharmacy label and the label on the bottle itself, the labeling was complete.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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

TITLE

(X6) DATE