STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG MEADOWS ASSISTED LIVING	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: September 2, 2025 Facility number: 013356 Residential Census: 92 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 10, 2025.	R 0000		
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration	R 0300	**•What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 5 had no adverse effects from eye drops without a date indicating when it was opened on the medication cart. Resident 5 eye drops	10/02/2025

	date. Based on observation and interview, the facility failed to date eye drops when opened for 1 of 2 medication carts observed. Findings include: On 9/2/25 at 11:00 a.m., the memory care unit's medication carts were observed. Resident 5 had eye drops in the medication cart that lacked a date to indicate when they were opened. On 9/2/25 at 1:30 p.m., a policy titled, "Storage and Expiration Dating of Medications, Biologicals," was provided by the Executive Director (ED). It indicated, " ...The community should ensure that medications and biologicals that (1) have an expiration dated on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier ...." Based on observation and interview, the facility failed to date eye drops when opened for 1 of 2 medication carts observed.		removed from the medication cart at the time of findings and reordered as indicated on 9/2/2025. **•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;** All residents had the potential to be affected. No residents were adversely affected. A medication storage and expiration date monitoring tool will be completed to ensure that no other medication or biologicals are found to be lacking an opening date by 9/22/2025 by DNS/designee. Education to be provided to all nursing staff qualified to administer medications and biologicals on proper dating techniques by 9/30/2025 by DNS/designee. **•What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** A medication storage and	

	Findings include: On 9/2/25 at 11:00 a.m., the memory care unit's medication carts were observed. Resident 5 had eye drops in the medication cart that lacked a date to indicate when they were opened. On 9/2/25 at 1:30 p.m., a policy titled, "Storage and Expiration Dating of Medications, Biologicals," was provided by the Executive Director (ED). It indicated, " ...The community should ensure that medications and biologicals that (1) have an expiration dated on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier ...."		expiration date monitoring tool will be completed to ensure that no other medication or biologicals are found to be lacking an opening date by 9/22/2025 by DNS/designee. Education to be provided to all nursing staff qualified to administer medications and biologicals on proper dating techniques by 9/30/2025 by DNS/designee. **•How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** A medication storage and expiration date monitoring tool will be completed to ensure that no other medication or biologicals are found to be lacking an opening date by 9/22/2025 by DNS/designee. Education to be provided to all nursing staff qualified to administer medications and biologicals on proper dating techniques by 9/30/2025 by DNS/designee. A medication storage and expiration date monitoring tool will be completed to be completed weekly x4, then monthly x3 to ensure all medications and	

			biologicals are dated appropriately. If 90 percent threshold is not met, disciplinary action and new action will be completed. The monitoring tool will be completed by DNS or ED/designee **•By what date the systemic changes will be completed.** 10/2/2025	
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interviews, the facility failed to accurately code a fall event for a resident with diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar levels) for 1 of 9 residents reviewed (Resident 2).	R 0349	**•What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 2 had no adverse effects from inaccuracy of documentation. Director of Nursing re-education by Director of Clinical Services and Executive Director on 9/2/25. **•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;** All residents had the potential to be affected. No residents were adversely affected. Fall	10/02/2025

	Findings include: On 9/2/25 at 11:29 a.m., a record review was completed for Resident 2. She had the following diagnoses which included, but were not limited to, shortness of breath, Alzheimer's disease, hypertension, high cholesterol, and diabetes mellitus. She was prescribed metformin (a diabetic medication) 1500 mg daily and pioglitazone (a diabetic medication) 30 mg daily. Her service plan indicated she was diabetic. The resident's record lacked an order to obtain a blood sugar. She had a fall event dated 8/24/25. The question is resident a diabetic was marked "no." She had a fall event dated 4/21/25. The question is resident a diabetic was marked "no." She had a fall event dated 2/12/25. The question is resident a diabetic was marked "no." On 9/2/25 at 2:45 p.m., during an interview with the Director of Nursing (DON), she indicated a blood sugar was not required when a resident falls. She		events were reviewed by 9/22/25 to ensure no further inaccuracies in documentation of fall events related to diabetes mellitus diagnoses by 9/22/2025. All licensed nurses to be educated on fall documentation accuracy and accuracy of clinical records by 9/30/2025 by DNS/Designee. **•What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Fall events were reviewed by 9/22/25 to ensure no further inaccuracies in documentation of fall events related to diabetes mellitus diagnoses. All licensed nurses to be educated on fall documentation accuracy and accuracy of clinical records by 9/30/2025 by DNS/Designee. **•How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**	

	acknowledged the question "is resident a diabetic" was answered in error. A policy titled, Assessment and Documentation Guidelines-SL dated 7/27/23 was provided by the Executive Director (ED) on 9/2/25 at 1:30 p.m. It indicated, " ...Purpose: To establish clear, consistent guidelines for documentation to ensure resident records are accurate, complete, timely, and compliant with regulations and professional standards ...." Based on record review and interviews, the facility failed to accurately code a fall event for a resident with diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar levels) for 1 of 9 residents reviewed (Resident 2). Findings include: On 9/2/25 at 11:29 a.m., a record review was completed for Resident 2. She had the following diagnoses which included, but were not limited to, shortness of breath, Alzheimer's disease, hypertension, high cholesterol, and diabetes mellitus. She was prescribed metformin (a diabetic medication) 1500 mg daily and pioglitazone (a diabetic medication) 30 mg daily.		Fall events were reviewed by 9/22/25 to ensure no further inaccuracies in documentation of fall events related to diabetes mellitus diagnoses. All licensed nurses to be educated on fall documentation accuracy and accuracy of clinical records by 9/30/2025 by DNS/Designee. Assessment and documentation guidelines monitoring tool for falls to be completed to be completed weekly x4, then monthly x3 to ensure all records are accurate. If 90 percent threshold is not met, disciplinary action and new action will be completed. The monitoring tool will be completed by DNS or ED/designee **•By what date the systemic changes will be completed.** 10/2/2025	

Her service plan indicated she was diabetic.

The resident's record lacked an order to obtain a blood sugar.

She had a fall event dated 8/24/25. The question is resident a diabetic was marked "no."

She had a fall event dated 4/21/25. The question is resident a diabetic was marked "no."

She had a fall event dated 2/12/25. The question is resident a diabetic was marked "no."

On 9/2/25 at 2:45 p.m., during an interview with the Director of Nursing (DON), she indicated a blood sugar was not required when a resident falls. She acknowledged the question "is resident a diabetic" was answered in error.

A policy titled, Assessment and Documentation Guidelines-SL dated 7/27/23 was provided by the Executive Director (ED) on 9/2/25 at 1:30 p.m. It indicated, "...Purpose: To establish clear, consistent guidelines for documentation to ensure resident records are accurate, complete, timely, and compliant with regulations and professional standards ...."

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 SIGNATURETyler Brammer	TITLEExecutive Director	(X6) DATE09/22/2025