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	02/27/2024

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 IN00428404. Complaint IN00428404 - No deficiencies related to the allegations are cited. Survey dates: February 19, 20, 21, 22, 23, 26 and 27, 2024. Facility number: 011367 Provider number: 155761 AIM number: 200851590 Census Bed Type: SNF: 24 SNF/NF: 116 Total: 140 Census Payor Type: Medicare: 16 Medicaid: 87 Other: 37 Total: 140 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 8, 2024	F 0000	Facility is requesting face to face IDR for F 684 as the facility disagrees with scope and severity assigned.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. "Based on observation, interview, and record review, the facility failed to identify bruising timely and failed to accurately document a new skin area on her chest for 1 of 1 residents reviewed for hospice and end of life services (Resident 4). Findings include: On 2/19/24 at 11:50 a.m., Resident 4 was initially observed. There was a large irregularly shaped bruise on the middle of her left upper arm. It was dark purple and green, with a raised bump in the middle of the bruise. A second more faded bruise was observed on her upper left shoulder as well. Resident 4 indicated she did not know what happened, and it was a little tender as she touched the area. During an interview on 2/21/24 at 1:26 p.m., Unit Manager (UM) 28 indicated, any new skin issues, open areas or bruises should be documented in the Resident's record as a "new skin event," and followed up with a progress note and wound referral. At that time, UM 28 reviewed Resident 4's record skin events and progress notes but indicated there was no documentation related to a bruise on her left arm. On 2/21/24 at 1:30 p.m., Resident 4 was observed with UM 28. Upon observation, UM 28 indicated she was not aware of the bruised area, and suspected it was from Resident 4 having leaned against her side rail. UM 28 indicated she would open a new skin event and have the Wound	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. Facility is requesting face to face IDR for F 684 as the facility disagrees with scope and severity assigned 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 4's medication plan and hospice documentation were reviewed and revised to ensure that resident is receiving care consistent with her goals by 3/20/2024. Resident 4's scratch has healed with no additional adverse effects. Resident is being monitored for s/sx skin breakdown. Resident 4 is offered hydration at least each shift by	03/20/2024

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	Nurse assess the area. On 2/21/24 at 1:34 a.m., Certified Nursing Aide (CNA) 32 entered Resident 4's room. CNA 32 indicated the resident had the bruise for several days and the Hospice nurse was in the day before and had noticed it too, but they did not know how Resident 4 got it. A hospice note dated 2/20/24 indicated, "RN [Registered Nurse] assessment, hypotensive [low blood pressure] not eating, sleeping majority day, comfort meds order put in..." The note lacked documentation of the bruised area to the resident's arm. Hospice notes from the previous visits on the 14th, 8th and 6th also lacked documentation of the bruised area on her arm. On 2/26/24 at 8:30 a.m., Resident 4 was observed with CNA 31. At that time, a new skin issue was noted on the middle of her chest. Resident 4 indicated her chest hurt from where she scratched it. The area was observed to be irregularly shaped, scratched raw and the wound edges were patchy and red. During an interview on 2/27/24 at 9:00 a.m., LPN 29 indicated she was not aware of a new skin issue on her back, just the raw area on her chest and preventative foam on her coccyx. On 2/27/24 at 9:03 a.m., a new skin event was reviewed with UM 28 indicated. The event indicated a new area to Resident 4's upper back. UM 28 indicated she had not seen the area, but it might have come from when the aides were turning or repositioning her. With Resident 4's permission her upper back was observed with UM		CNAs **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 receive a pain assessment to ensure pain plan of care is consistent with resident/family goals by 3/20/2024. All residents will receive a head to toe skin assessment to ensure no injuries of unknown injury are present by 3/20/2024. All residents will receive a Hydration assessment to ensure no s/sx dehydration are present by 3/20/2024. All residents will be assessed for s/sx infection by 3/20/2024. **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 ‘Hospice’ and ‘Skin Management Program’, policies by 3/20/2024. All clinical staff will be educated on the ‘Hospice’ and ‘Skin Management Program’ policies by 3/20/2024.	

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	28. There were no skin issues noted. UM 28 indicated, the skin even must have been incorrectly documented and meant to have been an assessment of her chest. On 2/21/24 at 11:51 a.m., Resident 4's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, acute on chronic diastolic (congestive) heart failure, chronic respiratory failure with hypoxia (shortness of breath), permanent atrial fibrillation (irregular heart beat), occlusion and stenosis of right carotid artery, Bifascicular block (a bifascicular block delays or stops electrical signals between the left and right bundle branches of the heart (fascicles) which affects the heart's lower pumping chambers (ventricles), and causes it to pump too slowly or out of rhythm (arrhythmia), and pulmonary hypertension (high blood pressure). The most recent comprehensive Minimum Data Set (MDS) assessment was a significant change MDS dated 12/14/23. The MDS indicated, Resident 4 was cognitively intact with a BIMS (brief interview for mental status) score of 15/15. A review of Resident 4's Hospice binder, scanned in Hospice notes, Events, Observations and nursing progress notes, lacked documentation of the bruise to her left arm and shoulder. A new skin event dated, 2/26/24 at 8:18 p.m., indicated, cleanse skin tear to "right upper back" with normal saline, pat dry and apply xeroform and cover with bordered gauze dressing. On 2/22/24 at 9:15 a.m., the Executive Director (ED) provided a copy of current facility policy titled, "Skin Management Program," revised 2/2022. The		Hospice Binders will be reviewed by 3/20/2024. All clinical staff will be educated on communication with hospice and documentation on changes in condition by 3/20/2024. All clinical staff will be educated on hospice end of life pain management by 3/20/2024. DNS/Designee will review hospice binders for updates during morning rounds. **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-'F684 Quality of Care' to review at least 10 hospice residents weekly to ensure accurate, timely documentation of new skin areas is present, to ensure that residents are receiving pain management plans in accordance with their plan of care and wishes, and to ensure that family communication is notated with any changes in resident or their plan of care. Complete weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained. The Regional Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going	

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	policy indicated, "It is the policy of American Senior Communities to ensure that each resident receives care, consistent with professional standards of practice ... procedure for wound prevention ... Any skin alteration noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes. The licensed nurse is responsible for assessing all skin altercations by the direct caregivers on the shift reported ... the wound nurse/designee will be notified of altercations in skin integrity ... the wound nurse/designee will complete further evaluation of the wounds identified and complete the appropriate skin evaluation on the next business day ...." 3.1-37(a)		areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 3.20.2024**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure medications and wound cleanser were secure and not found in an unlocked memory care (MC) linen closet for 18 of 28 residents who resided in the MC unit. The facility failed to ensure medications were not found in resident's rooms without	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.	03/20/2024

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	self-administration assessments for 4 of 4 residents reviewed for self-administration assessments (Resident 27, 68, 190, and 88). Findings include: 1 On 2/19/24 at 10:34 a.m., the MC linen closet was observed to be unlocked. Unlabeled and opened containers of nystatin topical powder (treats fungal skin infections), Calmoseptine (barrier skin cream), and an almost full 8 ounce bottle of wound cleanser were found in the room. On 2/19/24 at 11:00 a.m., Licensed Practical Nurse (LPN) 9 indicated the MC linen closet should have been locked. She indicated the nystatin powder, Calmoseptine, and wound cleanser should have been locked up because a memory care resident could have come in the linen closet and ingest it. She indicated they should have been thrown away because they were not labeled with resident's name. On 2/21/24 at 10:51 a.m., Resident 84 and Resident 76 were observed to be wandering in the MC unit. On 2/21/24 at 12:00 p.m., the MCSS provided care plans for MC residents who wander. The intrusively wandering care plans included: Residents 105, 56, 84, 69, 89, 42, and 76. The residents with wandering care plans included: Residents 43, 132, 71, 114, 116, 147, 130, 26, 44, 83, and 112. On 2/22/24 at 11:17 a.m., the Memory Care Support Specialist (MCSS) indicated he did not know for whom the nystatin powder and Calmoseptine was ordered. He indicated every door with a key pad should have been locked, including the linen closet. The current resident's		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?** Memory care linen closet was locked. All other facility linen closets were checked and assured to be locked by 3/20/2024. Identified residents' rooms were checked for meds at bedside and if found, IDT ensured orders, CP, labels, lockbox, and self-administration observation were in place by 3/20/2024. **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 linen closets will be examined to ensure they are locked securely by 3/20/2024. All residents' rooms will be checked for medications at bedside and if found, IDT will ensure orders, CP, labels,	

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	hygiene bins were kept in the supply room in the spa. A month ago, hygiene bins were reorganized. On 2/23/24 at 1:40 p.m., the Director of Nursing (DON) indicated the expectation was for the doors to be locked in MC. 2. On 2/23/24 10:54 a.m., Resident 27's and Resident 68's prescription medications were observed in Resident 27's room on a table against the wall. Resident 27's prescription medication was a zinc oxide paste skin protectant, with no resident name, label, or pharmacy information. Resident 68's prescription medication, dated 1/22/24, was hydrophilic wound dressing. The prescription label indicated it was Triad Wound Dressing Paste. The tube was observed to be almost empty. Her orders were reviewed. Barrier cream to buttocks every shift, as needed. Her skin care assessment indicated there were no wound types identified. On 2/23/24 at 11:12 a.m., Resident 68 indicated she was admitted on 1/18/24. She indicated she had no skin treatments or skin conditions. She was not aware of a prescription for Triad wound care paste. Her orders were reviewed: Triad Wound Dressing, apply a thin layer to the buttocks, every shift. Her skin care assessment indicated there were no wound types identified. On 2/23/24 at 11:26 a.m., Licensed Practical Nurse (LPN) and Certified Wound Care nurse (WCC) 10 indicated the house barrier cream was zinc oxide		lockbox, and self-administration observation is in place by 3/20/2024. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Staff members will be educated on the 'Storage and Expiration Dating of Medications, Biologicals' policy with focus on securement/locking of linen rooms and storage areas by 3/20/2024. The IDT team will be educated on the '5.3 Storage and Expiration Dating of Medications and Biologicals" policy by 3/20/2024. Nurses will be educated on the '5.3 Storage and Expiration Dating of Medications and Biologicals' policy by 3/20/2024. Nurses will be educated on the process for self-administration of medications by 3/20/2024. **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 ED/Designee will utilize QA tool-'F689 Linen Closet Securement' to review linen rooms weekly to ensure all are locked securely per policy. Complete weekly x4 weeks, monthly x 6 months, then quarterly until	

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	paste and should have had Resident 27's name on it. She indicated the Triad Wound cream for Resident 68 should not have been in Resident 27's room. She indicated she was confused because Resident 68 was not on Triad Wound cream. On 2/23/24 at 11:29 a.m., WCC 10 indicated Resident 27's Triad Wound cream was discontinued on 2/15/24 and started on barrier cream. The Triad cream should not have been in her room. She would order for Resident 68 a tube of Triad Wound cream since it was physician ordered. She would get a new container of barrier cream for Resident 27. On 2/23/24 at 11:39 a.m., Registered Nurse (RN) 24 indicated he did not apply any cream found in her room to Resident 27 and both creams should have been locked up in the treatment cart. On 2/23/24 at 1:41 p.m., the Director of Nursing (DON) the medications should have been kept in a secure location. 3 On 2/19/24 at 2:29 p.m., two eye medications were observed in Resident 190's room. She indicated the print was so small she was unable to read the labels. The bottles were observed to be shaped differently. The eye drop medications were BromSite (for treatment of inflammation and prevention of pain in patients undergoing cataract surgery) and Systane (treats dry, irritated eyes). Her medical record was reviewed. She had a physician's order for Systane, one drop in both eyes daily. She did not have an order for BromSite. She did not have a self-administration assessment or care plan for BromSite or Systane.		compliance is maintained. The DNS/Designee will utilize QA tool-'F689 Meds @ Bedside/Self Administration' to audit a minimum of 10 residents' rooms for meds at bedside; if any noted, audit for-label, order, careplan, and locked compartment in place. Complete weekly x 4 weeks, monthly x 6 months, and then quarterly until compliance is maintained. The Regional Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 3.20.2024**	

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	On 2/22/24 at 10:35 a.m., BromSite and Systane were observed to still be in her room. On 2/22/24 10:36 a.m., the Regional Clinical Support indicated she did not know Resident 190 had medications in her room. The resident did not have an order for BromSite or a self-administration assessment for either medication. She would go into her room and collect the medications. On 2/26/24 at 12:13 p.m., Resident 190 record was reviewed. A physician's order, dated 2/22/24, BromSite, give 1 drop in each eye daily. A care plan, dated 2/22/24, indicated Resident 190 chose to self-administer BromSite eye drops with a goal for her a safely self-administer the medication. A self-administration assessment, dated 2/22/24, indicated it was safe for her to administer BromSite and systane. On 2/23/24 at 1:41 p.m., the DON indicated the staff should be following the self-administration policy. 4. On 2/19/24 at 10:43 a.m., Resident 88's room was observed through the open door. A bottle of 3 milligram (mg) Melatonin tablets (used to treat insomnia) were observed on the Resident's bedside table, unsecured and unsupervised. On 2/19/24 at 11:15 a.m., Resident 88's room was observed. The bottle of Melatonin remained unattended at bedside. On 2/19/24 at 11:00 a.m., Resident 88's medical			

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	record was reviewed. Resident 88 was a long-term care resident who had diagnoses which included, but were not limited to, myasthenia gravis (an autoimmune disorder resulting in muscle weakness), Parkinson's disease (a nervous system disorder resulting in tremors and weakness), and insomnia. Resident 88's comprehensive care plans were reviewed and lacked provisions to include his preference and/or ability to store his own medications at bedside. Resident 88 did not have a current physician order to store and/or administer his own medication. The record lacked documentation of a self-medication administration assessment. During an interview on 2/19/24 at 11:33 a.m., the Director of Nursing (DON) indicated, Resident 88 should not have a bottle of Melatonin at his bedside and the Melatonin bottle had been removed by a licensed staff member. A current policy, titled, "Storage and Expiration Dating of Medications, Biologicals," dated 7/21/22, was provided by the Executive Director (ED), on 2/23/24 at 8:55 a.m. A review of the policy indicated, "Facility should ensure that only authorized Facility staff ...should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas ..." On 2/23/24 at 8:55 a.m., the Executive Director (ED) provided a copy of the current facility policy titled, "5.3 Storage and Expiration Dating of Medications and Biologicals", revised 7/21/22.			

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	The policy indicated, "Facility should not administer/provide bedside medications or biologicals without a Physician/Prescriber order and approval by the Interdisciplinary Care Team and Facility administration." "The facility should store bedside medications or biologicals in a locked compartment within the resident's room." 3.1-45(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure a resident, (Resident 70) who had recent medication adjustments and fluctuating blood pressures, received timely documentation from his Dialysis center after treatment sessions to ensure continuity of and to prevent the potential for complications related to post-Dialysis change of condition for 1 of 1 resident reviewed for Dialysis. Findings include: On 2/22/24 at 10:12 a.m., Resident 70's medical record was reviewed. He was a long-term care resident who had diagnoses which included, but were not limited to, end-stage renal disease and was dependent on renal dialysis and hypertensive heart disease. Resident 70's nursing progress notes were reviewed and revealed recurrent fluctuating blood	F 0698	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 70's dialysis binder will be reviewed upon return from	03/20/2024

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

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	pressures and the need for administration of as needed medications (PRN), which included, but were not limited to: a. 1/10/24 at 3:25 a.m., "Resident BP checked and was at 179/106. PRN clonidine administered. Writer re-checked BP later and was 154/96. Resident stable and resting at this time. Will continue to monitor progress ...." b. 1/15/24 at 3:26 a.m., "Resident BP checked was at 168/105, Clonidine 0.1 mg was administered to good effect, same re-checked was at 147/85, resident is resting in his room ...." c. 1/26/24 at 10:36 p.m., "This evening's blood pressure reading was 126 / 82 ...." d. 1/31/24 at 10:24 p.m., "This evening Blood Pressure: 93 / 58 ...." e. 2/2/24 at 6:09 a.m., "the Qualified Medication Aide [QMA] called writer due to Resident's blood pressure [BP] was 195/116, writer reassessed Resident and noted BP to be lower but still high, PRN clonidine administered. BP re-checked an hour later and BP back down to 147 / 67 ...." f. 2/3/24 at 12:05 a.m., "BP was 195/92. Administered clonidine as ordered PRN and effective for reducing BP to 142/86 ...." g. 2/6/24 at 10:26 p.m., "The Resident continues care with continuous blood pressure monitoring after clonidine 0.1 milligram [mg] administration, close vitals are measured every hour, the initial blood pressure was 182/94, dropped to 172/96 ... The recent blood pressure is 143/100. The Resident is stable and does not show any concern ...." h. 2/21/24at 9:27 a.m., "The Resident's vital signs were taken for his dialysis appt and was at 195/105 on his right arm, he was sitting and at rest at 9:05 a.m., PRN Clonidine 0.1 mg was given per PRN orders. BP rechecked at 9:17 a.m. and was 182/99. No chest pain, SOB, dizziness, headaches ...."		dialysis and if documentation from dialysis is not present, dialysis center will be called and documentation will be placed in resident's chart by 3/20/2024. Resident's EHR will have complete pre/post dialysis assessment event by 3/20/2024. **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 dialysis residents have the potential to be affected by the alleged deficient practice. All dialysis binders will be reviewed upon return from dialysis and if dialysis documentation is not present, documentation by nurse calling dialysis for report will be in resident's chart and completed by 3/20/2024. All dialysis events will be reviewed for completion by 3/20/2024 by DNS/designee. Medication adjustments will be completed per MD order. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** The clinical IDT team will be educated on the 'Dialysis Care' policy by 3/20/2024. The clinical IDT team will be	

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	A nursing progress note, dated 7/19/23 at 8:34 p.m., indicated, " ...Resident returned from dialysis center at 5 p.m. with his communication binder not filled out. Informed the Unit Manager about this and she will reach out tomorrow to the center ...." During an interview on 2/22/24 at 10:41 a.m., Registered Nurse (RN) 35 indicated, facility staff should contact the dialysis center if Resident 70 returned without his log filled out, then follow up with a progress note. Resident 70's Dialysis Event Logs was reviewed for the month of February and revealed the following: An Event was opened on the 5th but lacked documentation of a return assessment. The record lacked documentation of Dialysis Event assessments for the following days; the 2nd, 7th, 9th, 14th, 16th, and 21st. Resident 70's Dialysis binder was reviewed for the month of February and revealed, the Communication Tool had not filled out upon the completion of his Dialysis session by the Dialysis Nurse for the following dates: the 2nd, 5th, 12th, 14th and the 21st. The record lacked documentation that the facility's receiving nurse contacted the Dialysis center for follow up. During an interview on 2/22/24 at 1:03 p.m., the Director of Nursing (DON) indicated they had been having trouble getting the Dialysis center to fill out his post Dialysis logs. At that time, the Medical Record Coordinator (MRC) just called		educated on post-dialysis follow-up for obtaining documentation from dialysis center/noting changes by 3/20/2024. The clinical IDT team will be educated on pre/post dialysis event completion by 3/20/2024. Nurses will be educated on the 'Dialysis Care' policy by 3/20/2024. Nurses will be educated on post-dialysis follow-up for obtaining documentation from dialysis center/noting changes by 3/20/2024. Nurses will be educated on pre/post dialysis event completion by 3/20/2024. Contact with dialysis center to discuss expectations for post-dialysis center communication in binder to be completed after each dialysis run will be done by 3/20/2024. DNS/Designee will review each resident's blood pressure upon return from dialysis to ensure medication adjustments are not needed per MD order. **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-'F698-Dialysis' to audit all dialysis resident's dialysis binders and dialysis events for completion	

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	about once a week, or at the end of the month to request a copy of his full Run-Sheets to be faxed over and scanned in. Resident 70's scanned in Run-Sheets were reviewed. There were no scanned in Run-Sheets for the month of February. The latest set of Run-Sheets was from the month of January and included the following "out of range" observations: On 1/3/24 an out-of-range pre-BP was recorded at 189/104, his post weight was recorded out-of-range at 73.4 Kilograms (KG) and an out-of-range Interdialytic weight gain (IDWG- the result of salt and water intake between hemodialysis sessions). On 1/5/23 an out-of-range post-BP was recorded at 162/94. On 1/8/24 an out-of-range pre-BP was 182/106 and his post-BP was out-of-range at 162/91. On 1/10/24 an out-of-range pre-BP was 185/106. On 1/17/24 his post-weight was out-of-range at 71.0 KG. On 1/19/24 an out-of-range pre-BP was recorded at 196/97 and his post-BP was 177/93. On 2/22/24 at 2:45 p.m., the DON provided a copy of current facility policy titled, "Dialysis Care," revised 11/2017. The policy indicated, " ...ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility ... ongoing assessment and oversight of the resident before, during and after dialysis treatments for complications ... ongoing communication and collaboration with the dialysis facility regarding dialysis care and services ... A		and follow-up accuracy. Complete weekly x 4 weeks, monthly x 6 months, and then quarterly until compliance is maintained. The Regional Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 3.20.2024**	

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	dialysis even will be initiated in EMR [electronic medical record] to include time of transfer and completed on return to the unit ... the nurse in charge at time of return will review paperwork for new orders and/or notes accompanying the resident ...." 3.1-37(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to properly label medications with dates	F 0761	The creation and submission of this plan of correction does not	03/20/2024

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	when they were opened and failed to dispose of expired insulin for 3 of 5 medication room observed and 3 of 6 medication carts observed. Findings include: 1. On 2/26/24 10:01 a.m., RN 27 provided an escort to check medication rooms and medication carts for labeling and dating of medications. Upon observation of the 200 Front medication room, a bottle of tuberculin serum was found rolling around in the door of the refrigerator. The multi-dose vial lacked a date to indicate when it was opened. 2. On 2/26/24 at 10:12 a.m., the 300-medication cart was observed. a. Resident 17 had a bottle of refresh eye drops (a lubricant for the eyes). The bottle was not opened and a label on the bottle indicated to refrigerate. b. Resident 96 had a bottle of ipratropium 0.3% spray for the nose (used for runny and nasal stuffiness) lacked a date when opened. c. Resident 72 had a bottle of fluticasone prop 50 mcg spray (used for allergies). It lacked a date to indicate when it was opened. d. Resident 52 had a bottle of erythromycin 0.5% eye drops (an antibiotic for the eye). It lacked a date to indicate when it was opened. e. Resident 25 had a bottle of prednisolone ac 1% eye drops (used for inflammation of the eye). It lacked a date to indicate when it was opened. 3. On 2/26/24 at 10:30 a.m., the 200 back-hall-medication cart was observed. a. Resident 117 had an insulin pen, glargine-yfg 100 unit/ml (used for diabetes). It was dated 1/18/24 and was in use longer than the expiration date.		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?** Identified medications not stored correctly were removed from medication cart for destruction and replacements ordered from the pharmacy by 3/20/2024. **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 will be audited for expired/undated medications by 3/20/2024. Expired/undated medications will be pulled for destruction and replacements ordered by 3/20/2024.	

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	b. Resident 61 had an inhaler, anoro ellipta, 62.5-25mcg 700SE (used for breathing problems) on the medication cart with no dated to indicate when it was opened. c. Resident 74 had an albuterol suf hfa 90mcg inhaler (used for breathing problems lacked a date to indicate when it was opened. d. Resident 28 had trelegy ellipta 200-62.5-25 inhaler (used was present and lacked a date to indicate when it was opened. 4. On 6/26/24 at 10:50 a.m., the 400 B hall-medication cart was observed. a. Resident 23 had anor ellipta 62.5-25mcg inhaler on the medication cart. It lacked a date to indicate when it was opened. b. Resident 2 had albuterol suf hfa 90mcg on the medication cart. It lacked a date to indicate when it was opened. A policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles," was provided by the RCS (Regional Clinical Support) on 2/26/24 at 10:50 a.m. The policy indicated, "...Once any medication or biological package it opened, facility should follow manufacturer/supplier guidelines with respect to expiration dated for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened ...." 3.1-25(j) 3.1-25(m) 3.1-25(n)		**1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** The clinical IDT team will be educated on the 'Label/Store Drugs & Biologicals' policy by 3/20/2024. Nurses will be educated on the 'Label/Store Drugs & Biologicals' policy by 3/20/2024. All medication cart binders will have a copy of the Medication Expiration Dates in place by 3/20/2024. DNS/Designee will round each day to review medication carts to ensure expired meds are disposed of and medications are properly labeled. **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-'F761: Label/Store Drugs & Biologicals' to audit medication carts for a minimum of 10 medications per cart. Complete weekly x 4 weeks, monthly x 6 months, and then quarterly until compliance is maintained. The Regional Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going	

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			areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 3.20.2024**	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to provide appropriate hand hygiene while assisting residents with eating for 2 of 2 days of dining observations. (Resident 44, 89, 42, 76, 110, 84, 42, and 56). Findings include: On 2/19/24 at 12:33 p.m., Qualified Medication Aide (QMA) 14 was observed to cut up Resident 95's food, did not wash or gel her hands and provided food for Resident 44. On 2/19/24 at 12:35 p.m., the Memory Care Support Specialist (MCSS) was observed to move a dining room chair with his bare hands, did not wash or gel his hands, and provided food and cut-up food for Resident 89. On 2/19/24 at 12:36 p.m., QMA 14 provided Resident 42's food, she did not wash or gel her hands, and provided food for Resident 76, and without washing or gelling her hands, provided food for Resident 110. On 2/19/24 at 12:46 p.m., Licensed Practical Nursing (LPN) 16 pulled up a dining room chair with her bare hands, did not wash or gel her hands, then assisted Resident 84 with eating. On 2/19/24 at 12:51 p.m., QMA 14 left the dining room table while assisting Resident 42 with eating. When she returned to the table, she pulled the dining room chair up to the table with her bare hands, did not wash or gel and continued to assist Resident 42 with eating.	F 0812	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?** Identified residents will be assessed for s/sx infection by 3/20/2024. Residents 44, 89, 42, 76, 110, 84, 42, and 56 are receiving care from staff who are completing appropriate hand hygiene. QMA 14, LPN 16, CNA 15, and QMA 17 have been inserviced on hand hygiene **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	03/20/2024

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	On 2/19/24 at 12:57 p.m., Certified Nursing Aide (CNA) 15 left the dining room table while assisting Resident76 with eating. When she returned to the table, she pulled the dining room chair up to the table with her bare hands, did not wash or gel and continued to assist Resident 76 with eating, On 2/19/24 at 1:01 p.m., LPN 16 completed assisting Resident 84 with eating, she did not wash or gel, then provided a drink to Resident 56. On 2/20/24 at 12:33 p.m., QMA 17 was observed to pull up a dining room chair to the table with her bare hands. She did not wash or gel her hands before assisting Resident 110 with eating. She left the table and returned with two straws, she put one straw in an unidentified resident's drink and provided one for Resident 110. On 2/22/24 at 11:20 a.m., the MCSS indicated his expectation was for the staff to keep their hands clean. They should use their foot to pull the chair up to the table. On 2/23/24 at 1:45 p.m., the Director of Nursing (DON) indicated if the staff contaminated their hands, they should perform hand hygiene. A current policy, titled, "Hand Hygiene Policy," dated 12/2021, was provided by the Executive Director (ED), on 2/23/24 at 8:55 a.m. A review of the policy indicated, " ...to provide a standardized approach to Hand hygiene to reduce or minimize the transmission of infection from potential microorganism on the hands of all employees ...Healthcare personnel should sue an alcohol-based hand rub or wash with soap and water for the following clinical indications ...immediately before touching a resident ...after touching a resident or the resident's immediate		alleged deficient practice. Staff will be educated on hand hygiene during meal time by 3/20/2024 by infection preventionist/designee. **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 'Hand Hygiene' policy by 3/20/2024. Staff will be educated on the 'Hand Hygiene' policy by 3/20/2024. Increase availability of ABHR gel for staff by 3/20/2024. DNS/Designee will observe meals to ensure staff are completing hand hygiene per protocol **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-'F812-Hand Hygiene during Mealtime' to audit a minimum of 3 meals weekly on multiple units and different shifts. Complete weekly x 4 weeks, monthly x 6 months, and then quarterly until compliance is maintained. The Regional Consultant/Designee will provide	

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	environment ...." 3.1-21(i)(3)		ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 3.20.2024**	
F 0908 SS=D Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure all mechanical equipment was kept in safe operating condition for 1 of 1 observation of the laundry service area. Findings include: On 2/23/24 at 11:00 a.m., during a routine observation of the laundry service area, soiled linen was in an uncovered barrel. Housekeeping Supervisor acknowledged all soiled linen was to be covered. Clean clothes were bagged and lying	F 0908	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.	03/20/2024

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BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

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	on the floor in the soiled linen area. The Housekeeping Supervisor indicated the items were clothes which had been placed there by the nurse aides and the clothing needed to be labeled. She indicated it was ok for the linen to be on the floor because it was in bags. A laundry rack containing clean unbagged linens was uncovered. Observation of the dryer lint traps indicated dryer number 3 had a minimal amount of lint. Dryers number 1 and 2 contained a large amount of lint in the lint traps. Review of the lint trap cleaning log dated, February 2024, lacked documentation of cleaning from 1am to time of observation. The housekeeping Supervisor acknowledged the documentation log was not completed for 2/23/24. Housekeeping aide 22 indicated the laundry personnel cleaned dryer vents every hour. Housekeeper 23 indicated she had cleaned the dryer vents at 6:00 a.m. on 2/23/24 and acknowledged she had not signed the log as being completed. On 2/23/2024 at 12:16 p.m., the Infection Preventionist Nurse (IP Nurse) provided a document titled, "Laundry/Linen," dated 2/2012, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy ...To ensure the proper care and handling of linen and laundry to prevent the spread of infection, in resident -care areas and in the laundry facility ...3. Laundry area: General ...e. Scheduled daily cleaning (laundry staff) and routine cleaning (housekeeping) ...4. Laundry area: Soiled linen ...b. Keep soiled linen covered in container until ready to load into machine ...Cover clean linen carts/racks ...." On 2/23/2024 at 12:17 p.m., the IP Nurse provided		**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 deficient practice. The soiled linen was covered. The bag of clean clothes was removed from the floor. The clean linen rack was covered. The Dryer lint traps were cleaned by the housekeeping supervisor. **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 dryer vent lint traps will be examined to ensure they are free of debris by 3/20/2024. Laundry room will be examined to ensure no clean linen is on the floor, clean laundry rack is covered, soiled linen barrels are covered, and dryer vent logs are up to date by 3/20/2024. **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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	155761	A. BUILDING 00 B. WING	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	a document, titled, "Safety -Dryer Operation" dated 8/17 and revised on 12/21, and indicated it was the policy currently being used by the facility. The policy indicated, " ...Lint screens must be cleaned after EVERY load, or hourly, under normal shift operation. Lint trap logs filled out accordingly and retained by supervisor ...." 3.1-19(bb)		educated on the 'Laundry/Linen' policy by 3/20/2024. Housekeeping and laundry team will be educated on the 'Laundry/Linen" policy by 3/20/2024. Staff members will be educated on the 'Laundry/Linen' policy with focus on clean linen and soiled linen handling by 3/20/2024. ED/designee will review the laundry service area to ensure room is in safe operating condition. **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 ED/Designee will utilize QA tool-'F908-Laundry/Linen/Dryer Vent' to review laundry room weekly to ensure dryer vent logs are completed hourly and clean/soiled linens are handled/stored properly. Complete weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained. The Regional Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be	

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			developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 3.20.2024**	