STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MEADOW BROOK SENIOR LIVING	11011 VILLAGE SQUARE LANE FISHERS, IN 46038

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigations of Complaints IN00432803, IN00423692 and IN00423711. Complaint IN00432803 - No deficiencies related to the allegations are cited. Complaint IN00423692 - No deficiencies related to the allegations are cited. Complaint IN00423711 - State deficiencies related to the allegations are cited at R298. Survey dates: June 18 and 19, 2024 Facility number: 013163 Residential Census: 86 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 21, 2024.	R 0000		
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, interview, and record review, the facility failed to ensure the Indiana Department of Health's survey report results were	R 0042	What corrective actions will be accomplished for those residents	06/20/2024

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

Allison Roskam | Executive Director | 07/12/2024

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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	easily accessible for visitors and residents. This had a potential to affect 86 of 86 residents that reside in the facility. Findings include: During an environmental tour with the Maintenance Director on 6/19/24 at 2:00 p.m., the concierge desk was observed. A framed sign sitting on the desk indicated the survey report results were available at the desk. There was no observation of the survey report binder nor indication of the location of the report binder at the desk. An observation was made with the Executive Director (ED) of the concierge desk on 6/19/24 at 2:15 p.m. The ED at that time reached behind the desk and pulled out the marked survey reports binder from a bottom shelf. She indicated the report binder was available for the residents to come around the desk and retrieve the binder.		found to have been affected by the finding: No negative outcome identified. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No residents were adversely affected. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Binder moved to more accessible/visible area with sign. This was completed on 6/20/24 How the corrective action(s) will be monitored to ensure the finding will not recur: Administrator/Wellness Director or designee will check location weekly x3 months.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:			

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	(1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview, the facility failed to ensure a resident's ability to self-administer medications by completing a self-administration evaluation for 1 of 1 resident found to have medications at bedside. (Resident V) Findings include: A medication administration observation was conducted on 6/19/24 at 9:33 a.m. with Licensed Practical Nurse (LPN) 3. LPN 3 prepared Resident V's morning medications and entered Resident V's room to administer the medications. Upon entrance into the room it was observed, on the nightstand next to Resident V's bed, were two inhalers. LPN 3 picked up the inhalers and identified one as Proventil (an inhaled medication used to treat or prevent breathing issues; also known as albuterol) and the other as albuterol (an inhaled medication used to treat or prevent breathing issues such as asthma or chronic obstructive pulmonary disease (COPD)). LPN 3 indicated; he did not know who had left the inhalers at Resident V's bedside. An interview with Memory Care Coordinator (MCC) conducted at the same time as the observation in Resident V's room indicated,	R 0216	What corrective actions will be accomplished for those residents found to have been affected by the finding: No negative outcome identified for the resident that was affected. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No residents were adversely affected. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Memory Care Director or designee will educate staff on what is not appropriate in memory care resident rooms. Memory Care Director will e-mail all memory care families to educate about	07/01/2024

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	Resident V's family member sometimes brings and leaves medications for Resident V from outside the facility. MCC indicated, Resident V's family had been educated on the importance of not leaving medications for Resident V previously. MCC further indicated, Resident V did not have a self-administration of medication evaluation completed and/or approved for inhalers at bedside. The clinical record for Resident V was reviewed on 6/19/24 at 11:40 a.m. Resident V's diagnoses included, but not limited to, COPD, severe depression, dementia, anxiety, major neurocognitive disorder (a group of symptoms that cause a significant decline in mental function and ability to perform daily tasks), dependence on supplemental oxygen, and pulmonary fibrosis (a chronic lung disease that causes lung tissue to thicken and scar). Resident V's clinical record did not contain an approved self-administration of medication evaluation for the inhalers found at her bedside nor was there a physician's order for the self-administration of medication. A Saint Louis University Mental Status (SLUMS) evaluation (an assessment tool for mild cognitive impairment and dementia) dated 4/29/24 indicated; Resident V had dementia. An admission evaluation completed on 4/23/24 indicated, Resident V will not be self-administering medications. A list of residents who self-administer medications was provided by Executive Director (ED) on 6/18/24 at 10:29 a.m. and Resident V was not on that list. A physician's order dated 4/22/24 indicated, to		leaving items at bedside, and to hand all medications to nursing staff. How the corrective action(s) will be monitored to ensure the finding will not recur: Memory Care Director or designee will complete room checks for items not belonging in resident room. Room checks will be completed 5x per week for 2 weeks then weekly for 3 months	

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	administer to Resident V, two puffs of the albuterol inhaler four times daily for shortness of breath. A Self-Administration of Medications policy received on 6/19/24 at 11:57 a.m. from Director of Nursing (DON) indicated, "Policy Statement...A resident who takes his or her own medications must be evaluated by his or her physician and Wellness Director/designee to be certain it is an acceptable and safe arrangement. Procedure: 1. An alert and self-sufficient resident may request that his or her physician provide a written order to the community indicating an ability to self-administer medications. The physician must indicate the resident if capable of taking unsupervised. 2. A resident who is capable of self-administering her or her medication must be: a. Alert b. Oriented to person, place and time c. Able to recognize and recite the name of medication and proper time, dosage, and route of administration and side effects for each medication. 3. The Wellness Director at the community must also evaluate each resident who self-administers his or her medication by completing the 'Self-Administration of Medication Assessment' form or complete the assessment within the evaluation. The Wellness Director will approve each resident that self-administers medication to ensure safe and effective procedures are followed..."			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7;			

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	(B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation and interview, the facility failed to ensure its medication storage practices followed accepted pharmacy storage guidelines by having food in a medication room cabinet and bottled water in a medication refrigerator; and failed to ensure a discontinued medication order was followed up on timely (Resident Y). Findings include: 1. An observation of the medication rooms were conducted on 6/19/24 at 2:42 p.m. with Regional Clinical Support (RCS). a. In the first-floor medication room, an opened, large jar of applesauce was found in a medication cabinet next to medication supplies. The jar of applesauce which was half full had a date of 12/21 handwritten in black marker on the jar. The label on the jar indicated, to refrigerate after opening. b. An unopened bottle of water was observed in the second-floor locked medication fridge. An interview with RCS conducted at the same time as the observation indicated, the opened jar of applesauce would be thrown away. RCS also indicated; the medication fridge should have only	R 0298	What corrective actions will be accomplished for those residents found to have been affected by the finding: No negative outcome identified for the resident that was affected. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No residents were adversely affected. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Wellness Director or designee will complete staff education and inservices appropriate storage of resident used products and staff	07/01/2024

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	contained medications. A Medication Storage & Labeling Procedure policy received on 6/19/24 at 3:20 p.m. from RCS indicated, "Traditions Management shall keep all prescription medications in locked storage areas..." 2. A medication administration observation with Licensed Practical Nurse (LPN) 3 was conducted on 6/19/24 at 8:31 a.m. LPN 3 was prepping medications for administration to Resident Y. An interview with LPN 3 conducted at the same time as the observation indicated, one of the medications within one of Resident Y's pill packs was discontinued. LPN 3 explained, Resident Y's 81 mg (milligram) aspirin had been discontinued but the pill was still in the pre-made pill packets. LPN 3 removed and disposed of the aspirin tablet prior to administering all other medications to Resident Y. A hospice physician's order dated 4/5/24 at 10:57 a.m. indicated, Resident Y's aspirin 81 mg order was to be discontinued. An interview with Regional Support (RS) conducted on 6/19/24 at 2:14 p.m. indicated, the pre-made pill packet rolls for Resident Y were sent from their pharmacy in 7-day supply rolls meaning the pill packets were a 7-day supply of her daily medications. An interview with RCS conducted on 6/19/24 at 3:05 p.m. indicated, when speaking with the facility's pharmacy, the discontinue order for Resident Y's aspirin had not been received by them and without the order, they continued to place the 81 mg aspirin tablet into the pill packets. She further indicated, the order to discontinue		personal items. Education also to be provided on process for discontinuing medication and pharmacy notification How the corrective action(s) will be monitored to ensure the finding will not recur: Medication room and cart audits will be completed making sure everything is labeled correctly, and items are kept in the refrigerators. Audits will be completed 2x/week for 4 weeks starting 7/01/2024, then weekly for 4 weeks, and monthly on-going.	

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	Resident Y's aspirin, should have been followed up on in a more timely manner. RCS was unable to provide proof that the hospice physician's order for the discontinuation of Resident Y's aspirin had been received by their pharmacy. This tag relates to complaint IN00423711.			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (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 and interview, the facility failed to ensure the proper labeling of medications stored in 1 of 2 medication rooms in the facility. (Facility) Findings include: An observation of the medication rooms was conducted on 6/19/24 at 2:42 p.m. with Regional Clinical Support (RCS). The following was observed in the first-floor medication room: 1. An opened tube of Genteal Tears 0.3 % eye ointment for Resident 18 was found to have no open date on the tube nor on the medication	R 0301	What corrective actions will be accomplished for those residents found to have been affected by the finding: No negative outcome identified for the resident that was affected. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to	07/05/2024

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	baggie in which it was contained. 2. An unopened container of triamcinolone acetonide 0.1% cream (used to treat itching, redness, dryness, and discomfort of various skin conditions) was found without a resident name, physician's name, prescription number, date of issue, nor the name and address of the pharmacy which filled the prescription. An interview with Regional Clinical Support (RCS) conducted at the same time as the observation indicated, the Genteal Tears eye ointment once opened, should be labeled with an opened date. RCS also indicated; she was unable to identify which resident the unopened container of triamcinolone acetonide was prescribed. A Medication Storage & Labeling Procedure policy received on 6/19/24 at 3:20 p.m. from RCS indicated, "Traditions Management shall assure that the labeling of prescription medication and drugs meet the following criteria: 1. Every container of medicine and drugs prescribed for a resident for self-administration of assistance by non-licensed health care personnel, shall be clearly labeled with the resident's name, the proprietary or generic name of the medication dispensed and its strength, the name and address of the dispensing pharmacy, the name or initials of the dispensing pharmacist, thee prescription number, the date dispensed, the name of the prescribing physician or individual authorized under state law to prescribe medication, and the instructions for use including any cautions which may be required...Containers too small to bear a complete prescription label shall be labeled with at least the prescription number and the dispensing date and shall be dispensed in a container bearing a complete prescription label...2. Medicine and		be affected. No other residents were adversely affected. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Wellness Director or designee will complete staff education and inservices about labeling medications and appropriate storage of medications. How the corrective action(s) will be monitored to ensure the finding will not recur: Wellness Director or designee will audit medication carts and medication rooms 2x/week x4weeks, then weekly x 4 weeks then monthly ongoing.	

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	drugs dispensed by a health care facility pharmacy for administration by a qualified staff of physician to residents whereby the medicines and drugs are not in the possession of the resident prior to administration shall be clearly labeled...3. The residential care facility shall not repackage or relabel resident medications...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation and interview, the facility failed to maintain an infection control program by staff placing their index finger inside of medication cups and not performing hand hygiene prior to and after glove use when performing medication administration for 4 of 5 residents reviewed during medication administration. (Resident Y, 24, 21, and V) Findings include: The medication administration observations were conducted on 6/19/24 starting at 8:31 a.m. with Licensed Practical Nurse (LPN) 3 and ended at 10:05 a.m. During the observations the following was observed:	R 0407	What corrective actions will be accomplished for those residents found to have been affected by the finding: No negative outcome identified for the resident that was affected. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No other residents were adversely affected.	07/05/2024

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	a. After prepping Resident Y's medications, LPN 3 went to grab a medication cup to place the pills into but when LPN 3 grabbed the medication cup, he placed his index finger inside the cup and pinched the cup between his index finger and thumb. b. At 8:59 a.m., LPN 3 prepped Resident 24's medications. LPN 3 went to grab a medication cup to place the pills into but when LPN 3 grabbed the medication cup, he placed his index finger inside the cup and pinched the cup between his index finger and thumb. After that, he grabbed a cup of water, a facial tissue, the medication cup of pills, a pair of gloves and 3 bottles of eye drops then entered Resident 24's room. He handed the medication cup to the resident and when the pills were all taken, he donned the pair of gloves and administered the eye drops. LPN 3 did not perform hand hygiene prior to donning the gloves. c. At 9:13 a.m. LPN 3 prepped Resident 21's medications. LPN 3 went to grab a medication cup to place the pills into but when LPN 3 grabbed the medication cup, he placed his index finger inside the cup and pinched the cup between his index finger and thumb. LPN 3 administered Resident 21's pills, then donned a pair of gloves in preparation to place a pain patch on Resident 21's back however, upon lifting Resident 21's shirt, he noticed a pain patch was still applied to her back. LPN 3 then removed the old pain patch, doffed the gloves, touched the medication cart, the keyboard, and placed his left hand on his mouth and touched his lips with his bare hand. He then walked the medication cart down to the next resident's room. LPN 3 had not performed hand hygiene prior to or after glove use.		What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Wellness Director or designee will complete staff education and inservices about infection control and proper hand hygiene How the corrective action(s) will be monitored to ensure the finding will not recur: Wellness Director or designee will audit medication administration weekly x4weeks, then monthly x 3 months.	

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	d. LPN 3 did not perform hand hygiene after doffing gloves and placing his bare hand to his mouth prior to prepping Resident V's medications at 9:33 a.m. LPN 3 went to grab a medication cup to place the pills into but when LPN 3 grabbed the medication cup, he placed his index finger inside the cup and pinched the cup between his index finger and thumb. After administering medication pills to Resident V, LPN 3 donned a pair of gloves and prepared the resident's nebulizer medication into the nebulizer. LPN 3 had not done hand hygiene prior to donning the gloves. An interview with Memory Care Coordinator (MCC) conducted at 10:05 a.m. on 6/19/24 indicated, LPN 3's technique of grabbing a medication cup by placing his index finger inside the cup was breaking infection control and hand hygiene should be done prior to and after glove use. An Infection Control policy received on 6/19/24 at 11:45 a.m. from Regional Clinical Support (RCS) indicated, "Procedure: Handwashing-Handwashing is the most important practice for infection control. At minimum, employees shall...wash their hands...at the following times...Before and after providing personal or skilled nursing care...After contact with contaminated objects/resident equipment...Gloves...wash hands before and after..."			