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

FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155761 | A. BUILDING 00<br>B. WING | 03/31/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROWNSBURG MEADOWS | 2 E TILDEN<br>BROWNSBURG, IN 46112 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00336335, IN00348981, and IN00348225.<br><br>Complaint IN00336335 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00348981 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00348225 - Substantiated. Federal/State deficiencies related to the allegations are cited at F761.<br><br>Unrelated deficiencies are cited.<br><br>Survey dates: March 29, 30, and 31, 2021<br><br>Facility number: 011367<br>Provider number: 155761<br>AIM number: 200851590<br><br>Census Bed Type:<br>SNF/NF: 98<br>Total: 98<br><br>Census Payor Type:<br>Medicare: 8<br>Medicaid: 79<br>Other: 11<br>Total: 98<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on April 8, 2021. | F 0000 | | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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, interview, and record review, the facility failed to ensure an opened, multi-use vial of medication was properly labeled and stored for 1 of 1 medication vials randomly observed.<br><br>Findings include:<br><br>During a random observation on 3/29/21 at 4:11 p.m., an opened box labeled, "Tuberculin Purified Protein Derivative [PPD; a sterile liquid solution | F 0761 | 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.<br><br>This provider respectfully requests that the 2567 Plan of Correction be considered the letter of | 04/30/2021 |

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| | of a purified protein injected under the skin as an aid in the diagnosis of tuberculosis], Diluted Aplisol 5TU/ 0.1 mL" was observed through a small, unlocked, refrigerator door. The box contained one, opened vial of PPD. The vial did not have a label that indicated when it had been opened. The small refrigerator was kept, unlocked, in a conference room being used by non-facility staff persons. Inside the refrigerator, were two sealed containers labeled, "apple juice," one opened bottle of sports drink, an opened one-gallon plastic jug filled with an unidentified brown liquid lying on its side; and one sandwich wrapped in plastic cling wrap with the label "[brand name] Turkey Breast Maple." On top of the refrigerator were five closed packages of syringes with the needles attached, and an unopened package with the label "STAT Cup II One-step drug test".<br><br>During an interview on 3/29/21 at 4:26 p.m., the Director of Nursing Services (DNS) indicated she was unaware the opened vial of PPD was in the conference room refrigerator. She did not know how long the vial of PPD had been in the conference room refrigerator. The conference room was previously used as her office, and the refrigerator was for her personal food and drink storage. She thought maybe the opened vial of PPD had needed to be disposed, so her staff placed the vial of PPD in the refrigerator until it could be disposed of properly. The DNS indicated the vial of PPD should not have been kept in the refrigerator in the conference room because that particular refrigerator was not monitored to ensure the medication was stored at the proper temperature. She would need to throw away the vial of PPD, as the vial had been opened, was not labeled with the date it was opened, had been kept in a refrigerator that was | | credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.<br><br>**1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?**<br>· No residents were affected.<br>**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?**<br>· All residents have the potential to be affected by the alleged deficient practice.<br>· Undated vial of Tb solution was immediately removed from the office refrigerator and disposed of.<br>· All office employees were in-serviced and educated by CEN/designee on medication storage policy by April 30, 2021.<br>· All office refrigerators were audited to ensure compliance with medication storage policy.<br>· All clinical staff were in-serviced by the CEN/designee on medication storage policy by April 30, 2021.<br><br>**1.What measures will be put into place or what systemic** | |

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| | not monitored, and had been stored with food and drink items.<br><br>During an interview with the DNS on 3/30/21 at 11:53 a.m., she indicated, the facility staff did not usually store medications that were planned to be destroyed in a refrigerator, but "it's COVID and we're doing our best".<br><br>On 3/30/21 at 11:39 a.m., a policy titled, "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles," dated 4/5/19, was provided by the DNS. The DNS indicated this was the current policy in use by the facility at this time. The policy indicated, " ...Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/ cart or locked medication room that is inaccessible by residents and visitors ...Facility should ensure that food is not to be stored in the refrigerator, freezer, or general storage areas where medications and biologicals are stored ...Facility staff should record the date opened on the medication container ...Facility should ensure that medications and biologicals are stored at their appropriate temperatures...."<br><br>This Federal tag relates to Complaint IN00348225.<br><br>3.1-25(j)<br>3.1-25(m) | | **changes will you make to ensure that deficient practice does not recur?**<br>· All clinical staff were in-serviced by the CEN/designee on medication storage policy by April 30, 2021.<br>· Auditing rounds will be conducted daily by the CEN/designee until compliance is maintained using the Medication Storage Audit tool to ensure that medications are being stored appropriately per policy.<br>· The CEN/designee will provide ongoing training, oversight, resources, and competencies as needed using the Medication Storage Audit and QA tools identifying on-going areas of concern or areas not meeting threshold.<br><br>**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?**<br>· QA tool-Medication Storage Rounds Audit- will be completed by CEN/designee until compliance is maintained; increasing frequency if thresholds are not met.<br>· The CEN/designee will be responsible for the completion of the QA Tool daily x 4 weeks, then weekly x 4, then monthly x 3 months, and then quarterly | |

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| | | | thereafter for one year total with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director.<br>· If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.<br>· The facility will review, update and make changes to the POC as needed with input and oversight from the Clinical 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.<br><br>**Date of Compliance: 04/30/2021** | |
| F 0812<br>SS=D<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food<br>Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude | | | |

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| | residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, interview, and policy review, the facility failed to ensure staff wore hair covering while preparing food for 1 of 1 random kitchen staff observation, and the facility failed to ensure the ice scoop was not stored in the ice machine for 1 of 1 random observations of the ice machine.<br><br>Findings include:<br><br>1. On 3/30/21 at 8:47 a.m., Culinary Aide 12 was observed as she stood at a food preparation counter, over a large, plastic, open container of shredded cheese. Culinary Aide 12 was observed putting her hands into the container of cheese and mixing it within the container. Culinary Aide 12 did not have on a hair covering, and all of her hair was exposed.<br><br>During an interview on 3/30/21 at 8:50 a.m., Culinary Aide 12 indicated, she should have been wearing a hair covering while in the kitchen, preparing food for the residents.<br><br>During an interview on 3/30/21 at 8:52 a.m., the Assistant Culinary and Nutrition Manager 13 indicated, Culinary Aide 12 had been employed with the facility for more than three months as a Culinary Aide. Culinary Aide 12 should have worn a hair covering while in the kitchen, preparing food for the residents.<br><br>During an interview on 3/30/21 at 8:59 a.m., the Culinary and Nutrition Manager 7 indicated, | F 0812 | **F812 Food Procurement, Store/Prepare/Serve-Sanitary**<br>It is the intent of the facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·Immediate disciplinary action was performed on employee not wearing proper hair covering.<br>·Ice machine was cleaned out, ice scoop washed and sanitized.<br>·Signs were posted on all kitchen doors to indicated that no one is to enter the kitchen without proper hair covering.<br>·All food prepared by Culinary Aide 12 was discarded.<br>·No residents were affected by the deficient practice.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents receiving ice from the ice machine and consuming foods prepped by the employee | 04/30/2021 |

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| | kitchen staff were expected to wear a hair covering, that covers all of the staff member's hair, while in the kitchen. Culinary Aide 12 was observed in the kitchen, preparing food for the residents, without her hair covered, was against facility policy.<br><br>On 3/30/21 at 9:58 a.m., a policy titled, "Dietary Personal Hygiene," dated July 2015, was provided by the Administrator. The Administrator indicated this was the current policy in use by the facility. The policy indicated, " ...Employees will maintain good personal hygiene to prevent food contamination...Personal Cleanliness a. Wear a clean hat and/ or other hair restraint ...."<br><br>2. On 3/30/21 at 8:53 a.m., an ice scoop was observed inside an ice machine. This ice machine was the only ice machine observed in the kitchen to provide ice to the residents.<br><br>On 3/30/21 at 8:57 a.m., Assistant Culinary and Nutrition Manager 13 observed the ice scoop in the ice machine. The scoop was removed from the ice machine, and Assistant Culinary and Nutrition Manager 13 indicated the ice scoop should be not be stored inside the ice machine. Storing the ice scoop inside the ice machine increased the risk of cross contamination from whatever may have been on the scoop handle, to the ice stored inside the machine.<br><br>During an interview on 3/30/21 at 8:59 a.m., the Culinary and Nutrition Manager 7 indicated the ice scoop stored inside the ice machine was against facility policy.<br><br>On 3/30/21 at 9:58 a.m., a policy titled, "Cleaning Ice Machine and Scoop," dated February 2002, was provided by the | | not wearing proper hair covering have the potential to be affected by the alleged deficient practice.<br>·Ice containers were checked by Culinary Manager to ensure scoops were stored properly.<br>·Staff will ensure proper hair covering prior to kitchen entry per policy.<br>·Ice scoop will be stored properly per policy.<br>·Dietary staff will be re-educated on wearing proper hair covering as well as proper storage of ice scoop by the Certified Dietary Manager/designee by **4/23/2021.**<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>·Dietary staff will be re-educated on wearing proper hair covering as well as proper storage of ice scoop by the Certified Dietary Manager/designee by **4/23/2021.**<br>·The Certified Dietary Manager/designee will complete the Culinary Manager walk-through checklist daily with corrective action taken as needed to ensure compliance.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance** | |

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| | Administrator. The Administrator indicated this was the current policy in use by the facility at this time. The policy indicated, " ...Store ice scoop beside or on top of the machine in a clean non-porous container that allows water to drain off ...."<br><br>3.1-21(i)(3) | | **program will be put into place?**<br>·The Kitchen Sanitation/Environmental Review tool will be completed by the Certified Dietary Manager/designee weekly X 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee.<br>·Regional dietitian will complete sanitation review monthly for six months to ensure and monitor compliance beginning May 2021.<br>·If 90% threshold is not achieved, an action plan will be developed to ensure compliance. | |