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	11/17/2023

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00421732. Complaint IN00421732 - Federal/State deficiencies related to the allegations are cited at F925. Complaint IN00419352 - No deficiencies related to the allegations are cited. Complaint IN00418748 - No deficiencies related to the allegations are cited. Survey dates: November 13, 14, 15, 16, & 17, 2023 Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census Bed Type: NF: 21 Total: 21 Census Payor Type: Medicaid: 21 Total: 21 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 27, 2023.	F 0000	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 regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective December 28, 2023. **This facility respectfully requests consideration for paper compliance from this Plan of Correction.**	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ruth Fuchs	Administrator	12/11/2023

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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	Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility			

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	for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior			

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	to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to provide notice of transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 2 residents reviewed for hospitalization. (Resident 17) Findings include: Resident 17's clinical record was reviewed on 11/14/12 at 10:55 a.m. Diagnoses included epilepsy, schizophrenia, and profound intellectual disabilities. The resident was transferred to the hospital on 9/19/23 and returned to the facility on 9/20/23. The clinical record lacked an Ombudsman notification for a transfer/discharge on this date. A progress note, dated 9/19/23 at 11:10 p.m., indicated the resident threw himself onto the floor resulting in a cut above his right eye. The nurse practitioner was notified and an order to send the resident to the emergency room was obtained.	F 0623	**F623** It is the practice of Brookside Care Strategies to give copies of the transfer/discharge notice as required for all residents and/or legal representatives who are transferred or discharged from the facility. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected by the alleged deficient practice. Resident 17 did not have a negative outcome related to this alleged deficient practice. Resident 17 returned to the facility upon being discharged from the	12/28/2023

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	A progress note, dated 9/20/23 at 11:23 a.m., indicated the resident returned to the facility via two emergency medical technicians (EMT) on a stretcher. During an interview on 11/16/23 at 2:57 p.m., the SSD indicated she updated her "Monthly Discharges and Transfers" form using her dashboard every morning and found this method easier to keep track of instead of waiting until the end of the month and running the "Census Report". Since the resident did not have a census event for this emergency room transfer, she would not have known to include his name on her form. Review of the current policy, a letter provided by the Office of the State Long Term Care Ombudsman, dated 6/28/19, provided by the SSD on 11/17/23 at 3:03 p.m., indicated the following: "...When a resident is transferred on an emergency basis to an acute care facility but is expected to return, the Office of the State Long Term Care Ombudsman (SLTCO) must be notified...." 3.1-12(a)(6)(A)(iv)		hospital. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents who discharge/transfer from the facility have the potential to be affected by the alleged deficient practice. An audit of all residents who have transferred and/or been discharged in the past 90 days was completed by the Social Service Director and/or designee to ensure proper notifications were provided and the notice of transfer/discharge as soon as practicable. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed Nurses will be in-serviced by December 13, 2023, by Social Service Director on Notice of Transfer/Discharge. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator and/or designee will be responsible for	

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			Transfer/Discharge/Bed Hold QAPI Tool (Attachment A) weekly times 4 weeks, monthly times 4 months, then quarterly until continued compliance is maintained for two consecutive quarters. If any issue is identified regarding the Notice of Transfer/Discharge, the Social Service Director and/or designee will review the facility policy with the nurse involved at that time. Written counseling will be rendered for continued noncompliance. The results of the audits will be reviewed by the QAPI Committee at the monthly meeting. If the threshold of 100% is not achieved, an action plan will be developed and reviewed with the Committee at each subsequent meeting. The Committee may decide to stop the reporting of the audit results once the quarterly audits have been completed with 100% compliance.	
F 0640 SS=E Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates.			

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	(iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must			

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	transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on record review and interview, the facility failed to submit Minimum Data Set (MDS) information to CMS (Centers for Medicare and Medicaid Services) in a timely manner for 7 of 16 resident assessments reviewed. (Residents 10, 18, 19, 22, 24, 29, and 134) Findings include: The record of resident 10 was reviewed on 11/14/23 at 9:39 a.m. The resident's Quarterly MDS, dated 10/6/23, indicated a status of "Exported". The record of resident 18 was reviewed on 11/16/23 at 2:28 p.m. The resident's Discharge Return Not Anticipated MDS, dated 10/1/23, indicated a status of "Exported". The record of resident 19 was reviewed on 11/16/23 at 1:40 p.m. The resident's Discharge Return Anticipated MDS, dated 9/27/23, indicated a status of "Exported", and an Entry MDS, dated 10/10/23, indicated a status of "Exported". The record of resident 22 was reviewed on 11/14/23 at 11:30 a.m. The resident's Annual MDS, dated 10/9/23, indicated a status of "Exported". The record of resident 24 was reviewed on 11/14/23 at 2:40 p.m. The resident's Discharge Return Not Anticipated MDS, dated 10/11/23, indicated a status of "Exported", and an Entry MDS, dated 11/2/23, indicated a status of "Export Ready".	F 0640	**F640** It is the practice of Brookside Care Strategies to submit Minimum Data Set (MDS) information to CMS (Centers for Medicare and Medicaid Services) in a timely manner. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The issue with Brookside Care Strategies MDS submission has been remedied as of November 28, 2023. All open assessments that were ready to be transmitted have now been sent to CMS. Residents 10, 18, 19, 22, 24, 29 and 134 were amongst the assessments that were sent to CMS. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. An audit of all current residents was completed by the MDS Consultant to verify that	11/28/2023

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	The record of resident 29 was reviewed on 11/14/23 at 2:56 p.m. The resident's Discharge Return Anticipated MDS, dated 10/11/23, indicated a status of "Exported", and an Entry MDS, dated 10/26/23, indicated "Exported". The record of resident 134 was reviewed on 11/14/23 at 1:22 p.m. The resident's Entry MDS, dated 11/2/23, indicated a status of "Export Ready". During an interview on 11/16/23 at 3:00 p.m., the MDS Coordinator indicated the terms "Exported" and "Export Ready" were for MDS assessments that are prepared to send to CMS. The assessments had not been submitted to CMS due to a lack of security clearance for submitting to CMS's program at this time. This issue had been identified on 10/11/23 and this facility was the only one in the company having the issue. During an interview on 11/17/23 at 1:13 p.m., the Administrator indicated staff use the Resident Assessment Instrument (RAI) Manual as the facilities policy for MDS assessment.		each resident had all required assessments transmitted to CMS. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Interdisciplinary team inserviced regarding timeliness of transmitting MDS to CMS. A new security officer has been assigned to allow users to have access to the proper export tools on Point Click Care and IQIES so that moving forward staff will be able to access the correct systems timely. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The MDS Coordinator will be responsible for the timeliness of MDS transmission QAPI Tool (Attachment B) weekly times 4 weeks, monthly times 4 months, then quarterly until continued compliance is maintained for two consecutive quarters. If any issue is identified regarding the MDS submission, the MDS Coordinator will review the facility policy with the interdisciplinary team.	

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			The results of the audits will be reviewed by the QAPI Committee at the monthly meeting. If the threshold of 100% is not achieved, an action plan will be developed and reviewed with the Committee at each subsequent meeting. The Committee may decide to stop the reporting of the audit results once the quarterly audits have been completed with 100% compliance.	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.			

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	§483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview and record review, the facility failed to ensure staff were trained on proper technique when administering from an insulin pen for 1 of 2 residents observed for insulin administration. (Resident 16) Findings include: During a medication administration observation for Resident 16 on 11/16/23 at 7:17 a.m., QMA 4 administered insulin per physician order using a Novolog FlexPen insulin pen. QMA 4 dialed the pen dose to "2" and administered into the resident's abdomen. She did not prime the new needle prior to administration. Review of resident's clinical record was completed on 11/15/23 at 1:09 p.m. Diagnoses included diabetes mellitus-type II and diabetic neuropathy. A current physician's order, dated 3/9/23, indicated Novolog FlexPen per sliding scale. During an interview on 11/16/23 at 8:05 a.m., QMA 4 indicated she had not completed an airshot after placing a new needle on the insulin pen. She had looked for any air bubbles in the top of the pen, but was not aware she needed to prime the needle. A current facility policy, revised 1/2023, titled, "Insulin Administration-Use of Kwik Pen," provided by the DON on 11/16/23 at 12:17 p.m.,	F 0726	**F726** It is the practice of Brookside Care Strategies to ensure staff are trained properly on proper technique when administering from an insulin pen on insulin administration. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #16 was not negatively affected by the alleged deficient practice. QMA who did not prime the Kwik pen was immediately inserviced by the Director of Nursing when the concern was noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents who receive insulin via Kwik pen have the potential to be affected by this alleged	12/13/2023

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	indicated the following: "...Procedure:...9. PRIME the pen. (Turn the dose knob to select two units, hold the pen with the needle pointing up. Tap the cartridge holder to gently collect the air bubbles at the top and push the dose knob until it stops at "0"...." 3.1-37(a)		deficient practice. All QMAs and licensed nurses will be educated on the importance of priming insulin pens prior to injections. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The DON and/or designee will complete med pass audits. The DON and/or Designee will monitor the administration of insulin and ensure that it is in line with Brookside Care Strategies' policy on insulin administration. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON and/or designee will complete Insulin Administration Kwik Pen audits (Attachment C). The DON and/or Designee will observe the administration of insulin daily 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 3 months, then quarterly until continued compliance is maintained for two consecutive quarters. If any issue is identified regarding administration of insulin, the	

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			DON and/or designee will review the facility policy with the nurse or QMA involved at that time. Written counseling will be rendered for continued noncompliance. The results of the audits will be reviewed by the QAPI Committee at the monthly meeting. If the threshold of 100% is not achieved, an action plan will be developed and reviewed with the Committee at each subsequent meeting. The Committee may decide to stop the reporting of the audit results once the quarterly audits have been completed with 100% compliance.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-			

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	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure narcotics were reconciled per facility policy for 2 of 2 medication carts reviewed for medication storage. (East and West carts) Findings include: 1. During a medication storage observation of the East cart, accompanied by LPN 5 on 11/17/23 at 10:38 a.m., the "Narcotic Count Sheet" record was reviewed and the following dates lacked shift to shift reconciliation of controlled medications: In October 2023- 10/13 on evening and night shifts, 10/14 on day and evening shifts, 10/15, 10/16 on all three shifts, 10/18 on day and evening shifts, 10/19 on all three shifts, 10/20, 10/21 on day and evening shifts, 10/22 on all three shifts, 10/23 on day and evening shifts, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30 on all three shifts.	F 0755	**F755** It is the practice of Brookside Care Strategies to ensure narcotics are reconciled per facility policy. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be affected by the affected deficient practice. A facility wide audit was conducted to determine controlled drugs had been counted and coincided with the Narcotic Count Sheet. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to	12/13/2023

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	In November 2023- 11/1, 11/2, 11/3, 11/4, 11/5 on all three shifts, 11/6 on day and evening shifts, 11/7, 11/8, 11/9 on all shifts, 11/10 on night shift, 11/11 on all shifts, 11/12 on day and evening shifts, 11/13 on all three shifts, 11/14 on third shift, 11/15, 11/16 on all three shifts, 2. During a medication storage observation of the West cart, accompanied by LPN 5 on 11/17/23 at 10:40 a.m., the "Narcotic Count Sheet" record was reviewed and the following dates lacked shift to shift reconciliation of controlled medications: In October 2023- 10/23 on day and evening shifts, 10/24 on all three shifts, 10/25 on evening and night shifts, 10/26 on evening and night shifts, 10/27 on all three shifts, 10/28 on evening and night shifts, 10/30 on evening and night shifts, 10/31 on day shift. In November 2023- 11/1 on evening and night shifts, 11/2 on evening shift, 11/3 on all three shifts, 11/4 on day and evening shifts, 11/5 on all three shifts, 11/6 on day and evening shifts, 11/7 on day shift, 11/8 on night shift, 11/9 on evening and night shifts,		be affected by the alleged deficient practice. Facility audit conducted to complete a physical inventory of controlled medications. No issues were identified. Licensed nurses will be educated on policy for medication administration and documentation, and completion of the Narcotic Count Sheet. The Director of Nursing and/or designee will review Narcotic Count Sheets five times weekly to determine compliance with signage requirements. Review of narcotic administration records five times weekly to determine accurate and timely documentation has occurred to include both shifts. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nurses will be educated on policy for medication administration and documentation, and completion of the Narcotic Count Sheet. Director of Nursing and/or designee will review Narcotic Count Sheets five times weekly to determine compliance with signage requirements. Review of narcotic administration records five times weekly to determine accurate/timely documentation has occurred to include both shifts.	

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	11/10, 11/13 on all three shifts, 11/14 on evening shift, 11/15 on evening and night shifts. During an interview on 11/17/23 at 10:38 a.m., LPN 5 indicated nurses should sign the "Narcotic Count Sheet" at the beginning and end of each shift worked. During an interview on 11/17/23 at 1:00 p.m., the DON indicated the expectation for all nursing staff was for a narcotic count to be done between the incoming nurse and the outgoing nurse. Both staff members were to sign the "Narcotic Count Sheet". Review of the current, revised 7/12, policy titled "Medication Storage," provided by the Administrator on 11/17/23 at 12:52 p.m., indicated the following: "... 4. There should be a system of medication records that enables periodic accurate reconciliation and accounting of controlled medications. 5. At the change of custody, a physical inventory of all controlled medications is conducted by two licensed nurses and is documented...." 3.1-25(b)(3)		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Director of Nursing and/or Designee will audit Narcotic Count sheets (Attachment D) daily five times a week for 4 weeks, weekly for one month and then monthly for 3 months to determine the Narcotic Count Sheet was completed by oncoming and off going staff. Identified issues will be immediately addressed with re-education and or disciplinary action. The results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	
F 0761 SS=D 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			

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	§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 ensure medication bottles were labeled per facility pharmacy policy. This deficient practice had the potential to affect 21 of 21 residents who resided in the facility. Findings include: During an observation of the locked medication storage room on 11/17/23 at 10:45 a.m., accompanied by LPN 5, two bottles of omeprazole (a medication to treat heartburn) 20 milligrams (mg) were without resident identifier labels. During an interview at the time of the observation, LPN 5 indicated the medication bottle lacked proper labeling. During an interview on 11/17/23 at 1:00 p.m., the DON indicated the pharmacy would not send unlabeled medications to the facility and was unsure where the bottles would have came from.	F 0761	**F761** It is the practice of Brookside Care Strategies to label drugs and biologicals in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be affected by the affected deficient practice. It is the practice of this facility to label drugs and biologicals used in the facility in	12/13/2023

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	Review of a current policy, revised on 7/12, titled "Pharmacy Services", provided by the DON on 11/17/23 at 1:14 p.m., indicated the following: "... ii. All prescription medications have labels that show:...4. The resident's name. 5. Specific directions for use. 6. The prescriber's name. 7. Dispensing date. 8. Name, address, and telephone number of the dispensing pharmacy. 9. Identification number of the dispensing pharmacist...." 3.1-25(j)		accordance with currently accepted professional principles. All incorrectly labeled, dated, expired medications were disposed of in accordance with the pharmacy policies. All medications are stored and labeled appropriately in accordance with the pharmacy policies. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. An inservice for all nursing staff will be conducted on 12/13/2023. This inservice will review facility policy and procedures for proper labeling per facility pharmacy policy by the DON and/or designee. A facility audit will be completed by DON and/or designee for all medication storage areas to ensure all medications are stored, labeled, and dated correctly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An in-service for all nursing staff will be conducted on 12/13/2023.	

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			This in-service will review facility policy and procedures for proper labeling per facility pharmacy policy by DON and/or designee. DON and/or designee will complete rounds daily to ensure all medications are labeled per facility pharmacy policy. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DON and/or designee will be responsible for completing the QAPI Audit tool Medication Labeling Audit (Attachment E) weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters.	
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 maintain clean and uncluttered laundry facilities, clean bathroom air vents, and safe closet doors during random observations of the facility.	F 0908	**F908** It is the practice of Brookside Care Strategies to maintain a clean and safe environment for the residents.	12/28/2023

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	Findings include: During a medication administration observation on 11/16/23 at 8:08 a.m., Resident 19 indicated he felt his sinus pressure was related to the debris in the bathroom ceiling fan, where you could not even see the fan blades for all the lint and mouse droppings. During an observation with QMA 4 at the time of the medication administration, the bathroom air vent had a large amount of dark, thick, dust-like debris. The bathroom walls were had a large number of gnats on them. The wall to the right of the heating and air unit was bowed out from the wall. On 11/16/23 at 8:10 a.m., Room 7 was observed with the right bi-fold closet door out of the track and hanging loose. On 11/16/23 at 12:56 p.m., Room 11 was observed with the right bi-fold closet door out of the track and hanging loose. On 11/13/23 at 11:09 a.m., Room 18 was observed with one side of the bi-fold closet door out of the track and hanging loose. On 11/16/23 at 10:14 p.m., Room 12 was observed with both inner sides of the bi-fold doors were out of the slide track and hanging loose. On 11/16/23 at 10:14 a.m., facility dining room was observed with gnats flying around the room. On 11/16/23 at 10:15 a.m., Room 17's bathroom air vent was observed with a large amount of lint and debris on it. On 11/16/23 at 9:36 a.m., the laundry room was observed accompanied by the Housekeeping		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected. Upon note of concern the laundry room was immediately cleaned to create a clean and uncluttered environment. The items behind the washer and dryer were removed. No chemicals will be placed on the floor in the laundry room. The laundry room was deep cleaned. All bathroom air vents have been replaced by the Maintenance Director and housekeeping has been inserviced to clean these daily and the Maintenance Director will also check the vents monthly and clean the debris from them as needed. Pest control was called for the gnat problem as soon as this was reported to the administrator. The treatment for the gnats was effective. All closet doors that were unable to be fixed have been removed from the closet opening and a rod and curtain were provided temporarily to provide a safe, private closet space. Brookside Care Strategy will begin a remodel in the first quarter of 2024, which will include new closet space with easily operated doors.	

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	Manager. The small room had bleach and other chemicals placed on the floor which was un-tiled. Staff sorted dirty clothes in the doorway of the laundry room. Blankets were on the floor behind the washing machine. The clean laundry delivery storage filled in the hallway due to lack of space in the clean area. There was an open window in the laundry room with visible lint covering the screen. The Housekeeping Manager indicated during observation the blankets should not be behind the washer and maintenance was responsible for cleaning behind the washer and dryer. During an interview on 11/16/23 at 10:44 a.m., the Maintenance Director indicated he oversaw two buildings. The laundry staff was responsible for all cleaning inside the laundry area, which included behind the machines. During an interview on 11/16/23 at 11:24 a.m., the Administrator indicated pest control came to the facility monthly to treat for spiders, gnats, and mice, or when requested. The bathroom air vents had been cleaned on 10/21/23.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected. All concerns noted have been addressed. All staff including laundry, housekeeping, and maintenance staff inserviced on the importance of keeping the laundry room clutter free and clean, bathroom air vents being cleaned daily and to notify administrator of any concerns related to pest control. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An inservice with all staff including laundry, housekeeping and maintenance staff was completed on the importance of keeping the laundry room clutter free and clean, bathroom air vents being cleaned daily and to notify administrator of any concerns related to pest control. The administrator and/or designee will tour the facility daily 5 times a week for 4 weeks, weekly for a month and monthly for 3 months to ensure that the laundry room is clean and clutter free, bathroom air vents are clean and free of	

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			debris, and that there are no pest control problems including gnats. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Administrator and/or designee will be responsible for completing the QAPI Audit tool Daily Facility Rounds (Attachment F) daily 5 times a week for 4 weeks, weekly for a month and monthly for 3 months to ensure that the laundry room is clean and clutter free, bathroom air vents are clean and free of debris, and that there are no pest control problems including gnats.	
F 0925 SS=D Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to ensure the facility was free from pests and rodents. Findings include:	F 0925	F 925 It is the practice of Brookside Care Strategies to maintain an effective pest control program so that the facility is free of pests and rodents.	12/28/2023

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	During a confidential interview on 11/16/23, a staff member indicated mice were observed frequently in the halls and resident rooms. The facility cat had a mouse in his mouth in the hallway the morning of 11/15/23. During a confidential interview on 11/16/23 at 2:11 p.m., a staff member indicated the facility had a gnat and mouse problem. During a confidential interview on 11/16/23 at 2:18 p.m., a staff member indicated there was a mouse problem in the facility and they were seen frequently in inside the facility. During an observation in Resident 19's bathroom, all four walls had a large number of gnats and many were observed flying around the room. Gnats were observed flying in the hallway and dining area. During an interview on 11/16/23 at 11:24 a.m., the Administrator indicated pest control came to the facility monthly to treat for spiders, gnats, and mice. The pest control provider would come to the facility for other treatments as requested. A current facility policy, revised May 2008, titled, "Pest Control," provided by the Administrator on 11/17/23 at 1:10 p.m., included the following: "...Policy Statement...Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents...." This citation relates to Complaint IN00421732. 3.1-19(f)(4)		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected. Orkin Pest Control, which is the facilities pest control provider, was immediately consulted with regarding the facilities ongoing pest control issues. Orkin Pest Control sent a representative who suggested an exclusion program to eradicate the mouse problem. Brookside Care Strategies opted for this option and the treatment, which took two days, was completed on November 22, 2023. Orkin Pest Control also sent another technician to spray the locations where gnats were seen to eliminate this problem. All rooms have been deep cleaned to remove any remnants of mice and gnats. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. Orkin Pest Control collaborated with the facility to attempt to eradicate the mice as well as alleviate the problems	

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			related to gnats. Orkin Pest Control completed an exclusion program for the mice and a technician came in on 11-17-2023 and sprayed the locations that were noted to have gnats at the time of the inspection. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff will be inserviced on December 13, 2023, to include the procedure for notification of pest control problems to the administrator. Residents were provided education during resident council on 11-30-2023 on pest control and their need to notify the administrator and/or other staff if they have concerns related to pests in their rooms. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The administrator and/or designee will conduct rounds monitoring for pest/rodents, as well as asking staff and residents for concerns with this issue. The pest control company will continue to service the facility until the problem is solved and then will continue as	

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			preventative maintenance. The administrator and/or designee will utilize the monitoring tool daily times (Attachment F) four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure 100% compliance is obtained and maintained. The audits will be reviewed during the facility's monthly assurance meetings and the plan of correction will be adjusted accordingly if warranted.	