STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00426231. This visit included a State Residential Licensure Survey. Complaint IN00426231 - No deficiencies related to the allegations are cited. Survey dates: February 19, 20, 21, 22, 23, 26, 2024 Facility number: 003240 Provider number: 155703 AIM number: 201274720 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 reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 1, 2024.	F 0000		
F 0580 SS=E Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's			

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

Melissa Joffee | RN, HFA | 03/19/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	defined in §483.5) must disclose in its admission agreement its physical 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)(9). Based on interview and record review, the facility failed to notify appropriate parties of a resident's significant change of status for 2 of 5 residents reviewed for nutrition. The Medical Doctor (MD) or Registered Dietician were not notified of a significant weight loss, and the Doctor was not notified of a five pound weight gain as indicated in a weight order. (Resident 3, Resident 9) Findings include: 1. On 2/19/24 at 11:14 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and depression. The most recent quarterly MDS (minimum data set) assessment, dated 12/8/23, indicated a mild cognitive impairment, and no weight loss or gain. Current physician orders included, but were not limited to: Weight once a day, dated 2/16/24. Monthly weight and vital signs on the first of the month, dated 11/1/23. A current nutritional status care plan, dated 9/5/23, included but was not limited to the following intervention: Monitor/record weight routinely, notify MD/RD (Registered Dietician) of significant weight changes, dated 9/5/23. Resident 3's weights included, but were not	F 0580	**F-580 Notification of Changes S/S E** **I The corrective actions to be accomplished for those residents found to have been affected by the practice.** There were no negative resident outcomes by the alleged practice. The staff members found to have deficient practices in notification of change were immediately educated and understand when to notify the provider. **II The facility will identify other residents that may potentially be affected by practice.** Current residents have the potential to be affected by the alleged deficient practice. Audits were conducted to ensure nurses were notifying MD of changes (Attachment G). **III The facility will put into place the following systemic changes to ensure that the practice does not**	03/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limited to, the following: 10/3/23 130.2 11/1/23 115.6 (11.21% decrease in one month) Resident 3's clinical record lacked a notification to the MD or Registered Dietician of the significant weight loss that occurred on 11/1/23. On 2/22/24 at 2:00 P.M., the Regional Clinical Support indicated notification following Resident 3's significant weight loss on 11/1/23 could not be located. 2. On 2/19/24 at 10:36 A.M., Resident 9's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and depression. The most recent Quarterly MDS Assessment, dated 1/14/24, indicated a mild cognitive impairment, and no weight loss or gain. Current physician orders included, but were not limited to: Weight three times weekly. Notify MD if weight gain is 2 lbs (pounds) daily or 5 lbs in a week, dated 10/11/23. A current nutritional status care plan, dated 10/11/23, included but was not limited to, the following intervention: Monitor/record weight routinely, notify MD/RD of significant weight changes, dated 10/11/23. Resident 9's weights included, but were not limited to, the following: 2/7/24 235 lbs 2/9/24 240.8 lbs (5.8 lb increase in two days, 2/7-9/24)) 2/12/24 240.5 lbs (5.5 lb increase in five days, 2/7-12/24)		**recur.** Staff were educated regarding physician notification. Nurses educated on policy for change in a resident's condition or status. (Attachment A) **IV The facility will monitor the corrective action by implementing the following measures.** The SDC or designee will audit 5 random to ensure notification of changes were relayed to the physician 5 times per week for 4 weeks, then weekly for 4 weeks, then biweekly for 4 weeks then monthly for 3 months for a total of 6 months of monitoring using the Quality Improvement Tool F-580 audit tool. (Attachment B) **V Plan of correction completion date.** Date of compliance: March 11, 2024 The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000	Resident 9's clinical record lacked a notification to the MD of the weight gain that occurred on 2/9/24 and 2/12/24. On 2/22/24 at 2:00 P.M., the Regional Clinical Support indicated notification following Resident 9's weight gain on 2/9/24 and/or 2/12/24 could not be located. On 2/22/24 at 8:47 A.M., Licensed Practical Nurse (LPN) 5 indicated if a resident had a discrepancy in their weight, they should be re-weighed. The nurse working the floor was in charge of contacting the MD if the resident gained 2 lbs in a day or 5 lbs in a week. Once the MD was notified, it should be documented under the physician notification on the Medication Administration Record (MAR), and if a new order were to be obtained, it would be documented in the progress notes. On 2/26/24 at 12:05 P.M., a current Change in a Resident's Condition or Status policy was provided, revised 10/2010, and indicated "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status ... The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been ... A significant change in the resident's physical/emotional/mental condition ... The Nurse Supervisor/Charge Nurse will record in the resident's medical record" 3.1-5(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00		R 0000		
	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.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure medications were administered as ordered by the physician. A resident received a nebulizer medication that had been previously discontinued for 1 of 5 residents observed during medication administration. (Resident 12) Finding includes: During an observation on 2/23/24 at 10:31 A.M.,	R 0241	**R-241 Health Services (administering medications as 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 resident	03/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the Assisted Living (AL) Unit Manager, who was an LPN (Licensed Practical Nurse), administered 1 vial of albuterol sulfate solution labeled 0.63 milligrams per 3 milliliters (mg/ml) to the Resident 12 at that time. On 2/23/24 at 10:50 A.M., Resident 12's clinical record was reviewed. Diagnosis included, but was not limited to cough. Physicians orders included, but were not limited to: Discontinued order as of 2/11/2024: "albuterol sulfate solution for nebulization; 0.63 mg/3 mL; Amount to Administer: 1 vial; inhalation ...Four Times A Day ...Diagnosis [DX: Cough, unspecified ...Start/End Date 02/8/2024-02/11/2024" Current order as of 2/21/24: "...ipratropium- albuterol solution for nebulization; 0.5 mg- 3 mg (2.5 mg base)/ [per] 3 ml; Amount to administer: 1; inhalation. Four Times A Day [DX: [diagnosis] Cough, unspecified..." start date, 2/21/24. During an interview on 2/23/24 at 10:56 A.M., the AL Unit Manager indicated she administered the incorrect nebulizer solution as it was previously discontinued. 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, "1. Check physician order for right medication, route, dose, time..."		outcomes by the alleged practice. The staff member found to have deficient practices in health services was immediately educated and understands. All QMA's educated on scope of practice. **II The facility will identify other residents that may potentially be affected by practice.** Current residents have the potential to be affected by the alleged deficient practice. Audits were completed to ensure staff were administering medications as ordered by the physician. **III The facility will put into place the following systemic changes to ensure that the practice does not recur.** Staff were educated regarding administering medications as ordered by the physician. Nurses educated on policy for medication administration. (Attachment A) **IV The facility will monitor the corrective action by implementing the following measures.** The SDC or designee will audit medication pass to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			medications are being administered as ordered by the physician 5 times per week for 4 weeks, then weekly for 4 weeks, then biweekly for 4 weeks then monthly for 3 months for a total of 6 months of monitoring using the Quality Improvement Tool R-241 audit tool. (Attachment C) **V Plan of correction completion date.** Date of compliance: March 11, 2024 The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, interview, and record review, the facility failed to ensure the	R 0243	**R-243 Health Services**	03/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of the administered nebulizer solution was documented by the licensed nurse that administered the medication. An unauthorized Qualified Medication Aide (QMA) documented she gave the medication that was given by the Assisted Living (AL) Unit Manager LPN for 1 of 5 residents reviewed during a medication pass. (Resident 12). Finding includes: During an observation on 2/23/24 at 10:31 A.M., the Assisted Living (AL) Unit Manager LPN administered 1 vial of albuterol sulfate solution labeled 0.63 milligrams per 3 milliliters (mg/ml) to Resident 12. On 2/23/24 at 10:50 A.M., Resident 12's clinical record was reviewed. Diagnosis included, but was not limited to cough. Physicians orders included, but were not limited to: Discontinued order as of 2/11/2024: "albuterol sulfate solution for nebulization; 0.63 mg/3 mL; Amount to Administer: 1 vial; inhalation ...Four Times A Day ...Diagnosis [DX: Cough, unspecified ...Start/End Date 02/8/2024-02/11/2024" Current order: "...ipratropium- albuterol solution for nebulization; 0.5 mg- 3 mg (2.5 mg base)/ [per] 3 ml; Amount to administer: 1; inhalation. Four Times A Day [DX: [diagnosis] Cough, unspecified..." start date, 2/21/24. The clinical record lacked documentation of the actual medication administered by the LPN. The		**(documentation of medication)** **I The corrective actions to be accomplished for those residents found to have been** **affected by the practice.** There were no negative resident outcomes by the alleged practice. The staff members found to have deficient practices in health services were immediately educated and understand proper delegation to QMA's. All QMA's educated on scope of practice. **II The facility will identify other residents that may potentially be affected by practice.** Current residents have the potential to be affected by the alleged deficient practice. Audits were completed to ensure staff were documenting medications appropriately. **III The facility will put into place the following systemic changes to ensure that the practice does not recur.** **IV The facility will monitor the corrective action**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	current order which was not administered was documented as given by a QMA for the same time frame. During an interview on 2/26/24 at 11:31 A.M., the AL Unit Manager attempted to verify that she documented the nebulizer solution at that time, she indicated she was unsure why the QMA would have documented the nebulizer as being completed, given that she was the nurse that administered the medication. During an interview on 2/26/24 at 12:00 P.M., the AL Unit Manager found her written notes that she gave the medication and indicated that the nurse that gave the nebulizer should be the one that documented the administration, but sometimes the QMA's get annoyed when the medication appeared red highlighted print (overdue) on the charting system so they will sign the medication 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]..."		**by implementing the following measures.** The SDC or designee will audit 5 resident's medication administration record to ensure medications are documented by the appropriate licensed individual administering the medication 5 times per week for 4 weeks, then weekly for 4 weeks, then biweekly 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) **V Plan of correction completion date.** Date of compliance: March 11, 2024 The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on observation, interview, and record review, the facility failed to ensure as needed (PRN) medications administered by a Qualified Medication Aide (QMA) were authorized by a licensed nurse for 4 of 5 resident records reviewed. (Resident 3, Resident 4, Resident 5, Resident 6) Findings include: 1. On 2/23/24 at 2:45 P.M., Resident 3's clinical record was reviewed. Diagnoses included, but was not limited to, dizziness and osteoarthritis. Physician orders included, but were not limited to: Meclizine (for dizziness) 25 milligrams (mg) every 6 hours as needed (PRN). Amount to administer: 1 tablet. Acetaminophen (Tylenol) 500mg every 8 hours PRN. Amount to administer: 2 tablets. A PRN Medications Administration Record (MAR) for 2/1/24 through 2/23/24 indicated Meclizine 25mg had been administered on 2/3/24 and Acetaminophen 1000mg had been administered on 2/18/24 by QMA 9. The record lacked an authorization by a licensed nurse prior to being administered. 2. On 2/26/24 at 9:45 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, Rheumatoid Arthritis.	R 0246	**R-246 Health Services (PRN medication administered by QMA are authorized by LPN)** **I The corrective actions to be accomplished for those residents found to have been affected by the practice.** There were no negative resident outcomes by the alleged practice. The staff members found to have deficient practices in health services were immediately educated and understand proper delegation to QMA's. All QMA's educated on scope of practice. **II The facility will identify other residents that may potentially be affected by practice.** Current residents have the potential to be affected by the alleged deficient practice. Audits were completed to ensure LPN's are understanding of assessing residents and authorizing QMA's to administer PRN medication. **III The facility will put**	03/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Physician orders included, but were not limited to: Acetaminophen (Tylenol) 325mg every 6 hours as needed. Amount to administer: 1 tablet. A PRN MAR for 2/1/24 through 2/23/24 indicated Acetaminophen 325mg had been administered on the following dates, and the record lacked an authorization by a licensed nurse prior to being administered: 2/1/24 administered by QMA 21 2/2/24 administered by QMA 9 2/5/24 administered by QMA 21 2/7/24 administered by QMA 23 2/11/24 administered by QMA 21 2/14/24 administered by QMA 21 2/15/24 administered by QMA 21 2/19/24 administered by QMA 21 2/21/24 administered by QMA 23 2/22/24 administered by QMA 23 3. On 2/23/24 at 9:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, heart failure and acute kidney failure. Current physician orders included, but were not limited to: ipratropium-albuterol solution for nebulization; 0.5mg (milligram)-3mg (2.5mg base)/3mL (milliliters); 1 vial, four times a day as needed, dated 2/9/24. ipratropium-albuterol solution for nebulization; 0.5mg-3mg (2.5mg base)/3mL; 1 vial, every hour as needed, dated 2/9/24. Robitussin Cough-Chest Congestion DM liquid; 5-100mg/mL; 10mL four times a day as needed, dated 9/6/23. Robitussin Cough-Chest Congestion DM liquid;		**into place the following systemic changes to ensure that the practice does not recur.** **IV The facility will monitor the corrective action by implementing the following measures.** The SDC or designee will audit the medication administration record of 5 residents to ensure PRN medications are being assessed by a LPN before being administered by a QMA 5 times per week for 4 weeks, then weekly for 4 weeks, then biweekly for 4 weeks then monthly for 3 months for a total of 6 months of monitoring using the Quality Improvement Tool R-246 audit tool. (Attachment E) **V Plan of correction completion date.** Date of compliance: March 11, 2024 The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5-100mg/mL; 10mL four times a day as needed, dated 2/7/24. Resident 5's Medication Administration Record (MAR) for 2/2024 indicated the following as needed medications given by a Qualified Medication Aide (QMA): ipratropium-albuterol solution for nebulization given on 2/10/24 at 9:09 A.M. and 2:47 P.M., and 2/11/24 at 9:48 A.M. by QMA 9. ipratropium-albuterol solution for nebulization given on 2/10/24 at 7:48 P.M., 2/11/24 at 5:58 A.M. and 7:49 P.M., and 2/14/24 at 9:18 P.M. by QMA 21. Robitussin Cough-Chest Congestion DM liquid given 2/6/24 at 7:39 P.M., 2/11/24 at 5:58 A.M., 2/12/24 at 7:49 P.M., and 2/14/24 at 9:18 P.M. by QMA 21. Robitussin Cough-Chest Congestion DM liquid given 2/9/24 at 9:25 A.M., 2/10/24 at 9:09 A.M., and 2/12/24 at 9:47 A.M. by QMA 9. Robitussin Cough-Chest Congestion DM liquid given 2/13/24 at 7:52 P.M. by QMA 7. Robitussin Cough-Chest Congestion DM liquid given 2/8/24 at 7:46 P.M. and 11:57 P.M. by QMA 23. Resident 5's clinical record lacked authorization obtained from a licensed nurse prior to administration of the as needed medications given by QMAs. 4. On 2/23/24 at 10:00 A.M., Resident 6's clinical record was reviewed. Diagnosis included, but were not limited to, depression and respiratory			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failure. Current physician orders included, but were not limited to: ondansetron tablet, 4mg three times a day as needed, dated 12/31/23. Resident 6's MAR for 1/2024 indicated the following as needed medications were given by a QMA: ondansetron 4mg given 1/5/24 at 2:35 A.M. by QMA 21. ondansetron 4mg given 2/27/24 at 3:52 P.M. by QMA 9. Resident 6's clinical record lacked authorization obtained from a licensed nurse prior to administration of the as needed medication given by QMAs. On 2/26/24 at 11:33 A.M., QMA 7 indicated when giving an as needed medications, QMAs should check with the nurse first, given the medication, and then the nurse would follow up with that resident. QMA 7 indicated sometimes the authorization was put on a daily sheet, but there was no place on the MAR or progress notes to document that authorization was obtained. On 2/26/24 at 12:05 P.M., a current QMA Responsibilities form was provided. At that time, the Regional Clinical Support indicated the form functioned as the facility QMA policy. The form indicated "PRN [as needed] medications - As-needed medications require a nursing assessment prior to and after administration. If a resident requests an as-needed medication, or is indicated, please contact the supervising licensed nurse to perform and document the required			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment" 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; (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.			
R 0298 Bldg. 00	Based on interview and record review, the facility failed to ensure nebulizer treatments were not administered by Qualified Medication Aides (QMA) per facility policy and scope of practice for 1 of 4 residents reviewed for facility provided medications. (Resident 5) Finding includes: On 2/23/24 at 9:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, heart failure and acute kidney failure. Current physician orders included, but were not limited to: ipratropium-albuterol solution for nebulization; 0.5mg (milligram)-3mg (2.5mg base)/3mL (milliliters); 1 vial, four times a day as needed, dated 2/9/24.	R 0298	**R-298 Pharmaceutical Services (Nebulizer treatments administered by LPN)** **I The corrective actions to be accomplished for those residents found to have been affected by the practice.** There were no negative resident outcomes by the alleged practice. 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. **II The facility will**	03/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ipratropium-albuterol solution for nebulization; 0.5mg-3mg (2.5mg base)/3mL; 1 vial, every hour as needed, dated 2/9/24. Resident 5's Medication Administration Record (MAR) for 2/2024 indicated the following as needed medications given by a Qualified Medication Aide (QMA): ipratropium-albuterol solution for nebulization given on 2/10/24 at 9:09 A.M. and 2:47 P.M., and 2/11/24 at 9:48 A.M. by QMA 9. ipratropium-albuterol solution for nebulization given on 2/10/24 at 7:48 P.M., 2/11/24 at 5:58 A.M. and 7:49 P.M., and 2/14/24 at 9:18 P.M. by QMA 21. On 2/26 24 at 11:33 A.M., QMA 7 indicated QMAs did not administer nebulizer treatments. They were supposed to notify the nurse for the initial assessment, and the nurse would give the treatments. QMA 7 further indicated the nurse documented in the MAR that the nebulizer treatment had been administered, and QMAs were not supposed to document that they gave a nebulizer treatment or any other medication that they did not administer themselves. On 2/26/24 at 12:05 P.M., a current QMA Responsibilities form was provided. At that time, the Regional Clinical Support indicated the form functioned as the facility QMA policy. The form indicated "QMAs at [facility] may NOT perform the following tasks ... Nebulizer treatments ... If a resident requires these services, contact your supervising licensed nurse to complete these tasks."		**identify other residents that may potentially be affected by practice.** Current residents have the potential to be affected by the alleged deficient practice. Audits were completed to ensure QMA's were not practicing outside of scope of practice. **III The facility will put into place the following systemic changes to ensure that the practice does not recur.** **IV The facility will monitor the corrective action by implementing the following measures.** The SDC or designee will audit the medication administration record of 5 residents to ensure Medications are administered according to QMA scope of practice 5 times per week for 4 weeks, then weekly for 4 weeks, then biweekly for 4 weeks then monthly for 3 months for a total of 6 months of monitoring using the Quality Improvement Tool R-298 audit tool. (Attachment F) **V Plan of correction completion date.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE VILLAGE INC	1111 CHURCH AVE JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Date of compliance: March 11, 2024 The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	