STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 00 B. WING	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(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 the Investigation of Complaints IN00452299 and IN00453678. Complaint IN00452299 - Federal/state deficiencies related to the allegations are cited at F684 and F880. Complaint IN00453678 - Federal/state deficiencies related to the allegations are cited at F684 and F880. Survey dates: February 19 and 20, 2025 Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census Bed Type: NF: 35 Total: 35 Census Payor Type: Medicaid: 34 Other: 1 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 26, 2025.	F 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 03/7/2025 to the state findings of the recent complaint investigation. We are requesting paper compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to ensure insulin administration for 3 of 3 residents reviewed for insulin administration.	F 0684	Proper Administration of Insulin F684 It is the practice of this facility to ensure administration on	03/07/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paul Stanley	Administrator	03/18/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(Resident B and C) Findings include: 1. Resident B's clinical record was reviewed on 2/19/25 at 11:50 a.m. Diagnoses included type 2 diabetes mellitus (DM), unspecified altered mental status, unspecified poly neuropathy, and long term use of insulin. A physician's order, dated 1/3/25, indicated Lantus (a diabetic medication to treat to DM), administer 30 units subcutaneously in the morning. The electronic medication administration record (eMAR) indicated the medication had not been administered. The progress notes lacked documentation regarding the missed dose. A physician's order, dated 9/10/24, indicated Lispro (a diabetic medication to treat to DM), administer 10 units subcutaneously before meals. The eMAR indicated the medication had not been administered on 1/2/25 for the 4:00 p.m. dose. An administration note indicated the resident only took 4 units and lacked indication of physician notification regarding decreased administered dose. A physician's order, dated 9/10/24, indicated Lispro, administer per sliding scale: If 150-179, give 1 unit; if 180-209, give 2 units; if 210-239, give 3 units; if 240-269, give 4 units; if 270-299, give 5 units; if greater than 300, administer 6 units and recheck. If not resolved, contact provider. To be administered four times a day. The eMAR indicated the medication had not been administered and lacked a blood sugar reading on 1/1/25 for the 8:00 p.m. dose, and 1/2/25 for the 5:00 p.m. dose. The progress notes lacked documentation regarding missed doses.		insulin. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: ~~a.~~ Resident B, C, and D medication administration records were reviewed to ensure insulin medication orders were in place. b. License Nurses and QMA's were provided education on 3/7/25 regarding completing medication administration record and supportive documentation if needed. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficiency. b. An audit of residents' files who receive insulin has been completed and no other deficiencies noted. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. An audit form will be developed to monitor the administration of insulin and supportive documentation if doses are not given. b. An in-service was completed on 3-7 on insulin administration policy and documentation. 4. How will the corrective action be	

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	2. The clinical record for Resident C was reviewed on 2/19/25 at 3:30 p.m. Diagnoses included type one diabetes mellitus. A current physician's order, dated 1/31/25, indicated Novolog (medication to treat DM), administer 5 units subcutaneously before meals in addition to sliding scale as indicated. The eMAR lacked indication the medication had been administered on 1/11/25 and 1/12/25 at 4:00 p.m. The progress notes lacked documentation regarding missed doses. A current physician's order, dated 5/24/24, indicated Novolog, administer per sliding scale before meals. The eMAR lacked indication the medication had been administered on 1/11/25 and 1/12/25 at 4:00 p.m. The progress notes lacked documentation regarding missed doses. 3. The clinical record for Resident D was reviewed on 2/20/25 at 3:50 p.m. Diagnoses included type two diabetes mellitus and hypoglycemia. A current physician's order, dated 1/24/25, indicated Humalog, administer per sliding scale subcutaneously before meals and at bedtime. The eMAR lacked indication the medication had been administered on 2/2//25 at 4:00 p.m. and 2/10/25 at 8:00 p.m. The progress notes lacked documentation regarding missed doses. During an interview on 2/20/25 at 11:22 a.m., the DON indicated the staff were failing to sign off medication administration. There should not be blank spaces on the eMAR. This citation relates to Complaints IN00452299 and IN00453678.		monitored to ensure that the deficient practices will not occur: a. The Director of Nursing and/or Designee will complete the audit form on 5 resident's charts to ensure medication administration records including supportive documentation is completed weekly for 4 weeks, then every 2 weeks for the next 2 months. If discrepancies are noted, then immediate correction will be completed. b. Findings from the review and any corrective actions will be discussed during QAPI meetings x6 months or until 100% compliance is achieved. The QAPI committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. By what date the systemic changes will be made: 3/7/24	

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F 0880 SS=E Bldg. 00	3.1-37(a) 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to ensure the multi-use blood glucose monitoring device was sanitized per manufacturer's guidelines during a random observation of blood glucose testing. Findings include: During an observation of blood glucose testing on 2/20/25 beginning at 11:34 a.m., QMA 2 removed a blood glucose testing meter from the top drawer of the medication cart. She wiped the device with an alcohol swab. At 11:35 a.m., she entered Resident G's room and placed the cup with the device on the overbed table. She donned gloves, swabbed the resident's finger with an alcohol wipe, and obtained the sample and reading. At 11:39 a.m., she removed her gloves and wiped the device with an alcohol swab and performed hand hygiene. At 11:40 a.m., she entered Resident H's room and placed the cup with the device on the overbed table. She donned gloves and swabbed Resident H's finger and obtained the sample and reading. At 11:42 a.m., she removed her gloves and wiped the device with an alcohol swab and returned to the medication cart, placing the device back into the top drawer. During an interview on 2/20/25 at 11:44 a.m., QMA 2 indicated an alcohol swab was used to sanitize the blood glucose monitoring device between residents. They only had the one device on that medication cart to use for multiple residents.	F 0880	Infection Prevention and Control F880 It is the practice of this facility to ensure that all the multi-use blood glucose monitoring device is sanitized per manufacture's guidelines. 1.What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. There were no residents identified during the survey.b. The QMA during survey was educated individually by the DON regarding the policy of procedure of cleaning and disinfecting the Blood Glucose Monitoring which included what cleaning materials are acceptable.c. The DON, IP, and/or Designee have in-serviced License Nurses and QMA's on 3/5/25 regarding the policy and procedures of the Cleaning and Disinfecting the Blood Glucose Monitoring System which included what cleaning materials are acceptable. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged	03/07/2025

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	During an interview on 2/20/25 at 12:04 p.m., the DON indicated an alcohol wipe was not sufficient to use to sanitize the multi-use glucose monitoring device. A Manufacturer's policy, undated, titled, "Cleaning and Disinfecting the [Manufacturer's name] Blood Glucose Monitoring System," provided by the Scheduler on 2/20/25 at 2:43 p.m., included the following: "...Cleaning and Disinfecting...The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens. Only wipes with EPA registration numbers listed below have been validated for use in cleaning and disinfecting the meter...Meter surfaces must remain wet according to contact times listed in the wipe manufacturer's instructions...." This citation relates to Complaints IN00452299 and IN00453678. 3.1-18(b)		deficiency. b. The DON, IP, and/or Designee have in-serviced License Nurses and QMA's on 3/5/25 regarding the policy and procedures of the Cleaning and Disinfecting the Blood Glucose Monitoring System which included what cleaning materials are acceptable. The staff completed return demonstrations to ensure compliance.3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. The DON, IP, and/or Designee have in-serviced License Nurses and QMA's on 3/5/25 regarding the policy and procedures of the Cleaning and Disinfecting the Blood Glucose Monitoring System which included the includes the acceptable cleaning materials. The staff completed return demonstrations to ensure compliance.b. All new Licensed Nurses and QMA's will be educated during new hire orientation regarding the policy and procedures of the Cleaning and Disinfecting the Blood Glucose Monitoring System which includes the acceptable cleaning materials.4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The DON or Designee will randomly audit the cleaning and disinfecting the blood glucose	

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			monitoring system 3 times a week for the next 30 days, then weekly for the next 30 days, then monthly for the next quarter. If discrepancies are noted, then immediate actions will be taken to correct. Findings from review and any corrective actions will be discussed during QAPI meetings x6 months or until 100% compliance is achieved. The QAPI committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. By what date the systematic changes will be made: 3/7/25.	