STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155703		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/26/2024	
	PROVIDER OR SUPPLIE SIDE VILLAGE INC		1111 C	ADDRESS, CITY, STATE, ZIP COD HURCH AVE R, IN 47546		
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
F 0000 Bldg. 00	This visit was for a Licensure Survey a IN00426231. This Residential Licensure Complaint IN0042 the allegations are Survey dates: Februs Facility number: 00 Provider number: 10 AIM number: 2012 Census Bed Type: SNF/NF: 2 SNF: 20 Residential: 39 Total: 61 Census Payor Type Medicare: 5 Medicaid: 2 Other: 15 Total: 22 These deficiencies accordance with 41	Recertification and State and Investigation of Complaint visit included a State are Survey. 6231 - No deficiencies related to cited. uary 19, 20, 21, 22, 23, 26, 2024 03240 155703 274720	F 0000			
F 0580 SS=E Bldg. 00	§483.10(g)(14) N (i) A facility must	iv)(15) s (Injury/Decline/Room, etc.) otification of Changes. immediately inform the with the resident's				
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	

Melissa Joffee RN, HFA 03/19/2024

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155703		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/26/2024	
	PROVIDER OR SUPPLIEF	R	STREET ADDRESS, CITY, STATE, ZIP COD 1111 CHURCH AVE JASPER, IN 47546				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION
TAG	physician; and nother authority, the when there is- (A) An accident in results in injury ar requiring physicia (B) A significant or physical, mental, of that is, a deterior psychosocial status conditions or clinic (C) A need to alte (that is, a need to form of treatment consequences, or of treatment); or (D) A decision to the sequences, or of treatment); or (D) A decision to the sequences, or of treatment); or (D) A decision to the sequences, or of treatment); or (D) A decision to the sequences, or of treatment); or (D) A decision to the sequences, or of treatment); or (D) A decision to the sequences, or of treatment); or (D) A decision to the sequences, or of treatment); or (E)	tify, consistent with his or resident representative(s) volving the resident which and has the potential for intervention; hange in the resident's or psychosocial status ation in health, mental, or us in either life-threatening cal complications); in treatment significantly discontinue an existing due to adverse to commence a new form transfer or discharge the facility as specified in motification under paragraph ection, the facility must rinent information specified available and provided he physician. Ist also promptly notify the esident representative, if second or roommate ecified in §483.10(e)(6); or esident rights under Federal gulations as specified in of this section. Ist record and periodically is (mailing and email) and		TAG			DATE
	Admission to a co	mposite distinct part. A mposite distinct part (as					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E27111

Facility ID: 003240

If continuation sheet Page 2 of 17

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155703	B. W	ING		02/26	/2024
NAME OF F	PROVIDER OR SUPPLIER	.	-		ADDRESS, CITY, STATE, ZIP COD	-	
					HURCH AVE		
BROOKS	SIDE VILLAGE INC			JASPEI	R, IN 47546		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	,) must disclose in its					
	admission agreem						
	configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations						
	under §483.15(c)(
		and record review, the facility	F 0:	580	F-580 Notification of Change	ıs	03/11/2024
	failed to notify appropriate parties of a resident's significant change of status for 2 of 5 residents		1 0.		S/S E		03/11/2027
					-		
	reviewed for nutrition. The Medical Doctor (MD)				I The corrective		
		cian were not notified of a			actions to be accomplished	for	
	significant weight loss, and the Doctor was not				those residents found to have		
	notified of a five pound weight gain as indicated				been affected by the practice	э.	
	in a weight order. ((Resident 3, Resident 9)					
					There were no negative reside	ent	
	Findings include:				outcomes by the alleged prac	tice.	
					The staff members found to h	ave	
		:14 A.M., Resident 3's clinical			deficient practices in notification	on of	
		d. Diagnosis included, but			change were immediately		
		anxiety and depression. The			educated and understand whe	en to	
	_	ly MDS (minimum data set)			notify the provider.		
		2/8/23, indicated a mild					
	cognitive impairme	nt, and no weight loss or gain.			II The facility will		
	G . 1	1 1 1 1 1 1 4			identify other residents that		
		orders included, but were not			may potentially be affected by	рy	
	limited to: Weight once a day,	dated 2/16/24			practice.		
	weight once a day,	uaicu 2/10/24.			Current residents have the		
	Monthly weight and	d vital signs on the first of the			potential to be affected by the		
	month, dated 11/1/2	_			alleged deficient practice. Au		
					were conducted to ensure nur		
	A current nutritions	al status care plan, dated			were notifying MD of changes		
		t was not limited to the			(Attachment G).		
	following interventi]		
	_	ght routinely, notify MD/RD					
		an) of significant weight			III The facility will put		
	changes, dated 9/5/2				into place the following		
					systemic changes to ensure		
	Resident 3's weight	s included, but were not			that the practice does not		

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Facility ID: 003240

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CE	NIERS FOR	MEDICARE & MEDIC				ON	1B NO. 0938-039
	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE	SURVEY
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
			155703	B. WING		02/26	
			100700		_	02/20	72024
	NAME OF B	DOLUDED OD GLIDDLIEF		STREET	ADDRESS, CITY, STATE, ZIP COD		
	NAME OF P	ROVIDER OR SUPPLIER	C	1111 (CHURCH AVE		
	BROOKS	SIDE VILLAGE INC		JASPE	ER, IN 47546		
	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	\\\L	DATE
		limited to, the follo	wing:		recur.		
		10/3/23 130.2			Staff were educated regarding	a	
			21% decrease in one month)			9	
		11/1/25 115.0 (11.2	11 /6 decrease in one month)		physician notification. Nurses		
					educated on policy for change	e in a	
			l record lacked a notification to		resident's condition or status.		
		the MD or Register	ed Dietician of the significant		(Attachment A)		
		weight loss that occ	curred on 11/1/23.				
					IV The facility will		
		On 2/22/24 at 2:00	P.M., the Regional Clinical		monitor the corrective action	า	
			otification following Resident		by implementing the following		
		* *	ht loss on 11/1/23 could not be		measures.	.9	
		located.	nt 1033 on 11/1/25 could not be		illeasures.		
		located.			TI 000 I : 'II		
					The SDC or designee will aud		
			:36 A.M., Resident 9's clinical		random to ensure notification	of	
			d. Diagnosis included, but		changes were relayed to the		
		were not limited to,	anxiety and depression. The		physician 5 times per week fo	r 4	
		most recent Quarter	rly MDS Assessment, dated		weeks, then weekly for 4 wee	ks,	
		1/14/24, indicated a	mild cognitive impairment, and		then biweekly for 4 weeks the		
		no weight loss or ga			monthly for 3 months for a tot		
		8 8			6 months of monitoring using		
		Current physician o	orders included, but were not		Quality Improvement Tool F-5		
		limited to:	riders meraded, but were not		1	000	
			11 31 ('C 34D 'C ' 1)		audit tool. (Attachment B)		
		_	weekly. Notify MD if weight				
			ls) daily or 5 lbs in a week,				
		dated 10/11/23.			V Plan of correction		
					completion date.		
		A current nutritiona	al status care plan, dated				
		10/11/23, included	but was not limited to, the		Date of compliance: March 11	١,	
		following intervent			2024		
		~	ght routinely, notify MD/RD				
			nt changes, dated 10/11/23.		The results of these reviews	will	
		or orginificant weigh	ii changes, auca 10/11/23.			vv	
		Dogidant Ol: 14	a included but were		be discussed at the monthly		
		_	s included, but were not		facility Quality Assurance	•	
		limited to, the follo	wing:		Committee meeting monthly f	or 6	
		2/7/24 235 lbs			months and then quarterly		
		2/9/24 240.8 lbs (5.	8 lb increase in two days,		thereafter once compliance is	at	
		2/7-9/24))			100%. Frequency and duratio	n of	
		2/12/24 240.5 lbs (5	5.5 lb increase in five days,		reviews will be increased as		
		2/7-12/24)	3 /		needed if compliance is below	,	
				1		•	1

100%.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155703		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	ie survey ipleted 26/2024	
	ROVIDER OR SUPPLIER		1111 C	ADDRESS, CITY, STATE, ZIP HURCH AVE R, IN 47546	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	-	I record lacked a notification to ht gain that occurred on 2/9/24				
	Support indicated n	P.M., the Regional Clinical otification following Resident 4/9/24 and/or 2/12/24 could not				
	(LPN) 5 indicated in their weight, they nurse working the f contacting the MD day or 5 lbs in a we it should be document notification on the MR Record (MAR), and	A.M., Licensed Practical Nurse f a resident had a discrepancy should be re-weighed. The loor was in charge of if the resident gained 2 lbs in a ek. Once the MD was notified, ented under the physician Medication Administration I if a new order were to be be documented in the progress				
	Resident's Condition provided, revised 10 facility shall prompher Attending Physic (sponsor) of change medical/mental con Nurse Supervisor/C resident's Attending Physician when the change in the residently physical/emotional/	dition and/or status The harge Nurse will notify the Physician or On-Call re has been A significant ent's mental condition The Nurse Nurse will record in the				
R 0000						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER				COMPL	ETED
		155703	B. WI	NG		02/26/	2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1111 CHURCH AVE JASPER, IN 47546				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Nursing Home Complaint IN00426231. Complaint IN00426231 - No deficiencies related to the allegations are cited. Survey dates: February 19, 20, 21, 22, 23, 26, 2024 Facility number: 003240 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. 410 IAC 16.2-5-4(e)(1)		R 00	000			
Bldg. 00	provision of reside as ordered by the shall be supervise the premises or or (1) Medication shallicensed nursing p medication aides. Based on observation review, the facility fewere administered a resident received and been previously discobserved during me (Resident 12) Finding includes:	tion of medications and the ntial nursing care shall be resident ' s physician and d by a licensed nurse on	R 02	241	R-241 Health Services (administering medications a ordered by the physician) I The corrective actions to be accomplished for those residents found to have been affected by the practice. There were no negative resides	or e	03/11/2024
	During an observati	on on 2/23/24 at 10:31 A.M.,			There were no negative reside	nt	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155703	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/26/2024	
	PROVIDER OR SUPPLIER		1111 C	ADDRESS, CITY, STATE, ZIP COE CHURCH AVE ER, IN 47546		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE ROPRIATE COMPLETION DATE	
	an LPN (Licensed F vial of albuterol sulmilligrams per 3 mi 12 at that time. On 2/23/24 at 10:50 record was reviewed not limited to cough Physicians orders in to: Discontinued order "albuterol sulfate so mg/3 mL; Amount 1Four Times A Day unspecifiedStart/102/11/2024" Current order as of "ipratropium- albu 0.5 mg- 3 mg (2.5 madminister: 1; inhala [diagnosis] Cough, 2/21/24. During an interview AL Unit Manager in incorrect nebulizer: discontinued. On 2/23/24 at 2:19 in Nebulizer Treatment reviewed 12/28/22, Clinical Support and	as of 2/11/2024: Solution for nebulization; 0.63 to Administer: 1 vial; inhalation yDiagnosis [DX: Cough, End Date 02/8/2024-		outcomes by the alleged. The staff member found deficient practices in heat services was immediately educated and understand QMA's educated on scorp practice. II The facility will identify other residents may potentially be affect practice. Current residents have the potential to be affected be alleged deficient practice were completed to ensur were administering medicordered by the physician. III The facility will into place the following systemic changes to enthat the practice does not recur. Staff were educated regard administering medication ordered by the physician educated on policy for madministration. (Attachment of the corrective aby implementing the following systems.) The SDC or designee will medication pass to ensure the service of the staff of	to have lith y ds. All be of that eted by the . Audits e staff cations as	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155703		A. BUILDING B. WING	00	COMPLETED 02/26/2024	
	ROVIDER OR SUPPLIER		1111 CI	ADDRESS, CITY, STATE, ZIP COD HURCH AVE R, IN 47546	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				medications are being administered as ordered by the physician 5 times per week for weeks, then weekly for 4 weeks then biweekly for 4 weeks then monthly for 3 months for a tota 6 months of monitoring using to Quality Improvement Tool R-2 audit tool. (Attachment C)	t 4 ks, n al of he
				V Plan of correction completion date. Date of compliance: March 11 2024 The results of these reviews w discussed at the monthly facilit Quality Assurance Committee meeting monthly for 6 months then quarterly thereafter once compliance is at 100%. Frequency and duration of rev will be increased as needed if compliance is below 100%.	rill be ty and
R 0243	410 IAC 16.2-5-4(, ,			
Bldg. 00	in the individual 's records that indica (A) time; (B) name of medic (C) dosage (if app (D) name or initials administering the Based on observation	administering the ocument the administration medication and treatment te the: ation or treatment; licable); and sof the person drug or treatment. on, interview, and record	R 0243		03/11/2024
	review, the facility t	failed to ensure the		R-243 Health Services	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	CON	MPLETED
		155703	B. W	'ING		02/	26/2024
NAME OF T	DROLUDED OF CURRY TO			STREET .	ADDRESS, CITY, STATE, ZIP C	COD	
NAME OF F	PROVIDER OR SUPPLIEF	C.		1111 C	HURCH AVE		
	SIDE VILLAGE INC			JASPE	R, IN 47546		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION ne administered nebulizer	+	TAG		adiaction)	DATE
		nented by the licensed nurse			(documentation of me	edication)	
	that administered th	-			The correct	ive	
		fied Medication Aide (QMA)			actions to be accomp	_	
	documented she gave the medication that was				those residents found		
	given by the Assisted Living (AL) Unit Manager				been		
		dents reviewed during a					
	medication pass. (Resident 12).				affected by the pract	ice.	
	Finding includes:				There were no negative	e resident	
	-				outcomes by the alleg		
	During an observati	ion on 2/23/24 at 10:31 A.M.,			The staff members for	ınd to have	
	the Assisted Living (AL) Unit Manager LPN				deficient practices in h	ealth	
	administered 1 vial	of albuterol sulfate solution			services were immedia	ately	
	1	rams per 3 milliliters (mg/ml) to			educated and understa	and proper	
	Resident 12.				delegation to QMA's.		
					educated on scope of	practice.	
		A.M., Resident 12's clinical					
		d. Diagnosis included, but was			II The facility w		
	not limited to cough	1.			identify other residen		
	DI ' I '				may potentially be aff	fected by	
	· -	ncluded, but were not limited			practice.		
	to:				Current regidents have	o tho	
	Discontinued order	as of 2/11/2024			Current residents have potential to be affected		
		olution for nebulization; 0.63			alleged deficient practi	•	
		to Administer: 1 vial; inhalation			were completed to ens		
		yDiagnosis [DX: Cough,			were documenting me		
		End Date 02/8/2024-			appropriately.	aloations	
	02/11/2024"	246 02/0/2021			арргорнасту.		
	Current order:				III The facility w	ill put	
	"ipratropium- alb	uterol solution for nebulization;			into place the following	-	
		ng base)/ [per] 3 ml; Amount to			systemic changes to	-	
	administer: 1; inhal	ation. Four Times A Day [DX:			that the practice does		
	[diagnosis] Cough,	unspecified" start date,			recur.		
	2/21/24.						
		lacked documentation of the			IV The facility w		
	actual medication a	dministered by the LPN. The			monitor the correctiv	e action	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		155703	B. W	ING	_	02/26/	2024
	PROVIDER OR SUPPLIER			1111 C	ADDRESS, CITY, STATE, ZIP COD HURCH AVE R, IN 47546		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	T		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	•	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		was not administered was			by implementing the followir	na	
		en by a QMA for the same time			measures.	.9	
	frame.	an ey ar Quant for the same time			mododi oo.		
	During an interview AL Unit Manager a documented the net she indicated she we would have docume completed, given th administered the me During an interview AL Unit Manager for gave the medication that gave the nebuli documented the adm QMA's get annoyed appeared red highlig	on 2/26/24 at 11:31 A.M., the ttempted to verify that she pulizer solution at that time, as unsure why the QMA ented the nebulizer as being at she was the nurse that edication. on 2/26/24 at 12:00 P.M., the pund her written notes that she in and indicated that the nurse zer should be the one that ministration, but sometimes the lawhen the medication in the enter will sign the medication.			The SDC or designee will aud resident's medication administration record to ensur medications are documented the appropriate licensed individed administering the medication of times per week for 4 weeks, then biwe for 4 weeks then monthly for 1 month for a total of 4 months of monitoring using the Quality Improvement Tool R-243 audit tool. (Attachment D)	e by dual 5 nen ekly of	
	off if they know the nurse administered it. On 2/23/24 at 2:19 P.M., a current Licensed Nurse Nebulizer Treatment Clinical Skills Validation, reviewed 12/28/22, was provided by the Regional Clinical Support and indicated, "34. Documentation was completed on e-mar/MAR [electronic medication record]"				completion date. Date of compliance: March 11 2024 The results of these reviews we discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months then quarterly thereafter once compliance is at 100%. Frequency and duration of revisible will be increased as needed if compliance is below 100%.	vill be ity and riews	
R 0246 Bldg. 00	a qualified medica authorization by a	Deficiency ons may be administered by ition aide (QMA) only upon					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155703	B. W	ING		02/26/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			HURCH AVE		
BROOKS	SIDE VILLAGE INC				R, IN 47546		
שולטטונם	TIPE VILLAGE INC			UAGI E	1, 11, 17,010		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	authorization for e	each administration of a					
		All contacts with a nurse or					
	physician not on t	•					
	authorization to administer PRNs shall be						
		e nursing notes indicating					
	the time and date	of the contact.		2.4.6			00/11/2001
			R 02	246	R-246 Health Services (PRN		03/11/2024
		on, interview, and record			medication administered by		
		failed to ensure as needed			QMA are authorized by LPN)		
		administered by a Qualified (MA) were authorized by a			The		
	,	•			I The corrective		
	licensed nurse for 4 of 5 resident records				actions to be accomplished		
	reviewed. (Resident 3, Resident 4, Resident 5,				those residents found to have	'e	
	Resident 6)				been affected by the		
	Findings include:				practice.		
	Tilidings include.				There were no negative reside	ont	
	1 On 2/23/24 at 2:4	45 P.M., Resident 3's clinical			outcomes by the alleged pract		
		d. Diagnoses included, but			The staff members found to ha		
		dizziness and osteoarthritis.			deficient practices in health	ave	
					services were immediately		
	Physician orders in	cluded, but were not limited to:			educated and understand pro	oer	
	1 -	iness) 25 milligrams (mg) every 6			delegation to QMA's. All QMA	•	
		RN). Amount to administer: 1			educated on scope of practice		
	tablet.	•			, , , , , , , , , , , , , , , , , , , ,		
	Acetaminophen (Ty	vlenol) 500mg every 8 hours			II The facility will		
	PRN. Amount to ad	lminister: 2 tablets.			identify other residents that		
					may potentially be affected by	у	
	A PRN Medication	s Administration Record			practice.		
		hrough 2/23/24 indicated					
	_	d been administered on 2/3/24			Current residents have the		
	and Acetaminopher	_			potential to be affected by the		
		8/24 by QMA 9. The record			alleged deficient practice. Au		
		tion by a licensed nurse prior			were completed to ensure LPI		
	to being administer	ed.			are understanding of assessing	-	
					residents and authorizing QM		
		45 A.M., Resident 4's clinical			to administer PRN medication		
		d. Diagnoses included, but					
	was not limited to,	Rheumatoid Arthritis.					
			1		III The facility will put		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155703	B. W	'ING		02/26/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
BBOOKS	NDE VIII AGE ING				HURCH AVE		
BROOKS	SIDE VILLAGE INC			JASPEI	R, IN 47546		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Physician orders inc	cluded, but were not limited to:			into place the following		
	Acetaminophen (Ty	rlenol) 325mg every 6 hours as			systemic changes to ensure		
	needed. Amount to	, ,			that the practice does not		
					recur.		
	A PRN MAR for 2/1/24 through 2/23/24 indicated						
		omg had been administered on					
	the following dates, and the record lacked an				IV The facility will		
	authorization by a licensed nurse prior to being				monitor the corrective action	,	
	administered:				by implementing the following		
	2/1/24 administered	by QMA 21			measures.	~	
	2/2/24 administered	- ·					
	2/5/24 administered	by QMA 21			The SDC or designee will aud	it the	
	2/7/24 administered	by QMA 23			medication administration reco		
	2/11/24 administere	ed by QMA 21			of 5 residents to ensure PRN		
	2/14/24 administere	ed by QMA 21			medications are being assess	ed	
	2/15/24 administere	ed by QMA 21			by a LPN before being		
	2/19/24 administere				administered by a QMA 5 time	es	
	2/21/24 administere	ed by QMA 23			per week for 4 weeks, then we		
	2/22/24 administere				for 4 weeks, then biweekly for	-	
	3. On 2/23/24 at 9:0	00 A.M., Resident 5's clinical			weeks then monthly for 3 mon		
	record was reviewed	d. Diagnosis included, but			for a total of 6 months of		
	were not limited to,	heart failure and acute kidney			monitoring using the Quality		
	failure.				Improvement Tool R-246 audi	t	
					tool. (Attachment E)		
	Current physician o	rders included, but were not			,		
	limited to:				V Plan of correction		
	ipratropium-albuter	ol solution for nebulization;			completion date.		
	0.5mg (milligram)-3	3mg (2.5mg base)/3mL					
	(milliliters); 1 vial,	four times a day as needed,			Date of compliance: March 11	,	
	dated 2/9/24.				2024		
					The results of these reviews w	/ill be	
	ipratropium-albuter	ol solution for nebulization;			discussed at the monthly facili	ty	
		base)/3mL; 1 vial, every hour as			Quality Assurance Committee		
	needed, dated 2/9/2	4.			meeting monthly for 6 months	and	
					then quarterly thereafter once		
	Robitussin Cough-C	Chest Congestion DM liquid;			compliance is at 100%.		
	5-100mg/mL; 10mI	four times a day as needed,			Frequency and duration of rev	riews	
	dated 9/6/23.				will be increased as needed if		
					compliance is below 100%.		
	Robitussin Cough-C	Chest Congestion DM liquid;					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155703	A. BU	A. BUILDING 00 B. WING		COMPLETED 02/26/2024	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP COD		
BROOKSIDE VILLAGE INC				JASPEF	R, IN 47546		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT TAG DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	5-100mg/mL; 10mI dated 2/7/24.	L four times a day as needed,					
	(MAR) for 2/2024 i needed medications Medication Aide (Q ipratropium-albuter	ol solution for nebulization 9:09 A.M. and 2:47 P.M., and					
	given on 2/10/24 at	ol solution for nebulization 7:48 P.M., 2/11/24 at 5:58 A.M. 2/14/24 at 9:18 P.M. by QMA					
	given 2/6/24 at 7:39	Chest Congestion DM liquid P.M., 2/11/24 at 5:58 A.M., I., and 2/14/24 at 9:18 P.M. by					
		Chest Congestion DM liquid 5 A.M., 2/10/24 at 9:09 A.M., A.M. by QMA 9.					
	Robitussin Cough-Ogiven 2/13/24 at 7:5	Chest Congestion DM liquid 52 P.M. by QMA 7.					
	_	Chest Congestion DM liquid 6 P.M. and 11:57 P.M. by QMA					
	obtained from a lice	I record lacked authorization ensed nurse prior to se as needed medications given					
	record was reviewe	:00 A.M., Resident 6's clinical d. Diagnosis included, but depression and respiratory					

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		IDENTIFICATION NUMBER 155703	A. BUILDING B. WING	00	COMPLE 02/26/2	TED			
NAME OF PROVIDER OR SUPPLIER BROOKSIDE VILLAGE INC			1111 C	STREET ADDRESS, CITY, STATE, ZIP COD 1111 CHURCH AVE JASPER, IN 47546					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE			
TAG	failure. Current physician or limited to: ondansetron tablet, needed, dated 12/31 Resident 6's MAR f following as needed QMA: ondansetron 4mg gi QMA 21. ondansetron 4mg gi QMA 9. Resident 6's clinical obtained from a lice administration of the by QMAs. On 2/26/24 at 11:33 giving an as needed check with the nurse wand then the nurse we resident. QMA 7 in authorization was powas no place on the document that author the Regional Clinical functioned as the faindicated "PRN [as As-needed medicati	rders included, but were not 4mg three times a day as /23. for 1/2024 indicated the I medications were given by a ven 1/5/24 at 2:35 A.M. by ven 2/27/24 at 3:52 P.M. by record lacked authorization	TAG	DEFICIENCY		DATE			
	indicated, please con	as-needed medication, or is ntact the supervising licensed d document the required							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155703		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(x3) date survey completed 02/26/2024	
	PROVIDER OR SUPPLIER		1111 C	ADDRESS, CITY, STATE, ZIP COD CHURCH AVE ER, IN 47546	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
R 0298 Bldg. 00	410 IAC 16.2-5-6(Pharmaceutical Si (2) A consultant pi employed, or unde (A) be responsible in 856 IAC 1-7; (B) review the dru practices in the fai (C) provide consu procedures of ord administering, and as medication rec (D) report, in writin his or her designe dispensing or adm (E) review the dru receiving these se sixty (60) days. Based on interview failed to ensure neb administered by Qu (QMA) per facility for 1 of 4 residents medications. (Residents medications. (Residents) Finding includes: On 2/23/24 at 9:00 record was reviewed were not limited to, failure. Current physician of limited to: ipratropium-albuter	parvices - Deficiency parmacist shall be per contract, and shall: per contract, and storage pering, storing, per disposing of drugs as well per decepting; per contract or drugs; per cont	R 0298	R-298 Pharmaceutical Service (Nebulizer treatments administered by LPN) I The corrective actions to be accomplished to those residents found to have been affected by the practice. There were no negative reside outcomes by the alleged pract. The staff members found to have deficient practices in pharmaceutical services were immediately educated on QMA scope of practice. All QMA's educated on scope of practice.	ent ice.
		four times a day as needed,		II The facility will	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155703		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/26/2024		
NAME OF PROVIDER OR SUPPLIER BROOKSIDE VILLAGE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1111 CHURCH AVE JASPER, IN 47546				
	SIDE VILLAGE INC SUMMARY S (EACH DEFICIEN REGULATORY OR ipratropium-albuter 0.5mg-3mg (2.5mg needed, dated 2/9/2. Resident 5's Medica (MAR) for 2/2024 i needed medications Medication Aide (Q ipratropium-albuter given on 2/10/24 at 2/11/24 at 9:48 A.M ipratropium-albuter given on 2/10/24 at and 7:49 P.M., and 21. On 2/26 24 at 11:33 did not administer in were supposed to no assessment, and the treatments. QMA 7 documented in the M treatment had been not supposed to doc	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ol solution for nebulization; base)/3mL; 1 vial, every hour as 4. tion Administration Record indicated the following as given by a Qualified MA): ol solution for nebulization 9:09 A.M. and 2:47 P.M., and I. by QMA 9. ol solution for nebulization 7:48 P.M., 2/11/24 at 5:58 A.M. 2/14/24 at 9:18 P.M. by QMA A.M., QMA 7 indicated QMAs ebulizer treatments. They of tify the nurse for the initial nurse would give the further indicated the nurse MAR that the nebulizer administered, and QMAs were ument that they gave a or any other medication that	1111 C	HURCH AVE	dits MA's	
	Responsibilities for the Regional Clinica functioned as the fa indicated "QMAs at the following tasks resident requires the	P.M., a current QMA m was provided. At that time, al Support indicated the form cility QMA policy. The form [facility] may NOT perform Nebulizer treatments If a ese services, contact your I nurse to complete these		practice 5 times per week for weeks, then weekly for 4 wee then biweekly for 4 weeks the monthly for 3 months for a tot 6 months of monitoring using Quality Improvement Tool R-2 audit tool. (Attachment F) V Plan of correction completion date.	ks, n al of the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155703	A. BUILDING <u>00</u> B. WING		(X3) DATE COMPL 02/26 /	ETED	
NAME OF PROVIDER OR SUPPLIER BROOKSIDE VILLAGE INC			STREET ADDRESS, CITY, STATE, ZIP COD 1111 CHURCH AVE JASPER, IN 47546				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
					Date of compliance: March 11 2024 The results of these reviews was be discussed at the monthly facility Quality Assurance Committee meeting monthly formonths and then quarterly thereafter once compliance is 100%. Frequency and duration reviews will be increased as needed if compliance is below 100%.	will or 6 at n of	

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