STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155761	A. BUILDING 00 B. WING	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00456348. Complaint IN00456348 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: April 21, 22, 23, 24, and 25, 2025 Facility number: 011367 Provider number: 155761 AIM number: 200851590 Census Bed Type: SNF/NF: 107 SNF: 21 Total: 128 Census Payor Type: Medicare: 5 Medicaid: 75 Other: 48 Total: 128 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 7, 2025.	F 0000		
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg Based on observations, interviews, and record review, the facility failed to ensure a safe and orderly discharge from the facility for 1 of 1 residents (Resident 118) reviewed for transfers and discharges.	F 0624	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or	05/19/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jocelyn Brooks	RN, Director of Nursing	05/14/2025

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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	Findings include: On 4/21/25 at 9:58 a.m. Resident 118 was observed as she lay in bed. There was a catheter drainage bag hanging on the side of the bed, with a small amount of dark yellow urine in the tubing. Resident 118 indicated that she was unhappy with her stay at the facility, and she wanted to leave. She did not know why she had a catheter, and she complained of being constipated for a week. On 4/24/25 11:04 a.m. Resident 118's medical record was reviewed. She was a rehabilitation resident whose diagnoses included but were not limited to malignant neoplasm of the larynx (throat cancer), constipation, and urinary tract infection (UTI). A progress note, dated 4/21/25 at 1:38 p.m., indicated an unidentified staff member was walking past the nurses' station when Resident 118 and her family member walked by with a couple of bags with them. They indicated Resident 118 was going on a leave of absence (LOA), to go to CVS pharmacy to pick up her prescriptions that someone called in for her. The resident's family member signed her out in the LOA binder and said he was bringing her back after they were done. The note indicated the resident then mouthed to the unidentified staff member "I'm leaving this place!" A progress note, dated 4/21/25 at 9:55 p.m., indicated an unidentified staff member received report that Resident 118 was on LOA with her family member and had not returned at that time. A progress note, dated 4/22/25 at 12:14 a.m., indicated Resident 118 remained LOA at that time.		of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident 118 along with son declined x3 to return to facility for discharge procedure; son educated on risks of not returning on 4/23/2025. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All residents who have admitted within the last 30 days will be educated on the discharge procedures by 5/19/2025. All residents will be educated on the discharge procedures during their initial care plan meeting (therapy will cut, MD order to dc, paperwork/education, etc. as applicable) by 5/19/2025. All residents who choose to discharge AMA will be provided	

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	According to the LOA book, Resident 118 signed out on 4/21/25 at 12:00 p.m. A progress note, dated 4/22/25 at 5:54 a.m., indicated Resident 118 remained LOA, though the Residents' personal vehicle remained in the facility parking lot. A progress note, dated 4/22/25 at 2:52 p.m., indicated Resident 118 remained out on LOA. The facility had attempted to contact Resident 118 and the resident's family member twice with no success, but voicemails were left. Resident 118 had a Brief Interview for Mental Status (BIMS) score of 15 (indicating her cognitive function was intact). The note indicated the facility left a voice mail with Anthem Medicaid (the resident's insurance) to make them aware that the resident had been out for more than 24 hours. The note indicated Resident 118 was to be discharged from the facility Against Medical Advice (AMA) at that time. The record lacked any additional information related to the resident's discharge, her belongings, or the disposition of her medications. During an interview on 4/24/25 at 1:35 p.m. the Assistant Director of Nursing (ADON) indicated Resident 118 went LOA on 4/21/25 and ultimately left AMA on 4/24/25 at 12:00 p.m. The ADON indicated she saw the resident return to the facility to get her belongings and leave but did not pay enough attention to see whether Resident 118 still had her catheter in or not. During an interview on 4/25/25 at 12:45 p.m., the Executive Director (ED) indicated a few staff members saw Resident 118 get her belongings, get in her car, and leave the facility. He indicated no		with education on risks of leaving AMA and will be provided as safe as possible discharge (education, paperwork, etc. as applicable). All residents who choose to AMA will be provided with all the above and will sign the AMA discharge observation by 5/19/2025. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** The IDT team will be educated on the 'Discharge Against Medical Advice' policy by 5/19/2025. All nurses will be educated on the 'Discharge Against Medical Advice' policy by 5/19/2025. All newly admitting residents will be educated on the discharge procedures during their first care-plan meeting by 5/19/2025. **1.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?** The DNS/Designee will utilize QA tool-'F624 Preparation for Safe/Orderly Transfer/Discharge' to review discharged residents weekly for completion. Complete weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained.	

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	AMA or discharge paperwork was signed and he was unsure if anyone attempted to talk to her or if she had her catheter in or not. During an interview on 4/25/25 at 1:00 p.m. the Director of Nursing (DON) indicated she called Resident 118's family member during the facilities morning meeting on 4/22/25, she indicated she talked to him and begged him to bring the resident back so they could care for her. The resident's family member indicated he would "figure things out" but never called the DON back. The DON indicated Registered Nurse (RN) 13, the unit manager for the unit Resident 118 was residing on, gave the resident discharge information and education on her catheter as the resident was walking out the door. During an interview on 4/25/25 at 1:15 p.m. RN 13 indicated Resident 118 showed up to the facility, saying she's getting out of here. She indicated the resident went into her room and gathered her things with her family member. At that point RN 13 indicated upper management was supposed to take over and handle discharge and education. RN 13 indicated even if a resident discharged AMA they should have still given that resident discharge instructions and education on catheter care. On 4/24/25 at 1:35 p.m. the ADON provided a copy of a current facility policy titled, "Discharge Against Medical Advice" dated 10/2022. This policy indicated, " ...documentation in the medical record should indicate the facility staff attempted to provide other options to the resident and inform the resident of potential risks of leaving AMA ...4. Facility staff will document in the medical record the options offered risks explained and information given to the		If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 5/19/2025**	

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	resident/representative. Documentation will be completed on the discharge against medical advice observation in matrix ...5. Every effort should be made to give the resident/representative as much information as possible to assist in a safe transition ...6. The discharge against medical advice observation and accompanying information should be reviewed with the resident/representative. If the resident/representative refuse the review, that must be noted on the observation. The resident/representative will also sign the observation indicating their understanding of the information ...." 3.1-12(a)(21)			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan Based on observations, interviews and record reviews, the facility failed to ensure a newly admitted resident, (Resident C) had a baseline care plan in place to address his immediate medical needs for a new surgical wound upon his admission for 1 of 3 new admission records reviewed. Findings include: 1. On 4/21/25 at 9:50 a.m. Resident C's wife was observed as she left the hall and stopped a nurse to ask about her husband's leg. She indicated to the unidentified nurse that his leg was still bleeding and had gotten all over his sheets. On 4/21/25 at 10:32 a.m., Resident C was observed as he laid in bed. He had a left below the knee amputation (BKA) which was wrapped up however, he had bleed through the dressing and	F 0655	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident C's physician	05/19/2025

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	bandage. A folded sheet had been placed under his soiled dressing and there was a moderate amount of bright red stains on the white sheet as well. Resident C indicated, he admitted to the facility on Friday the 18th. Everything had been find at the hospital after his amputation, but shortly after he arrived to the facility, he noticed he started bleeding through the bandage. He and his wife, (who was also a resident) had talked to several staff member, but he still had not had a dressing change. On 4/23/25 at 9:15 a.m., Resident C was observed. His bandage remained dry and intact, and he indicated he had not needed it changed since the bleeding seemed to have stopped. On 4/23/25 at 8:50 a.m. Resident C's medical record was reviewed. He was a newly admitted resident for aftercare following a left BKA with a history of atherosclerosis of native arteries of extremities with gangrene, (a condition where hardened plaque buildup in the arteries of the legs and feet leads to poor blood flow and tissue death [gangrene]). and peripheral vascular disease ([PVD] a condition where blood flow to the extremities, primarily legs and feet, is restricted due to narrowed or blocked blood vessels). The record lacked a baseline care plan for his immediate medical needs related to his left BKA. On 4/24/25 at 10:40 a.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, "IDT Baseline Care Plans," revised 4/2018, and indicated, baseline care plans should be added to the Care Plans upon admission to provide orders and interventions which were critical for the first 48 hours after admission. The policy indicated, "It is the policy		orders were reviewed to ensure that resident was receiving treatment care for amputated leg incision on 4/21/2025. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All residents admitted within the last 30 days will have their hospital discharge orders reviewed for treatment transcription accuracy by 5/19/2025. All residents admitted within the last 30 days will have their baseline care plans reviewed for completion within 48 hours of admission by 5/19/2025. All residents admitted within the last 30 days will have their baseline care-plans reviewed for inclusion of healthcare information needed to properly care for resident by 5/19/2025. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** The IDT team will be educated on the 'IDT Baseline Care Plan' policy by 5/19/2025. All nurses will be educated	

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	of this facility that each resident will have an interdisciplinary baseline care plan developed within 48 hours of admission the baseline care plan will be developed in collaboration with the resident, family and/or representative and direct care staff to incorporate findings based on the admission assessment, observations, interviews, and resident preferences. The baseline care plan will include resident centered goals and interventions relative to resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental and psychosocial needs procedure: baseline care plans will be opened in matrix and initiated within 48 hours of admission to the facility by the admitting nurse in collaboration with the interdisciplinary team the baseline care plan will include but is not limited to the following colon the residents initial goals for care instructions ... the Baseline Care Plan will include, but not limited to the following ... the resident's immediate health and safety needs, physician's orders ...."		on the 'IDT Baseline Care Plan' policy by 5/19/2025. All nurses will be educated to enter all parts of discharge orders including treatments by 5/19/2025. DNS/Designee will monitor all new admissions to ensure a base lien care plan is developed to meet the resident's immediate medical needs. **1.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?** The DNS/Designee will utilize QA tool-'F655 Baseline Care Plan' to ensure baseline care plans are initiated within 48 hours of admission and that the care plan is patient specific. Complete weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 5/19/2025**	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, interview and record review, the facility failed to ensure a resident (Resident 87) received care plan revisions to	F 0657	The creation and submission of this plan of correction does not constitute an admission by this	05/19/2025

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	implement new goals and/or approaches to address her diabetic management for 1 of 5 residents reviewed for unnecessary medications. Findings include: On 4/22/25 at 9:00 a.m., Resident 87 was observed in bed. A over-bed table with a breakfast tray was observed in front of her, but Resident 87 indicated she did not want to eat her breakfast. Resident 87 indicated she did not like the food and because of her diabetes, there were certain things she could or could not eat. On 4/23/25 at 10:16 a.m., Resident 87's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to diabetes mellitus type II (a blood sugar disorder) and kidney failure. A nursing progress note, dated 2/21/25 at 10:14 p.m., indicated, Resident 87 had refused all evening medications and refused to have her blood glucose checked. She was asked three separate times but remained adamant about her refusal. An interdisciplinary team (IDT) progress note, dated 3/4/25 at 9:20 a.m., reviewed Resident 87's recent refusals of evening medications and blood sugar checks. Her refusal was attributed to delusions of contracting an illness due to sharing a room. She was provided assurance and staff showed her infection prevention tasks. A nursing progress note, dated 4/6/25 at 9:04 p.m., indicated, Resident 87 refused insulin that shift. She stated she felt she did not need to take medication. Resident 87 continued to refuse her insulin but took her oral medication.		provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident 87's comprehensive care plan was reviewed and revised to include her history of behaviors for refusing medications, insulins, and meal schedules for her diabetic management on 5/12/2025. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All diabetic residents have the potential to be affected by the alleged deficient practice. All diabetic residents will have their care plans and medication adherence reviewed for any refusals or deviations from care-plan by 5/19/2025. All diabetic residents found to be non-adherent to their diabetic plan of care will have their care	

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	A nursing progress note, dated 4/15/25 at 11:51 p.m., indicated, Resident 87 had received her scheduled insulin, but refused to eat her dinner and refused to eat any snacks. Her blood sugar level was taken and was 152. A nursing progress note, dated 4/19/25 at 5:18 a.m., indicated, Resident 87 refused to have her blood sugar checked and refused her scheduled insulin. She stated, she didn't need to have her blood sugar checked and she felt like she didn't need any insulin. The resident was reminded of the importance of taking her insulin and getting her blood sugars checked. She had a care plan dated 8/21/24 which indicated, she was at risk for adverse effects of hyperglycemia/hypoglycemia (high/low blood sugar) related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. This care plan, and her full care plan set, lacked revision to include her history of behaviors for refusing her medications, insulin and meal schedules for her diabetic management On 4/24/25 at 10:40 a.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, "IDT Comprehensive Care Plan Policy," revised 8/2023. The policy indicated, "It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on the Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on the resident's needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental,		plans updated by 5/19/2025. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** The IDT team will be educated on the 'IDT Comprehensive Care Plan' policy by 5/19/2025. The IDT team will review resident's charts during clinical meeting and review/revise care plans as indicated by 5/19/2025. **1.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?** The DNS/Designee will utilize QA tool-'IDT Comprehensive Care Plan' to review residents weekly to monitor that care plans are being revised as needed for any non-adherence. Complete weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 5/19/2025**	

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	and psychosocial well-being ... care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MSDS assessment ...." 3.1-35(d)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care A. Based on record review and interview, the facility failed to obtain resident weights as ordered for 2 of 2 residents reviewed for weights (Resident 74 and 107). B. Based on observations, interview and record review, the facility failed to ensure a newly admitted resident, (Resident C) had physician's orders in place and treatments rendered for a new surgical wound upon his admission for 1 of 5 residents reviewed for quality of care. C. Based on record review and interview the facility failed to ensure a resident's (Resident B) physician's ordered were followed to apply and remove a transdermal medication patch for 1 of 5 residents reviewed for quality of care. Findings include: A1. On 4/23/25 at 11:04 a.m., a record review was completed for Resident 74. She had the following diagnoses which included but were not limited to dementia, hyperlipidemia (high cholesterol), depression, and insomnia. She had an order, dated 1/21/25, to obtain her weight weekly on Monday.	F 0684	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Residents 74 & 107's weight orders were reviewed with NP for refusals and care plans were reviewed and updated on 5/12/2025. Resident C's physician orders were reviewed to ensure that resident was receiving treatment care for amputated leg incision on 4/21/2025.	05/19/2025

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	Her weight was not obtained on 2/3/25, 2/24/25 and 3/10/25. She had a care plan dated 12/3/20 that indicated she was at risk for unintentional weight loss related to dementia. The goal indicated she would be free from significant weight changes. A2. On 4/23/25 at 10:30 a.m., a record review was completed for Resident 107. He had the following diagnoses which included type 2 diabetes mellitus, congestive heart failure (CHF), hyperlipidemia, mild cognitive impairment, and difficulty in walking. Resident 107 had an order, dated 3/5/25, to obtain daily weight for CHF daily and to notify the physician if there was a weight gain of 3 pounds a day or 5 pounds in a week. Resident's March 2025 medication administration record (MAR) was reviewed. He was missing weights for the following dates: 3/14/25, 3/15/25, 3/17/25, 3/19/25, 3/20/25, 3/21/25, 3/22/25, 3/23/25, 3/26/25, 3/27/25, 3/28/25, 3/29/25, 3/30/25, and 3/31/25. Resident's April 2025 MAR was reviewed. He was missing the following weights: 4/1/25, 4/2/25, 4/5/25, 4/6/25, 4/8/25, 4/18/25, 4/21/25, and 4/22/25. On 4/24/25 at 1:45 p.m. the Regional Nurse Consultant (RCS) provided an updated MAR for Resident 107. The MAR was complete with indications that he refused his weight. This was added after the weight concerns had been brought to her attention. He had a care plan dated 2/24/25 which indicated he had the potential for impaired gas exchange		Resident B's order for the transdermal patch was reviewed and revised to ensure that physicians' orders were followed correctly on 3/27/2025. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with daily weight orders that decline weights at any time have the potential to be affected by the alleged deficient practice. All residents with daily weight orders will have their weights reviewed for any refusals by 5/19/2025. It will be explained to residents the risk of refusing weights. All residents with daily weight orders who have refused any weights will have their care plans reviewed and revised by 5/19/2025. All newly admitted residents have the potential to be affected by the alleged deficient practice. All newly admitted residents within the last 30 days will have their physician orders reviewed for timely transcription of treatment orders by 5/19/2025. All residents with topical patch orders have the potential to be affected by the alleged deficient practice.	

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	155761	A. BUILDING 00 B. WING	04/25/2025

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	related to respiratory failure, his head of bed is elevated while lying, CHF, oxygen use. On 4/24/25 his care plan was updated indicating he refuses to be weighed at times. This information was added after weights were brought to management's attention. On 4/24/25 at 2:00 p.m., during an interview with the Director of Nursing (DON), she indicated they need to do a better job at recording refusals. She wanted to continue with daily weights because Resident 107 had a new diagnosis of CHF. A policy titled, "Resident Weight Monitoring" with a date of 9/2024 was provided by the DON on 4/23/25 at 9:29 a.m. It indicated, " ...It is the policy of this facility to weigh residents no less than monthly or per physician orders. Residents may exercise their right to refuse to be weighed ..." B. On 4/21/25 at 9:50 a.m. Resident C's wife was observed as she left the hall and stopped a nurse to ask about her husband's leg. She indicated to the unidentified nurse that his leg was still bleeding and had gotten all over his sheets. On 4/21/25 at 10:32 a.m., Resident C was observed as he laid in bed. He had a left below the knee amputation (BKA) which was wrapped up however, he had bleed through the dressing and bandage. A folded sheet had been placed under his soiled dressing and there was a moderate amount of bright red stains on the white sheet as well. Residnet C indicated, he admitted to the facility on Friday the 18th. Everything had been find at the hospital after his amputation, but shortly after he arrived to the facility, he noticed he started bleeding through the bandage. He and his wife, (who was also a resident) had talked to several staff member, but he still had not had a dressing change.		All residents with topical patch orders were reviewed to ensure that physician orders for patch removal were being followed correctly on 4/4/2025. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** The IDT team will be educated on the 'Resident Weight' and 'Nursing Admission/Return Admission' policies by 5/19/2025. All nurses will be educated on the 'Resident Weight' and 'Nursing Admission/Return' policy by 5/19/2025. All nurses will be educated to enter all parts of discharge orders including treatments by 5/19/2025. All nurses and QMAs will be educated on accuracy of medication/treatment administration as it relates to topical patch placement and removal by 5/19/2025. All nurses and QMAs will be educated on documentation of physician notification for any patch orders that were not followed correctly by 5/19/2025. All new physician orders for medications will be reviewed in clinical meetings and care plans will be revised as indicated by 5/19/2025. **1.How the corrective action(s) will be monitored to ensure the**	

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	On 4/21/25 at 10:44 a.m., Registered Nurse (RN) 12 indicated, he had not seen Resident C yet, but had been alerted that his bandage had bled through, so he was going to put a PRN (as needed) dressing in place since his bandage was soaked through. On 4/21/25 at 10:47 a.m., Resident C's physician's orders were reviewed and revealed no dressing/treatment orders schedule or as needed for his left BKA. On 4/22/25 at 8:55 a.m., Resident C was observed. He remained in bed and his dressing was observed soiled with bright red drainage. He indicated, he bled through his dressing and it seemed that the wound would not stop bleeding. On 4/22/25 at 1:33 p.m., Resident C was observed. He had a new bandage which appeared to be dry and intact. Resident C indicated, it seemed like it was under control now. On 4/23/25 at 9:15 a.m., Resident C was observed. His bandage remained dry and intact, and he indicated he had not needed it changed since the bleeding seemed to have stopped. On 4/23/25 at 8:50 a.m. Resident C's medical record was reviewed. He was a newly admitted resident for aftercare following a left BKA with a history of atherosclerosis of native arteries of extremities with gangrene, (a condition where hardened plaque buildup in the arteries of the legs and feet leads to poor blood flow and tissue death [gangrene]). and peripheral vascular disease ([PVD] a condition where blood flow to the extremities, primarily legs and feet, is restricted due to narrowed or blocked blood vessels).		**deficient practice will not recur, i.e. what quality assurance program will be put into place?** The DNS/Designee will utilize QA tool-'F684 Quality of Care' to ensure daily weight orders, discharge treatment orders, and topical patch orders were followed. Complete weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained. The DNS/Designee will utilize QA tool-'F684 Quality of Care' to ensure care plans are up to date for any new physician orders as indicated. Complete weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 5/19/2025**	

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	On 4/23/25 at 12:26 p.m., the Infection Preventionist (IP) provided a copy of Resident C's hospital discharge summary and instructions. The hospital record was dated 4/18/25 and indicated, "continue daily dressing changes, wash with soap/water and pat dry. May leave open to air if no drainage and clean environment versus dry dressing. Staples to remain 4-6 weeks ...." A physician's order for treatment and dressing to his left BKA was not placed in the order set until 4/22/25. Resident C's Treatment Administration Record (TAR) was reviewed from his admission on 4/18/25 until 4/21/25 and revealed no treatments or wound dressings had been administered over the weekend after his admission. A late nursing progress note was added to his record on 4/23/25 at 3:16 p.m., (dated effective for 4/21/25 at 3:04 p.m.) which indicated, " ...changed wound dressing to resident's left BKA with a pressure wrap. His wound was bleeding out from the previous dressing onto his bed sheets. Wound has some staples still remaining, the oozing of blood was coming from one of the staples ...." On 4/24/25 at 10:22 a.m., the Infection Preventionist (IP) provided a copy of current facility policy titled, "Nursing Admission/Return Admission Policy and Procedure), revised 7/2024. The policy indicated, " ...Upon admission, physician orders must be obtained. Transcribe the admission orders from the original orders sent from the hospital or physician's office ...." C. A confidential interview during the survey			

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	indicated Resident B was taken to the hospital were they found two Nitroglycerin (ointment or skin patch is used to prevent angina [chest pain] caused by coronary artery disease [CAD]) patches on the resident. On 4/22/25 at 1:38 p.m., Resident B's medical record was reviewed. She had been a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, Alzheimer's disease (an irreversible and degenerative brain disease which affects memory and cognition) hypertension (high blood pressure) and heart failure. She was discharged to the hospital on 4/5/25 and did not return to the facility. A nursing progress note, dated 3/25/25 at 1:10 p.m., indicated, Resident B's family requested she be sent to the ER for assessment and evaluation after a fall earlier that morning. Resident B was transferred to the hospital, but returned the same day with no major injuries or infections. On 4/24/25 at 11:35 a.m., the Director of Nursing (DON) provided a copy of a hospital emergency room (ER) summary from 3/25/25. The ER summary indicated, " ...she did have 2 nitroglycerin patches on, one of them was expired ...." At the time of her hospitalization on 3/35/25 she had an order for the following, nitroglycerin patch 24 hour; 0.2 mg/hr; Amount to Administer: 0.2 mg/ hr; transdermal every 12 hours. The order included specific instructions to place "ON 12 hours during the day (y) OFF 12 hours at night ...."			

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	A nursing progress note dated 4/2/25 at 3:23 p.m., indicated, Resident B had a Nitro patch on her left shoulder from yesterday. It was removed and replaced with a new patch on left shoulder. The note lacked documentation the physician had been notified. The physician's order active for her Nitro patch on 4/2/25 indicated specific instructions to remove the old patch at bedtime. Resident B's comprehensive care plan was reviewed and lacked implementation and/or revision to include person-centered goals and interventions related to her heart failure and the use of a nitro transdermal patch. On 4/25/25 at 9:50 a.m., the Director of Nursing (DON) provided a copy of a nursing in-service. The DON indicated that Resident B's family was upset when she returned to the facility and told the administrator (ADM) that two Nitro patches were on her back. The ADM told the DON, and the DON conducted an in-service and audit to correct the issue. The DON indicated they conducted the in-service and audits at the time they were made aware on 3/25/25. The DON indicated, there was no specific policy, but it was basic nursing standards of care to follow physician's orders as written and to update the care plans with interventions as needed. The in-service material and audit tools were reviewed but had not been initiated until 4/4/25. On 4/24/25 at 10:40 a.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, "IDT Comprehensive Care			

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	Plan Policy," revised 8/2023. The policy indicated, "It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on the Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on the resident's needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being ... care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MSDS assessment ...." This citation relates to Complaint IN00456348. 3.1-37			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation and interview, the facility failed to prevent the potential for accidents when medications were left bedside with residents without self-administration assessments for 2 of 2 random observations (Residents 78 and 118), and when a nurse was observed leaving medications unattended on top of the medication cart during a medication pass observation which had the potential to affect 2 of 2 residents in the hallway when the medication was unattended. Findings include: 1. On 4/20/25 at 9:46 a.m. Resident 78 was observed sitting up in his wheelchair. On his bedside table was a clear cup and inside there were 7 pills ranging in color and size. Resident 78	F 0689	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **1.What corrective action(s) will be taken for those residents found to have been**	05/19/2025

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	indicated he had not taken them yet because he had an upset stomach. He indicated the nurse left them there for him to take. A record review was completed. Resident 78 had the following diagnoses which included but were not limited to cerebral infarction (stroke), type 2 diabetes, difficulty swallowing, hyperlipidemia, and hypertension. On 4/23/25 at 1:30 p.m., the Director of Nursing (DON) indicated Resident 78 lacked a self-administration assessment and the nurse should not have left the medications at bedside. 2. On 4/21/25 at 9:58 a.m., Resident 118 was observed as she laid in bed. As the resident explained that she had been constipated for the last week, she pulled a bottle of Dulcolax (an over the counter stool softener) out of her purse. On 4/24/25 at 11:04 a.m., Resident 118's medical record was reviewed. She was a rehabilitation resident whose diagnoses included but were not limited to malignant neoplasm of the larynx (throat cancer), constipation and Urinary Tract Infection (UTI). On 4/24/25 at 10:30 a.m., the Assistant Director of Nursing (ADON) indicated Resident 118 did not have a self-administration assessment and should not have any medications at bedside. 3. On 4/24/25 at 8:15 a.m., Registered Nurse (RN) 6 was observed as she passed medications. When preparing medications for a resident she separated the residents blood pressure medication from all the other medications and put it in its own medication cup. When taking the medications to the resident RN 6 left the medication cup with the		**affected by the deficient practice?** Resident 78 took his medications per physician order with a nurse present after surveyor observation on 4/20/2025. Resident 118 discharged on 4/22/2025. No residents were affected by RN leaving medication on top of medication cart on 4/24/2025. RN 6 was educated related to drug administration by DNS/Designee. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All residents will be audited for any medications at bedside by 5/19/2025. Any residents with medications at bedside will be reviewed for ability to self-administer the medication. Orders and care plan will be reviewed and updated for those found able to self-administer medication by 5/19/2025. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** The IDT team will be	

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	blood pressure medication in it on top of the medication cart unattended. At the time the medication was left unattended there were two unidentified residents in the hallway. A policy titled, "Storage and Expiration Dating of Medications and Biologicals" was provided by the Assistant Director of Nursing (ADON) on 4/24/25 at 1:35 p.m. It indicated, " ...Facility should not administer/provide bedside medications or biologicals without a physician/prescriber order and approval by the interdisciplinary team and facility administration ....". 3.1-45(a)		educated on medication administration and medications left at bedside by DNS/Designee. ·All nurses and QMAs will be educated on medication administration and medications left at bedside by DNS/Designee. ·DNS/Designee will round daily to ensure medications are not left at bedside for residents who have not been assessed to self-administer medications. **1.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?** The DNS/Designee will utilize QA tool- 'F689 Free of Accident Hazards/Supervision' to review residents weekly to ensure any medications that are at bedside have a Self-Administration observation completed and a physician order in place. Complete weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained. The DNS/Designee will utilize QA tool- 'F689 Free of Accident Hazards/Supervision' to review med pass moments weekly to ensure all medications are administered and taken by residents with nurse/QMA present and no medications were left unattended on the medication cart. Complete weekly x4 weeks,	

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			monthly x 6 months, then quarterly until compliance is maintained. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After 6 months, the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 5/19/2025**	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observations and interviews, the facility failed to date insulin and eye drops when opened and failed to remove expired tuberculin serum and insulin from the refrigerator for 3 of 6 medication carts and 2 of 4 medication rooms. Findings include: On 4/23/25 at 1:03 p.m., 200 hall medication cart was observed. Resident 282 had an insulin pen dated 3/22/25. Resident 281 had a vial of folic acid inside the refrigerator on 200-hall that was undated. The 300-hall medication cart was observed. Resident 25 had a NovoLog insulin pen undated, and glargine insulin pen undated. Resident 86 had an insulin pen Semglee with no date to indicate when it was opened. Resident 38 had a bottle of brimodine 0.2% with no date to indicate when it was opened. The 300-hall medication room was observed. Inside the refrigerator was a vial of tuberculin	F 0761	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Insulin and eye drops which were not dated when opened were discarded. Expired tuberculin serum	05/19/2025

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	serum that had a date of 3/20/25 on it. The 400-hall back medication cart was observed. Resident 1 had a insulin pen glargine with no date to indicate when it was opened. On 4/25/25 at 11:32 a.m., during an interview with the Director of Nursing (DON), she indicated they had been auditing the carts to ensure items had dates on them. A policy titled "Storage and Expiration Dating of Medications and Biologicals" was provided by the Assistant Director of Nursing (ADON) on 4/24/25 at 1:35 p.m. It indicated, " ...Facility should ensure medications and biologicals that 1) have an expired date on the label ...Once any medication or biological package is opened, the facility should follow manufacturer/suppliers guidelines with respect to open dates for opened medications ....". 3.1-25(j) 3.1-25(m) 3.1-25(n)		and insulin were discarded. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All medication carts and medication rooms were audited by DNS/Designee will be audited for expired or undated insulin, eye drops, medication vials, or tuberculin solution. Any medications found to be expired or undated will be removed for destruction by 5/19/2025. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** The IDT team will be educated on the 'Storage & Expiration Dating of Medications and Biologicals' policy by 5/19/2025. All nurses and QMAs will be educated on the 'Storage & Expiration Dating of Medications and Biologicals' policy by 5/19/2025. DNS/Designee will inspect the medication carts and medication rooms for not dated and expired medications. **1.How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e. what quality assurance program will be put into place? The DNS/Designee will utilize QA tool-'F761 Label/Store Drugs & Biologicals' to review medication carts/medication rooms for expired or undated insulin, eye drops, medication vials, or tb solution. Complete weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After 6 months, the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 5/19/2025**	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on observations, interviews and record review the facility failed to ensure the medical record reflected accurate documentation of a pressure injury for a resident for 1 of 25 residents reviewed for accurate documentation (Resident 16). Findings include: On 4/22/25 at 10:15 a.m., Resident 16 was observed as he lay in bed. He was pleasantly confused at times, but he could answer most questions appropriately. He had a pressure-relieving boot on his right heel and	F 0842	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.	05/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155761	A. BUILDING 00 B. WING	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

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	another pressure-relieving boot was on the floor at the foot of the bed. On 4/24/25 at 1:35 p.m., Resident 16's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to Type 2 Diabetes and Urinary Tract Infections (UTI). A progress note, dated 11/15/24 at 10:35 p.m., indicated Resident 16 arrived at the facility in a wheelchair with bilateral edema in his lower extremities and a pressure ulcer on his right heel. A progress note, dated 3/16/25 9:59 p.m., indicated Resident 16 had a dressing changed to his right heel ulcer. An admission assessment, dated 11/15/24, indicated Resident 16 had a pressure ulcer on his right heel. A weekly skin assessment, dated 11/26/24, indicated Resident 16 had open areas on his left foot. A weekly skin assessment, dated 12/3/24, indicated Resident 16 had open areas on his left foot with eschar (a hardened crust of black or brown dead tissue, that forms over a wound). A weekly skin assessment, dated 12/10/24, indicated Resident 16 had open areas on his left heel. A weekly skin assessment, dated 12/24/24, indicated Resident 16 had open areas on his heel, it did not specify which heel. A weekly skin assessment, dated 12/31/24,		**1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident 16 was evaluated to ensure he only had one pressure ulcer to his right heel that was present on admission. Evaluation was done 4/25/25. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All residents with open skin areas will have their weekly skin assessments reviewed to ensure the nurse documented the correct anatomical location of the skin impairment by 5/19/2025. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** The IDT team will be educated on the 'Documentation Guidelines for Nursing' policy by 5/19/2025. All nurses will be educated on the 'Documentation Guidelines for Nursing' policy by 5/19/2025. DNS/Designee will review residents with wound documentation to ensure	

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	indicated Resident 16 had open areas on his heel, it did not specify which heel. A weekly skin assessment, dated 1/14/25, indicated Resident 16 had open areas on his heel, it did not specify which heel. A weekly skin assessment, dated 1/28/25, indicated Resident 16 had open areas on his left heel. A weekly skin assessment, dated 3/4/25, indicated Resident 16 had open areas on his left, it did not specify where the open areas were located. An admission assessment, dated 3/13/24, indicated Resident 16 had a pressure ulcer on his right heel. In an interview on 4/24/25 at 12:00 p.m., Registered Nurse (RN) 11 indicated Resident 16 has a pressure ulcer on his right heel only. In an interview on 4/25/25 at 11:00 a.m., the Director of Nursing (DON) indicated Resident 16 did not have open areas anywhere but his right heel. She indicated that the skin assessments that say he had a wound on his left heel were incorrectly charted and she was going to have the nurses who charted incorrectly fix the mistakes. On 4/24/25 at 1:35 p.m. the Assistant Director of Nursing (ADON) provided a copy of a current facility policy titled, "Documentation Guidelines for Nursing" dated 7/2024. The policy indicated, " ...Purpose: to accurately document in an organized manner all information related to the resident in the medical record ...." 3.1-50(f)		accuracy. **1.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?** The DNS/Designee will utilize QA tool-'Documentation Guidelines for Nursing' to review the weekly skin assessments of residents with open skin impairments for accurate location documentation. Complete weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 5/19/2025**	

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