DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	06/19/2023

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 the Investigation of Complaint IN00410354. Complaint IN00410354 - Federal/state deficiencies related to the allegations are cited at F684. Survey dates: .June 15, 16, 17, and 19, 2023. Facility number: 011367 Provider number: 155761 AIM number: 200851590 Census Bed Type: SNF/NF: 103 SNF: 20 Total: 123 Census Payor Type: Medicare: 28 Medicaid: 82 Other: 13 Total: 123 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 26, 2023.	F 0000	br> 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.	
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 facility must ensure that residents receive treatment and care in accordance with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jocelyn Brooks RN	Director of Nursing	07/03/2023

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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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. A. Based on observation, interview, and record review, the facility failed to ensure a resident was assessed prior to being moved after a fall and failed to ensure appropriate first aide after an accident on the facility bus for 1 for 3 residents reviewed for falls (Resident B). B. Based on interview and record review, the facility failed to get an x-ray in a timely manner for 1 for 3 residents reviewed for falls (Resident D). Findings include: A. On 6/15/23 at 10:03 a.m., Resident B's record was reviewed. His diagnoses included, but were not limited to, complication of vascular prosthetic device, presence of artificial heart valve, myocardial infarction (heart attack), chronic kidney disease, chronic osteomyelitis (bone infection), cirrhosis of liver (progressive liver disease), tobacco use, and hypertension (high blood pressure). His anticoagulant medications included aspirin 81 milligrams (mg) daily due to vascular prosthetic device, clopidogrel 75 mg tablet daily due to presence of prosthetic heart valve, and enoxaparin 40 mg daily injection. A fall care plan goal, target dated 8/15/23, indicated the goal would be for Resident B's fall risk factors to be reduced in an attempt to avoid significant fall related injury. The facility Medical Director note, dated 5/9/23, indicated Resident B had a complex medical history prior to coming to the facility. He was on	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. 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 D X-ray delay was reviewed by IDT 6/23/2023 to ensure delay did not result in delay in treatment or change in care. · Resident B care plan was reviewed. He has discharged from facility. **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.	06/23/2023

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	IV antibiotics due to a post-surgical infection acquired in the hospital. A nursing progress note, on 6/5/23 at 2:15 p.m., the Wound Care Coordinator (WCC) 5 indicated Resident B was in route to the facility from a physician's appointment. Resident B fell forward out of the wheelchair and landed on his hands and knees on the bus floor. The fall was witnessed by the bus driver. Resident B and Bus Driver 7 both indicated he did not hit his head. First aide was provided, and Resident B was assisted getting back into his wheelchair. The WCC 5 assessed Resident B upon his arrival to the facility He was alert and oriented x 3 (person, place, and time). He was able to provide a verbal statement of the incident. He sustained the following injuries: hematoma with skin tears to the left elbow, skin tear to his left pinky finger, skin tear with bruising to his right thumb, skin tear with bruising to right posterior forearm, and bruising to the right elbow. Resident B voiced discomfort to his left elbow, he stated pain was from the bruising. An elbow sling was provided to his left arm as a precaution. He continued to move his left arm despite being educated to keep it immobile. First aide was provided on the facility bus after the incident by the bus driver. WCC 5 removed the dressings placed by the bus driver and cleansed the skin tears. Steri-strips were applied and wrapped with kerlix and secured in place. The family was notified of the incident and requested Resident B be sent to the emergency room (ER) for evaluation. He was transported by a local ambulance company. His physician was notified. An Interdisciplinary Team (IDT) note, dated 6/6/23 at 1:05 p.m., was written by the Assistant Director of Nursing (ADON). She indicated Resident B had new wound/skin injury on his		· All residents with orders for xrays in the last 30 days will be reviewed to ensure timeliness of procedure & facility vendor was used by 6/23/2023. · All residents receiving facility bus services in the last 30 days will be audited to ensure no incidents occurred by 6/23/2023. · All residents with falls were reviewed by DNS/Designee to ensure residents were assessed appropriately. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** · All members of the IDT team will be educated on the bus incident policy by 6/20/2023. · All members of the bus transportation department will be re-educated on the bus incident policy by 6/20/2023. · All clinical members of the IDT team will be educated on using facility vendor for xrays versus hospice providers by 6/20/2023. · Nurses will be in-serviced and educated by DNS/designee on ordering xrays through facility vendor only by 6/20/2023. · DNS/designee to review activity report daily to ensure xrays are completed as ordered.	

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	right elbow with bruising and skin tear 3 centimeters (cm) by (x) 3 cm. Skin tear to his right posterior forearm of 5 cm x 2 cm. A skin tear to his right thumb 5 cm x 2.5 cm. His left pinky finger was 2 cm x 1.5 cm. A skin tear with hematoma (bruise) to his left elbow of 12 cm x 8 cm. His left elbow was swollen, and he was in pain. She indicated his seat belt was applied per facility staff on the bus. The IDT determination was Resident B removed his seat belt while he was being transported on the bus. He fell forward from his wheelchair when the bus came to a stop. Resident B was educated on not removing his seat belt mid-transfer. First aide was administered at the time of his injuries, then Resident B was sent to the ER for evaluation and treatment per family request. The resident, his family members, and his physician/nurse practitioner were notified. A second IDT note with further information, dated 6/6/23 at 2:00 p.m., indicated Resident B was admitted to the hospital. Resident B's hospital records, dated 6/5/23, were reviewed. ER documents indicated Resident B arrived with multiple abrasions and skin tears throughout bilateral forearms and fingers. Resident had a S4 sacral fracture and a forearm laceration. The ER documents indicated a laceration repair, location not indicated, on 6/6/23 at 11:55 a.m., where an 8 cm simple, macerated (softened skin tissue due to a dressing) wound was reapproximated (brought together) with 7 sutures. During an interview, on 6/15/23 at 10:30 a.m., the Transportation Coordinator indicated she scheduled all resident's needs for transportation. She indicated her office was right behind the receptionist area. When the receptionist received		**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-Bus Transport to review resident bus trips weekly to ensure incidents were addressed per policy-weekly x4 weeks, monthly x 6 months, then quarterly until compliance is maintained. · The DNS/Designee will utilize QA tool-Xray Order Timeliness to audit a minimum of 5 residents' xrays to ensure facility vendor was used and imaging was completed timely weekly x 4 weeks, monthly x 6 months, and then quarterly until compliance is maintained. · The Regional RAI 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 RAI Consultant for sustaining substantial compliance for no less than 6 months. After six months	

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	a call about Resident B being injured on the bus due to a fall after a sudden stop, she told Bus Driver 7 to call 911 immediately. Bus Driver 7 should have called 911 and waited for them to arrive, then the resident could have refused care from EMS. The Transportation Coordinator indicated she was CPR (cardiopulmonary resuscitation) and First Aide certified and her knowledge was to call 911 and not to move the resident. She indicated Resident B refused emergency services, and asked Bus Driver 7 to not call 911. Bus Driver 7 indicated Resident B was bleeding. Again, Resident B refused 911 services. She told Bus Driver 7 to get the first aid kit and "wrap him up the best you can," bring him back to the facility, and the wound nurse would be on standby to receive him. The Transportation Coordinator observed Resident B was in his locked and anchored wheelchair with his safety belt on his waist and across his chest. Resident B was bleeding from his arms. Resident B appeared relaxed, he did not moan or groan, the only thing he said was he wanted off the bus. The Wound Care Coordinator (WCC) 5 did not come on the bus to assess the resident before Bus Driver 7 and the Transportation Coordinator moved him into the facility. Resident B was asking for his phone. It was found on the floor of the bus. Resident B was moved into the facility as WCC 5 was arriving at the front of the building. The Transportation Coordinator indicated she probably should have left Resident B in place on the bus and let the WCC 5 nurse enter the van to access him. She indicated that after Resident B was being taken care of by WCC 5. She went out with Bus Driver 7 to clean up the bus. There was "a lot of blood." Resident B had quite a few wounds. During an interview, on 6/15/23 at 11:42 a.m., WCC 5 indicated she was notified by the Director of		the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 6/23/2023**	

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	Nursing (DON) that a resident was injured on the facility bus. She grabbed immediate items she would need to care for his wounds: 4 x 4 gauze, kerlix, saline, wound cleanser, skin prep, and steri-strips. Resident B met her at the front door. She did not know the resident had had a fall, the DON indicated the resident was injured on the bus and wound need wound care. She immediately accessed him at the entrance. She was alerted the resident fell out of the wheelchair. The most of his injuries were on the left arm. She removed the gauze and kerlix dressings. She didn't know how many dressings were removed. His wounds were measured on his bilateral (both) arms, cleansed, and she applied steri-strips and dry dressings. A hematoma on his left arm was in the elbow region. He had other bruising, mostly on his bilateral arms, but had some bruising on a hand. He was provided a left arm sling and probably needed an x-ray. Once she was finished with the dressings. She did a full assessment of his range of motion (ROM) and a neurological assessment. During an interview, on 6/15/23 at 12:20 p.m., Bus Driver 7 indicated he was the only bus driver on 6/5/23. The Bus Driver 7 indicated he had a green light and had to make a sudden stop because just before an ambulance entered the intersection, it flipped on its red lights and sirens. He made an abrupt stop and swerved. He heard something go "boom." He immediately turned around and Resident B was on the floor of the bus. He rushed back to him and said he was going to call 911. Resident B refused the offer of 911 twice. He observed blood on Resident B. The resident indicated to "just let me lay here" because it took 2 staff members to move him. Bus Driver 7 indicated to the resident he was strong enough to lift him. The resident used his legs, and they took			

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	baby steps to get to the wheelchair. He moved the resident into the wheelchair and the chair did not move at all. After the resident was in the wheelchair, Bus Driver 7 called his boss, Activity Director (AD) 11. She indicated for him to call 911 and get the resident to the hospital. Bus Driver 7 asked the resident if he could take him directly to the ER since he did not want an ambulance because he needed checked out. He offered to take him to the hospital twice. Resident B refused all attempts at EMS and ER care. Bus Driver 7 indicated there was a lot of blood. The resident had a lot of blood on himself and Bus Driver 7. Resident B indicated he was okay. The resident's main focus was to get him back to the facility. Bus Driver 7 managed Resident B's wounds by using the gauze from the first aid kit. He covered the wounds to stop the bleeding. He indicated he had the first aid classes. His main thought was to stop the bleeding. He was nervous but saw no bruises on Resident B's face and didn't feel like he needed to call 911. He put the dressings on Resident B while he was down on the bus floor because he was bleeding "furiously." During an interview, on 6/15/23 at 2:50 p.m., the DON indicated the Executive Director (ED) called her to indicate Resident B had an accident on the bus. He was refusing to go to the hospital He had injures on his arms and skin tears. The facility bus was bringing him back here to the facility. In general terms, he was okay and was talking. The DON called WCC 5 and had her meet the resident up at the front of the facility. She called the family members but was unable to reach either of them. During an interview, on 6/15/23 at 8:38 a.m., Licensed Practical Nurse (LPN) 9 indicated Resident B was non-compliant. On 6/5/23, WCC 5 rolled Resident B to the nurses' station. He was			

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still bleeding from the elbow. He had blood on his clothes and elbow. He was on a video call with his family. He told his family he was in an accident and the family wanted him to go to the ER. The resident was only on the unit for about 5 minutes, in that time LPN 9 gave him an oxycodone 5 mg tablet because he said he was in pain. He indicated he was "aching all over and in excruciating pain."

During a second interview, 6/16/23 at 11:13 a.m., Bus Driver 7 indicated to lift the Resident he got behind him and put his arms under Resident B's arms and wrapped them around his shoulders. Bus Driver 7 indicated he sat in the wheelchair first, asked the resident to raise his legs up, and told him to push up. Bus Driver 7 pivoted and was able to get Resident B into the chair. It took three attempts to get him in the chair. He buckled him because he knew the wheelchair was stable. Bus Driver 7 indicated he did not remember all of the transportation policy.

On 6/19/23 at 9:49 a.m., the ED provided Bus Driver 7's First Aid CPR AED certification. The certificate indicated it expired 4/2019. The ED indicated the First Aid did not expire. Bus Driver 7 was CPR and First Aide trained prior to coming to the facility.

During an interview, on 6/19/23 at 10:16 a.m., the AD 11 indicated bus drivers were shown how to use the First Aid kit. She told them to get gauze out, and always elevate the wounds. Bus Driver 7 called her and told her Resident B slid out of his wheelchair. Bus Driver 7 indicated he did not want 911. She told him to get the first aid kit, apply pressure to the area of the arm. Bus Driver 7 indicated he had spoken with Receptionist 10, and he needed nursing at the front of the building.

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The WCC 5 texted her and indicated she was going to take care of it. She indicated she did not keep up with CPR and First Aide certification for bus drivers.

On 6/19/23 at 11:02 a.m., the AD 11 provided more information regarding the first aide training she provided for the bus drivers. It indicated the location of the first aid kit. Items inside and how to use them, like sterile bandages for applying pressure and the Stop the Bleed kit, with the instructions inside the kit.

On 6/19/23 at 11:20 a.m., a bus driver job description was provided by the ED. It indicated, " ...The Bus Driver has a primary responsibility with ensuring the health, safety and welfare of the residents while transporting to and from activities outside the community ...CPR and First Aide certification preferred ...."

On 6/16/23 at 3:08 p.m., the DON indicated if there was an injured on the facility bus, they should be directed to seek EMS, in conjunction with and honoring the resident's rights.

A current policy, titled, "ASC Facility Bus/Van Transportation Guidelines," dated 7/2013, was provided by the ADON, on 6/16/23 at 9:04 a.m. A review of the document indicated, " ...Seat belt are required to be worn by driver and passenger(s)...911 must be called immediately for any resident requiring medical attention...Any injury must be reported to the facility ED/DNS immediately ...."

A current policy, titled, "Resident Rights," dated 11/16, was provided by the ADON, on 6/16/23 at 9:04 a.m. A review of the document indicated, " ...All staff members recognize the rights of

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	residents at all times and residents assume their responsibilities to enable personal dignity, wellbeing, and proper delivery of care ...." B. On 6/16/23 at 10:53 a.m., Resident D's record was reviewed. Her diagnoses included, but were not limited to, Alzheimer's disease (degeneration of the brain), dementia (persistent loss of intellectual function), and hypertension (high blood pressure). Her Brief Interview of Mental Status (BIMS) score indicated she had severely impaired cognition. A fall care plan, dated 4/19/23, indicated Resident D was at risk for falls due to a history of falls, age, and high risk medication use. The interventions were reviewed. No new intervention was added after the 5/10/23 fall with left femur (thigh bone) fracture as advised by the IDT progress note, dated 5/12/23 at 2:09 p.m. A hospice care plan, dated 3/23/23, indicated Resident D required hospice and would experience death with dignity and physical comfort as the disease allowed. A nursing progress note, dated 5/10/23 at 12:06 p.m., indicated at approximately 8:20 a.m., Resident D was noted to be lying on her left side on the floor yelling out for help. The resident had been trying to self-transfer from her bed to her wheelchair. Resident D immediately complained of left hip pain. Pain was noted with passive range of motion, no bruising was noted. Skin tears observed to left pinky finger and ring finger knuckle. The Director of Nursing (DON) and hospice made aware. The resident's family was made aware. A new order for Morphine 20 mg/mL (milligram per milliliter) oral concentrate indicated to give 0.25 milliliters (mL) by mouth every 4 hours			

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	as needed for pain or shortness of breath. An x-ray was ordered by hospice for her left upper leg and hip. Her x-ray was not performed during this shift. Scheduled Tylenol was administered. A nursing progress note, dated 5/11/23 at 11:40 a.m., indicated her left upper leg and hip x-ray had not been performed during this shift. Per hospice they used their own radiologist who would perform the imaging. A nursing progress note, dated 5/11/23 at 10:45 p.m., more than 38 hours after Resident D's fall, indicated the x-ray technician came in for the hip film. The interpretation was still pending. An Interdisciplinary Team (IDT) progress note, dated 5/12/23 at 2:09 p.m., indicated the x-ray results were received and showed an acute left femoral fracture. The physician and family were notified. The resident was not sent to the ER for evaluation and treatment. Short term interventions were put in place at the time of the fall: Assist resident with a.m. care, position for comfort, and offer and assist resident to get up before the breakfast meal was served. Orders and care plan updated. A nursing progress note, dated 5/14/23 at 2:06 a.m., indicated the fall intervention were in place per plan of care. A nursing progress note, dated 5/23/23 at 1:46 p.m., indicated the hospice nurse gave a new order for Norco (narcotic pain reliever) 10-325 mg scheduled every 6 hours. On 6/16/23 at 9:59 a.m., the DON indicated Resident D did not get her care plan updated because after her fall, the risk factor of why she			

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	fell were eliminated. After her fall on 5/10/23, she became bedfast (confine to bed) because of the femur fracture. At an unknown date and time, the Assistant Director of Nursing (ADON) indicated, regarding the delay in Resident D's x-ray, the facility had made a procedural change. The facility was to get their own x-rays. Hospice could get their own x-ray too. A current policy, titled, "IDT Comprehensive Care Plan Policy," dated 10/19, was provided by the ADON, on 6/16/23 at 10:33 a.m. A review of the document indicated, " ...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input ...." A current policy, titled, "Fall management Policy," dated 8/22, was provided by the ADON, on 6/16/23 at 10:33 a.m. A review of the document indicated, " ...A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate intervention ...." This Federal tag related to Complaint IN00410354. 3.1-37(a)			