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	01/10/2023

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 IN00398857. Complaint IN00398857 - Substantiated. Federal/state deficiencies related to the allegations are cited at F552 and F726. Survey dates: January 10, 2023. Facility number: 011367 Provider number: 155761 AIM number: 200851590 Census Bed Type: SNF/NF: 111 SNF: 11 Total: 122 Census Payor Type: Medicare: 24 Medicaid: 79 Other: 19 Total: 122 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 19, 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 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 2/3/2023.	
F 0552 SS=D Bldg. 00	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jocelyn Brooks	MSN, RN, DNS	01/26/2023

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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	§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.			
	Based on observation, interview, and record review, the facility failed to ensure a resident (Resident B) had the right to participate in her treatment plan according to her preferences for 1 of 3 residents reviewed for Resident's Rights. Findings include: During a confidential interview, it was indicated, Resident B's family was out of town when they were contacted and asked about giving Resident B an annual Flu shot and a COVID-19 booster. Her family indicated Resident B received her flu shot every year but requested that her vaccinations not be administered until they returned from vacation so that they could be close in case of any adverse reactions. Resident B had experienced adverse reactions to vaccines in the past. Resident B had an extensive psychiatric history which included psychotic manic episodes that were triggered by vaccinations, certain medications, steroids, etc. The family wished to be	F 0552	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 2/3/2023. **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** · Resident B consent form	02/03/2023

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	close enough to assist the staff if the vaccination triggered a manic attack, and/or go with her to the hospital if an adverse reaction occurred. When the family called to check on Resident B while they were still out of town, Resident B indicated her arm was sore because she had gotten the flu shot. Resident B had asked for staff to wait for her family's return but was told, "oh they don't know what they are talking about." Fortunately, Resident B had not had a bad reaction, but it was still upsetting because both the family and Resident B had requested to wait but staff had given the flu vaccine anyway. During an interview on 1/10/23 at 11:05 a.m., Resident B was observed in her room. She sat in a recliner chair beside her bed. She was neat, clean, odor free and able to answer questions appropriately. When asked about her flu and COVID-19 vaccines, Resident B indicated she had been given the flu shot while her family was out of town. When staff came with "the needle," she asked the nurse to wait a couple days until her daughter returned from vacation. But the nurse indicated, "oh she doesn't know any better," and gave the shot anyway. Resident B indicated it did not make her mad, but her arm had been sore and that made her anxious. On 1/10/23 at 10:20 a.m., Resident B's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, Parkinson's disease, dementia (in other diseases classified elsewhere, unspecified severity), with other behavioral disturbance, generalized anxiety, and recurrent major depressive disorder. An annual Minimum Data Set (MDS) assessment, dated 10/27/22, indicated Resident B was		and care plan has been updated to indicate vaccine will only be administered if family are in town. **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 consent forms were audited to ensure there were no special instructions for administration of the vaccine. · All residents have the potential to be affected by the alleged deficient practice. · Nurses and IDT team will be re-educated on Resident Rights by 2/3/2023. · Nurses and IDT team will be re-educated on process to obtain consent by 2/3/2023. · All residents will have consent on file and reviewed prior to administration of vaccines. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** · Nurses will be educated on Resident Rights and consent process by 2/3/2023. · All members of the IDT will be educated on Resident Rights and consent process by 2/3/2023. · The Director of	

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	cognitively intact, and it was very important to her that her family was involved in her care. She had a comprehensive care plan, initiated 8/19/21, which indicated she had been determined to have a mental illness and per the Pre-Admission Screen and Record Review (PASRR) Level II review. The diagnoses related to this determination were anxiety disorder and unspecified psychosis. Interventions for this plan of care included, but were not limited to, having her family involved in her care. She had a comprehensive care plan, initiated 8/2/21, which indicated she was at risk for experiencing symptoms of anxiety i.e., fidgety, restless, shortness of breath and she could self-report feeling anxious. Interventions for this plan of care included, but were not limited to, discuss with family which was identified as most important to her. She had a comprehensive care plan, initiated 5/17/21, which indicated she had strong family and spiritual support, and she was encouraged to continue to use those strengths. She had a comprehensive care plan, initiated 8/27/21, which indicated she had behavioral issues such as refusing showers, daily living care, and meals at times. Interventions for this plan of care included but were not limited to the fact that her family was very supportive, staff were to update family and family would provide support to staff for encouragement to allow personal care. An Influenza Vaccination Consent, dated 10/5/22, indicated, "verbal OK [family member's name]," and signed by Registered Nurse (RN) 7.		Nursing/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern. **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 Infection Preventionist/Designee will use CQI audit for Resident Vaccine Consents weekly x 4 weeks then monthly x 6 months until compliance is maintained. · The Director of Nursing/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern. · The facility will review, update and make changes to the POC as needed with input and oversight from the Director of Nursing/Regional Nurse Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 2/3/2023**	

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A review of Resident B's Medication Administration Record (MAR) revealed RN 7 the flu administered the vaccine on 10/19/22.

A grievance had been filed on Resident B's behalf, dated 10/14/22. The grievance indicated, " ...daughter requested flu and covid vaccine not be given until daughter was back from vacation this week due to extensive psych history. Flu vaccine was given 10/19/22." The Director of Nursing (DON), and the nursing department head reviewed the grievance and the indicated, " ...no covid or flu shot given while family not there."

During an interview on 1/10/23 at 1:45 p.m., the DON indicated she was not aware that the flu shot had been given. Resident B specifically liked her daughter to be involved with her care because she would often get nervous or anxious. The DON indicated Resident B was alert and oriented and able to make her own decisions, so consent for the flu vaccine should have been given to her first. Consent for vaccinations was often resident-specific, and Resident B "very much" preferred to have her family involved.

During an interview on 1/10/23 at 1:40 p.m., the Administrator indicated it was his expectation that if a resident was able to speak for themselves and were of sound mind, they would have the right to participate in their plan of care. In order to do that the interdisciplinary team took each resident's personalities into consideration because they had different needs. Staff were to have conversations around residents' preferences and adjust resident's care plans as needed and follow the resident's plan of care.

On 1/10/23 at 2:55 p.m., the Administrator provided a copy of current facility policy titled,

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	"Resident Rights," revised 11/2016. The policy indicated, " ...this document informs each resident/responsible party of his/her rights and responsibilities regarding medical care while a resident at the facility ... facility must ensure that the resident can exercise his or her rights without interference ...." The Administrator indicated the facility followed Federal and State regulations. This Federal tag relates to Complaint IN00398857. 3.1-3(n)(3)			
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 had sufficient knowledge and competency to administer medication for 3 of 4 resident reviewed for medication administration (Resident E, F, and G). Findings include: 1. On 1/10/23 at 9:35 a.m., Qualified Medication Aide (QMA) 8 was observed while pulling medication from the medication cart for Resident E. She looked for metoprolol (treats high blood pressure) 25 milligrams (mg), ordered to give daily, but it was not in the cart. She indicated it ran out yesterday. She was not observed to inform License Practical Nurse (LPN) 9 who was available to assist her to get it from the Emergency Drug Kit (EDK). On 1/10/23 at 11:08 a.m., QMA 8 administered Resident E's medications. She had not told the nurse of the missing medication and did not give the metoprolol 25 mg as ordered by the physician. On 1/10/23 at 11:17 a.m., LPN 9 realized QMA 8 did not have Resident E's metoprolol at 9:35 a.m. LPN 9 indicated to QMA 8 she should have informed the nurse prior to giving him his medications at 11:08 a.m. LPN 9 indicated she could have gotten it from the EDK and she reminded QMA 8 to be sure to take his blood pressure to determine if he	F 0726	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 2/3/2023. **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** · Resident E is receiving his medication as prescribed. QMA 8 was educated on medication administration on 1/10/2023 by unit manager. · Resident F is receiving the medication as prescribed. QMA 8 was educated on medication administration on 1/10/2023 by unit manager.	02/03/2023

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	could have the blood pressure medication according to the physician's order. 2. On 1/10/23 at 9:48 a.m., QMA 8 removed the medication punch cart for tizanidine (treats muscle spasms) 2 mg for Resident E. It indicated to give 2 mg at bedtime. She removed the tablet form the punch card into the medication cup. She indicated she did not check the physician's order with the medication punch card before she popped the tablet into the medication cup. She indicated she needed to work on that aspect of resident medication administration. A review of Resident E's Medication Administration Record (MAR) indicated he was to have tizanidine 2 mg twice a day from 7 a.m. to 11:00 a.m. and 7:00 p.m. to 11:00 p.m. A second physician's order on the MAR indicated he was to have tizanidine 2 mg at bedtime 7:00 p.m. to 11:00 p.m. The tizanidine was ordered twice from 7:00 p.m. to 11:00 p.m. Nursing initials were noted on the MAR indicating the medication was administered in the morning and twice from 7:00 p.m. to 11:00 p.m. 3. On 1/10/23 at 9:52 a.m., QMA 8 pulled medications for Resident F. She had an order for furosemide (diuretic) 40 mg, once daily. As QMA punched it out of the card, it broke in half. Half went into the medication cup and half landed to top of the medication cart. She disposed to both of those pills. She successfully punched one whole tablet into the medication cup on her second try. She indicated there was another half pill stuck in the punch card after someone had tried to punch a whole pill in the medication cup. She left the half pill in the punch card and replaced it in medication cart.		· Resident G is receiving the medication as prescribed. QMA 8 was educated on medication administration on 1/10/2023 by unit manager. **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. · Nurses and QMAs will be educated on Dose Preparation and Medication Administration by 2/3/2023. · Nurses and QMAs will have their skills validated in Medication Administration by 2/3/2023. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** · Nurses and QMAs will be educated on Dose Preparation and Medication Administration by 2/3/2023. · Nurses and QMAs will have their skills validated in Medication Administration by 2/3/2023. · Director of Nursing/designee will conduct rounds each shift to ensure residents are receiving medication as prescribed. · The Director of Nursing/Designee will provide	

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	4. On 1/10/23 at 10:08 a.m., QMA 8 started pulling medications for Resident G. She had 2 physician's orders for Zoloft (treats depression) and three different medication punch cards. One punch card did not have an order for it. The first physician's order indicated to give Zoloft 100 mg, the amount to administer, once a day, give with 50 mg (1 ½ tablets) to equal 175 mg. The second physician's order indicated to give Zoloft 50 mg, amount to administer 75 mg, once a day, give with 100 mg to equal 175 mg daily. The first card QMA 8 pulled from the medication cart indicated, on the pharmacy punch card, Zoloft 50 mg, give 50 mg daily with 100 mg and 25 mg to equal 175 mg. The second card pulled indicated Zoloft 100 mg, give with 50 mg plus 25 mg to equal 175 mg. The third card pulled indicated Zoloft 25 mg, give with 100 mg plus 50 mg to equal 175 mg. No pill was given from this punch card. She was observed putting the following in the medication cup: one 100 mg tablet, one 50 mg tablet, and ½ of a 50 mg tablet. On 1/10/23 at 10:22 a.m., LPN 9 indicated there was not an order for the Zoloft 25 mg. On 1/10/23 at 10:23 a.m., QMA 8 indicated the physician's order was only 150 mg. During an interview, on 1/10/23 at 2:07 p.m., the Director of Nursing (DON) indicated Resident E's tizanidine dose was correct and the metoprolol was given. Resident F's Zoloft order was written		ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern. **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 Clinical Education Nurse/Designee will use CQI audit tool for Medication Administration weekly x 4 weeks then monthly x 6 months until compliance is maintained. · The Director of Nursing/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. · The facility will review, update and make changes to the POC as needed with input and oversight from the Director of Nursing/Regional Nurse Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 2/3/2023**	

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	correctly, and the right dose was given, and she would find and remove the furosemide ½ tablet left in the punch card in the medication cart. A current policy, titled, "6.0 General Dose Preparation and Medication Administration," dated 12/1/07, provided by the DON, on 1/10/23 at 9:45 a.m. A review of the policy indicated, " ...Facility staff should not split tablets ...The pharmacy should be contacted to provide the correct dose ...Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident ...Confirm that the MAR reflects the most recent medication order ...Administer medication within timeframes ...." This Federal tag relates to Complaint IN00398857. 3.1-14(i)			