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	04/04/2023

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00400310, IN00404071 and IN00404794. Complaint IN00400310 - No deficiencies related to the allegations are cited. Complaint IN00404071 - Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00404794 - No deficiencies related to the allegations are cited. Survey dates: March 28, 29, 30, 31, April 3 and 4, 2023. Facility number: 011367 Provider number: 155761 AIM number: 200851590 Census Bed Type: SNF/NF: 113 SNF: 16 Total: 129 Census Payor Type: Medicare: 35 Medicaid: 77 Other: 17 Total: 129 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 13, 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jocelyn Brooks	MSN, RN, DNS	04/21/2023

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure care plans were in place for 2 of 22 residents reviewed for care plans (Resident 119 and 184). Findings include: On 3/31/23 at 2:20 p.m., Resident 119's medical chart was reviewed. A new facility diagnosis, dated 2/3/23, indicated, "other seizures." Further diagnoses were dementia progress degeneration of the brain), chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), history of multiple falls with fractures: sacrum, rubs, proximal right femur, weakness, history of falling, abnormalities of gait and mobility, unsteadiness on feet, and reduced mobility. A nursing progress note, dated 1/31/23 at 10:23 p.m., Licensed Practical Nurse (LPN) 15 indicated Resident 119 was sitting at a table at 6:48 p.m., when she observed the resident begin to actively seizure, noting her arms and legs stiffen and her body convulse (involuntary contraction of the muscles). Her head tilted back, her face flushed, and her eyes rolled back. The resident initially did not respond to verbal or tactile stimuli. The total time of active convulsing was 30-45 seconds. LPN 15 gently shook the resident's shoulders and the resident responded with garbled speech with her	F 0656	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?** · No residents were affected. **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.	04/24/2023

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	eyes rolled back. Within a few seconds, the resident was able to speak clearly and accurately. She stated her full name and date of birth. Her vitals were stable, except her oxygen saturation was 87% on room air. LPN 15 observed the resident appear to lose consciousness again for a few seconds on two additional occasions. The resident exhibited body stiffening, her head tilted back, and eyes rolled back. The estimated time of each of these incidents were 3-5 seconds. Two CNAs entered the dining room and stayed at resident's side while LPN 15 retrieved an oxygen concentrator and applied 2 LPM (liters per minute) of oxygen via nasal cannula (NC). The NP and DON were notified of findings and order received per NP to call 911 and send Resident 119 to the emergency room (ER) if her daughter was in agreement. LPN 15 called Resident 119's daughter who confirmed she did want her mother to be seen at the ER. Resident 119 had 3 additional episodes in which her head [neck] went flaccid and her eyes rolled back for approximately 3-5 seconds. Emergency Medical Technicians (EMT) arrived and were provided all pertinent paperwork including her code status form. Resident 119 was transported via ambulance to the ER, Called ER and gave report. Daughter called stating she was at the hospital with her mother and would update staff with the findings. Records from the local hospital Emergency Department (ED) indicated Resident 119 was admitted for seizures. She apparently had episodes that lasted 5 -30 seconds and was reported as, "eyes rolling back, whole body shaking," with consciousness between episodes. Unsure of how many seizures she had at the facility. In the ED she had an x-ray notable for fracture of the sacrum, acute or sub-acute and 3rd and 4th right rib fractures. She was given Keppra,		· All residents' care plans will be reviewed by IDT to ensure accuracy of diagnoses and code statuses are in place on care plan by 4/24/2023. · All MDS employees will be in-serviced and educated by Regional RAI Consultant on accuracy of care planning by 4/24/2023. · All members of the IDT will then be in-serviced by the MDS team by 4/24/2023. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** · All MDS employees will be in-serviced and educated by Regional RAI Consultant on accuracy of care planning by 4/24/2023. · All members of the IDT will then be in-serviced and educated by the MDS team by 4/24/23. · The MDS Coordinator/Designee will audit a minimum of 5 residents' careplans for diagnosis and code status accuracy weekly x 4 weeks, monthly x 3 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	

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	1 L (liter) of normal saline (NS). There was a concern for cystitis. She was given gentamycin and ampicillin. Neurology was consulted. The one time medication of levetiracetam (Keppra) was given IV push on 1/31/23 at 8:50 p.m. New onset seizures of uncertain etiology (origin), seizure precautions, and neurology consulted. The hospital assessment/plan indicated, "seizure," with, " ...potentially contributing etiologies to include chronic microvascular changes and dementia, UTI may have contributed to altered mental status but unlikely to have significantly increased her seizure risk ...." and " ...get brain MRI (internal imaging) ...." Hospital records, dated 2/2/23, indicate on physical exam indicated patient was frail and weak, more awake than yesterday. Her assessment/plan indicated seizure. Suspicious for recent new onset seizures, being seen by neurology, currently on seizure precautions as well as Keppra. The Inpatient Discharge Instructions indicated her diagnoses included, but were not limited to, anemia, B12 deficiency, coronary artery disease, COPD, dementia, difficulty walking, hypertension, and seizure. Educational materials were provided for the resident of, " ...Seizure: New Onset with Unknown Cause (Adult) ...You have had a seizure. A seizure happens when a surge of random, uncontrolled electrical activity occurs in the brain. A seizure can have many causes. Often it's not possible to figure out the exact cause of a seizure from a single exam You might need other tests. Having 1 seizure doesn't mean that you will continue to have seizures, It doesn't mean that you have epilepsy. But until you doctor knows the cause the your seizure, you are at risk for another seizure. Having 1 seizure without a know		areas of concern or areas not meeting threshold. **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?** · QA tool-Care Plan Accuracy-will be completed by MDS/Designee until compliance is maintained; increasing frequency if thresholds are not met. · The MDS/designee will be responsible for the completion of the QA Tool weekly x 4 weeks, then monthly x 6 months, and then quarterly thereafter until compliance is maintained with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · 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 the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 4/24/2023**	

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	cause put you at higher risk of having another seizure, especially in the next 2 years ...." A Nurse Practitioner's progress note, on 2/6/23 at 2:13 p.m., indicated Resident 119 was being seen for an Acute/Medically Necessary visit, after readmission to the facility for medical management. Resident was seen today for review and medical management after recent return to the facility. Resident 119 was sent out for 'seizure-like activity' and was being treated for UTI at time of transfer. The hospital reported she was worked up for Seizure of unknown origin, UTI and rib fractures. The hospital discharge instruction indicated to stop some of her chronic medications: bupropion 150 mg daily (antidepressant), Marinol 2.5 mg twice daily (treats nausea, vomiting, appetite loss), quetiapine 25 mg twice daily (antipsychotic), Incruse Ellipta 62.5 mcg daily (respiratory inhaler) and Ventolin HFA 90 mcg 2 puffs four times a day as needed (respiratory inhaler). The hospital added in an additional 25mg of Sertraline (antidepressant) daily. Resident was in wheelchair, pleasant and cooperative remains a high fall risk, no side effects from recent medication changes noted. Assessed to evaluate and review medical records in order to direct medical care. Neurological issues were memory problems. In my judgement, as the physician/provider, the care provided today required professional assessment, planning, management, or monitoring. The Nurse Practitioner progress notes, dated 1/31/23 and 3/6/23, before and after the note written on 2/6/23 did not mention any information regarding the new onset of seizures or risk of seizure plan of care. Resident 119's care plan, dated 3/25/23, indicated			

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	she was at risk for falls due to repeated falls and resulting in right rib fractures, sacral fracture, urinary tract infection (UTI), right hip fracture, history of incarcerated (trapped and swollen) inguinal (groin) hernia, small bowel obstruction, dementia, anemia, coronary artery disease (CAD), chronic obstruction pulmonary disease (COPD), hyperlipidemia (HLD), hypertension (HTN), prolonged QT interval (heart rhythm disorder), pulmonary nodule, chronic kidney disease (CKD), history of tobacco use, history of transient ischemic attack (TIA) (stroke), prediabetes, osteoarthritis (OA), degenerative disc disease (DDD), and depression. Factors contributing to her fall risk include a history of falls, residents' age, incontinence, use of high risk medications, need for assistance with mobility, cognitive deficits, impulsive, history of wearing house shoes from previous home setting (with slippery soles). The nursing approaches included, but were not limited to, staff assist resident with standing when restless and/or attempting to self-transfer, increased general supervision of resident during activities and meals, assist resident with toileting and keep pathways free of clutter. The "at risk" fall care plan did not mention the resident was at risk for seizures or had a history of seizures at any time. Seizures were not mentioned under the problem, goal, or approaches. All care plans were reviewed. The facility did not have an at risk for seizures or a history of new onset seizures care plan. Resident 119's other care plans were reviewed. They did not mention the resident was at risk for seizures or had a history of new onset seizures. a. Resident was at risk for skin breakdown due to repeated falls, dated 2/22/23. b. Resident was at risk for insomnia with diagnosis of insomnia, dated 2/6/23.			

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	c. Resident was experiencing delusions, including a mechanical cat being a real cat, dated 1/10/23. d. Resident became resistant and combative with incontinence care, dated 12/21/22. e. Resident refused showers and care, dated 12/9/23. f. Resident became verbally aggressive due to believing another room was hers and other resident had same first name as this resident. She went into other resident's rooms, dated 12/5/23. g. Resident packed up belongings in suitcase and carry them around at times when exit seeking, dated 11/30/22. h. Resident enjoyed the following types of activities: Cards, music, socialization, work related tasks, dated 11/30/22. i. Resident was at risk for elopement per the Elopement Risk Assessment as evidenced by a dementia diagnosis and exit seeking behaviors, dated 11/30/22. j. Resident's return to the community was not feasible due to her need for 24 hour care due to dementia. The resident's discharge goal is to remain in the facility, dated 11/30/22. k. Resident was at risk for signs and symptoms of anxiety (worried facial expressions, repetitive movements, shortness of breath, nausea, sweating, tremors, irritability, insomnia, reports of anxiety, etc.). Resident had a diagnosis of dementia, dated 11/30/22. l. Resident was at risk for signs and symptoms of depression (sad facial expression, withdraw, decreased appetite, tearfulness, insomnia, verbalization of depression, etc). Resident has a diagnosis of dementia, dated 11/30/22. m. Resident resided on a secured memory care unit related to diagnosis of of dementia. Physician had determined resident was clinically appropriate to reside on secured unit, dated 11/30/22.			

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	n. Resident exhibits cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score less than 13. Resident was severely impaired, dated 11/30/22. o. Resident/legal representative had formulated an advanced directive, dated 11/28/22. p. Resident was at risk for bleeding/bruising related to use of aspirin (ASA), dated 11/28/22. r. s. Resident was at risk for alteration in mood status: depression/depressive symptoms due to placement in nursing facility, loss of independence, dated 11/28/22. t. Resident was at risk for ineffective tissue perfusion, dated 11/28/22. u. Resident was at risk for impaired gas exchange, dated 11/28/22. v. Resident was at risk for adverse side effects related to use of psychotropic medication, dated 11/28/22. x. Resident had upper dentures, at risk for complications, dated 11/28/22. y. Resident was at risk for constipation due to: decrease mobility, medications, dated 11/28/22. z. Resident was at risk for pain, dated 11/28/22. aa. Resident was at risk for fluid imbalance, dated 11/28/22. bb. Resident required assistance with toileting, dated 11/28/22. cc. The resident's life story details, dated 11/28/22. dd. Resident Strengths: Strong-willed, opiniated, hardworking, caring, and compassionate, dated 11/28/22. ee. Resident did actively exit seek, dated 11/28/22. ff. Resident had nutritional risk due to dementia and malnutrition, dated 11/24/22. gg. Resident was at risk for skin breakdown due to repeated falls, dated 11/24/22. hh. Resident required assistance with activities of daily living (ADL) including bed mobility, transfers, eating and toileting, related to debility			

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	with repeated falls, 11/24/22. ii. Resident required assistance and/or monitoring for AM/PM care, nutrition, hydration, and elimination, dated 11/24/22. During an interview, on 4/4/23 at 10:45 a.m., the ADON indicated Resident 119 had a seizure of 1/31/23. She went to the hospital on 1/31/23, and returned 2/3/23. Once she went to the hospital there was an incidental finding of an acetabular fracture and rib fractures. During an interview, on 4/4/23 at 11:30 a.m., regarding whether Resident 119 should have had a seizure (or risk of seizure) care plan, the MDS Coordinator (MDSC) indicated there were no follow-up orders and no medications after her hospital stay. This information was confirmed by the Nurse Practitioner's (NP) note on 2/6/23. Safety measures were in place in the fall care plan. The concern was to prevent injuries and the fall care plan did that. The IDT (Interdisciplinary Team) indicated there was no seizure care plan needed because the hospital discharge (DC) paperwork indicated seizure-like activity. The DC summary did have a diagnosis of seizure, but when talking to the NP for this facility during the follow-up she stressed it was seizure-like activity. The facility felt like the fall care plan identified the risks appropriately. The resident did not fall with this event that sent her to the hospital. When someone would have a seizure, one thing is to prevent injuries, and assuming one would fall with a seizure. The facility is not monitoring for seizure activity. The quarterly MDS assessment, dated 2/17/23, indicated she was diagnosed with a seizure disorder or epilepsy. During an interview, on 4/4/23 at 11:48 a.m., the DON indicated the first hospital ordered follow-up			

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	for the seizure-related MRI was completed. The second MRI was scheduled. During an interview, on 4/4/23 at 12:52 p.m., the MDSC indicated after reading through the NP and physician notes and noticed NP and physician did not have a diagnosis of seizures. She indicated she called the NP, NP indicated she and the physician believe the resident did not have a new diagnosis of seizures. MDSC obtained a verbal order from the NP to discontinue the diagnosis of seizures in the resident's medical record and removed the active diagnosis of seizures on the quarterly MDS assessment, dated 2/17/23. On 4/4/23 at 11:17 a.m., the Minimum Data Set (MDS) was reviewed. The quarterly assessment, dated 2/17/23, indicated Resident 119 had a seizure disorder or epilepsy. On 4/4/23 at 1:01 p.m., the MDSC indicated she was deleting the diagnosis of seizures after talking with NP 16. On 4/4/23 at 2:28 p.m., the ADON indicated the facility had 2 residents with seizure activity in the Memory Care area. 2. On 3/30/23 at 10:52 a.m., Resident 184's record was reviewed. A physician's order, dated 3/17/23, indicated the resident was a Full Code status. No advanced directive (code status) care plan was observed. His diagnoses included, but were not limited to, chronic obstruction pulmonary disease (constriction of the airways and difficulty/discomfort in breathing), congestive heart failure (chronic condition where the heart			

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	does not pump blood as well as it should), and obstructive sleep apnea (intermittent airflow blockage during sleep). No POST form (Physician Orders for Scope of Treatment) was observed. During an interview, on 4/3/23 at 9:56 a.m., Resident 184 indicated his advanced directive was that he wanted resuscitation. During an interview, on 4/3/23 at 10:03 a.m., the Director of Nursing (DON) reviewed Resident 184's chart. She indicated she was not seeing an advanced directive (code status) care plan. He was admitted on 3/16/23. During an interview, on 4/3/23 at 11:21 a.m., the MDS Coordinator indicated Resident 184 did not have a code care plan. One was started 4/3/23. A current policy, titled, "Advanced Directive Policy," dated 2/2020, was provided by the Director of Nursing, on 4/3/23 at 2:00 p.m. A review of the policy indicated, " ..the facility will follow the resident's plan of care to reflect the resident's preferences as expressed in the Directive, in accordance with state law ...." 3.1-35(a) 3.1-35(b)(1)			
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			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observations, interview and record review, the facility failed to ensure a resident who had a history of chronic venous ulcers and wound infections received interventions to prevent new areas from re-opening and becoming infected for 1 of 5 residents reviewed for nursing services (Resident C), and the facility failed to ensure a resident received a routine lab and complaints of acute pain noted on her Dialysis communication log were addressed for 1 of 5 residents reviewed for nursing services (Resident E). Findings include: 1. During a confidential interview, it was indicated, Resident C had been in a car accident in which her legs had been run over. She had broken her left ankle in three places and had bad road rash on her right leg. Before the accident she had struggled with poor circulation and sores, but the accident made it worse. She came for rehabilitation and had been going out-patient to a wound clinic for her legs. At the end of January, her leg wounds had healed, and she no longer required out-patient wound care, and the Brownsburg Meadows took over her leg care. Not long after they took over, Resident C developed new wounds. It was indicated when family visited they always found her in her wheelchair, and they had to help get her into her recliner to elevate her legs Upon the family's return from vacation a few weeks later, Resident C was found without her compression stocking on, and several new wounds had developed. It was indicated, "her legs looked awful, she had loose wrapped in place at times that were soaked with drainage." There were	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 C care plan was reviewed and updated by IDT on 4/19/23. Electronic health record was reviewed, and a skin assessment has been completed within the last 7 days as of 4/19/2023. · Resident E is deceased. **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	04/24/2023

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	several large blisters, and her legs were red and tender.. The family arranged to have her taken back to the out-patient wound clinic the following day. When Resident C arrived to the wound clinic, they told her she needed to go directly to the Emergency Room (ER). So Resident C went to the ER where she was admitted and it was determined she had cellulitis (bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin) and Methicillin-resistant Staphylococcus aureus (MRSA, an infection that is difficult to treat because of resistance to some antibiotics. Staph infections-including those caused by MRSA-can spread in hospitals, other healthcare facilities, MRSA infection in her wounds). During an interview on 3/30/23 at 11:38 a.m., Resident C was observed in her room. She sat upright in her wheelchair (WC). There was a personal recliner next to her bed. She was neat, clean, and odor free. Although she wore long pants, they pulled up at her ankles so that stocking/wraps were observed in place to both her legs. When asked what happened to her legs and why they were wrapped, Resident C sighed deeply and chuckled slightly, she indicated, "my legs are a mess." She indicated, after a car accident, the sores on her legs had gotten worse and were always giving her problems. She indicated, "they are much better now," but she still has some pain associated with the sores and swelling. When asked if she ever liked to lay down in bed or elevate her legs in her recliner, Resident C indicated sometimes, but it was hard to get staff to help her transfer since she could not stand on her own. Throughout the survey week, Resident C was observed seated in her WC and not utilizing her		potential to be affected by the alleged deficient practice. · All residents' receiving dialysis services will be reviewed to ensure communication binder information has been reviewed upon return from dialysis center by 4/24/2023. · All residents with active or a history of wounds will have their careplan reviewed to ensure preventative measures are in place by 4/24/2023. · All residents will have a weekly skin assessment completed within the last 7 days by 4/24/2023. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** · All clinical members of the IDT team will be educated on ensuring dialysis residents were reviewed upon return from dialysis for follow-up needs by 4/24/2023. · All clinical members of the IDT team will be educated on wound prevention careplanning and weekly skin assessment follow-up by DNS/designee by 4/24/2023. · Nurses will be in-serviced and educated by DNS/designee on reviewing dialysis binder for follow-up needs by 4/24/2023. · Nurses will be in-serviced and educated by DNS/designee	

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	recliner or bed to elevate her legs. On 3/30/23 at 2:13 p.m., Resident C was observed. She remained seated in her WC, in her room as she watched T.V. On 3/31/23 at 12:29 p.m., Resident C was observed. She was seated in her WC and rummaged through her dresser drawers. On 3/31/23 at 2:45 p.m., Resident C was observed. She was seated in her WC and watched T.V. On 4/3/23 at 9:58 a.m., Resident C was observed. She was seated in her WC and rummaged through her dresser drawers. She had an envelope and greeting card and indicated she was looking for a pen. On 4/3/23 at 2:34 p.m., Resident C was observed. She remained in her WC. She pushed herself slightly back in forth, in almost a rocking motion. On 4/4/23 at 10:15 a.m., Resident C was observed being assisted into the shower room by a Certified Nursing Assistant (CNA). On 4/4/23 at 11:20 a.m., Resident C was observed seated in her WC in her room. Her hair was damp from her recent shower, and she indicated, she enjoyed her shower and felt very good. On 3/31/23 at 12:30 p.m., Resident C's medical record was comprehensively reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, chronic peripheral vascular disease (PVD, a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), heart failure and cellulitis.		on completing weekly skin assessments per order by 4/24/2023. · DNS/designee will review dialysis communication log is completed and timely by reviewing each day and ensuring concerns are being addressed. · DNS/designee will review medical records to ensure weekly skin observations are completed. · IDT will review care plans for residents who are new admits or have a change of condition to ensure the care plan is updated with wound care and dialysis. **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-Quality of Care to audit a minimum of 5 residents' dialysis binders, skin careplan, and weekly skin assessment compliance 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	

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	A nursing progress note, dated 1/26/23 at 3:47 p.m., Resident C had been to her out-patient wound appointment. Upon return, her wraps had been changed and the areas had all been healed, therefore, the facility was to resume Resident C's edema management. She had a physician order dated 1/26/23 for weekly skin observations to be completed on Wednesdays. The record lacked documentation that weekly skin observations had been completed 2/8/23, 2/15/23, and 2/22/23. On 2/6/23 the Nurse Practitioner, (NP) conducted a fall follow-up visit and although her skin was noted to be fragile, with pedal pulse palpable (PPP, which means a pulse can be detected on the top of the foot), the NP did not review and or assess Resident C's skin beneath her compression wraps. During the same visit, the NP gave new order to start Resident C on an antibiotic medication for indications of a urinary tract infection (UTI). A nursing progress note, dated 2/13/23 at 11:18 p.m., indicated Resident C's 2-layer wraps had been changed, although there was no indication of the condition of her skin at the time of the treatment. A Skin Sweep tool was dated 2/20/23. The sheet indicated Resident C's leg wraps were in place, there were no new areas of concern noted on the sheet, and interventions currently in place were barrier cream at bedside, WC cushion in place and at least 2 pillows on bed. A new skin even was opened on 2/20/23 which indicated, "impaired skin integrity to LLE" (left		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 the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 4/24/2023**	

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	lower extremity). The area measured 4 cm (centimeters) long by 3 cm wide. The area was bright red, and a new order was placed to cleanse skin impairment to LLE with normal saline, pat dry and apply skin prep to the peri wound then apply Medihoney pad and cover with foam dressing, and to change 2 times a week with a 2 layer wrap. During an interview with the Director of Nursing (DON) and Wound Nurse (WN) present, on 4/4/23 at 11:27 a.m., the WN provided a copy of a nursing progress note. The progress note was a late-recorded note created 4/4/23 at 10:13 a.m. but dated effective for 2/20/23. The note indicated, Resident C's 2-layer wraps had been changes and in doing so, a skin tear with discoloration was noted to the LLE. Resident C indicated she bumped it when getting into bed. The NP was notified and placed new orders for treatments. Resident C was encouraged to elevate her bilateral lower extremities when at rest, either in bed or in her recliner. On 2/22/23 the NP visited Resident C for a regularly scheduled medical review. The note indicated, "[Resident C] seen today for review and medical management ... she has multiple comorbidities that increase her risk of complications, thus routine review is deemed necessary to evaluate ... goes to outside wound for treatment with bil [bilateral] LE wraps in place ... nursing does not report acute complaints/concerns ...." The NP note indicated Resident C was still utilizing an out-patient wound clinic even though the facility had resumed treatments after 1/26/23 and the NP note did not mention/review the new area/skin tear noted on her leg from 2/20/23.			

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	A nursing progress note, dated 2/24/2at 4:27 p.m., indicated, that during an assessment of Resident C's LLE the area was red, warm and tender with moderate serosanguinous drainage. The NP was notified, and a new order was placed for Keflex (an antibiotic medication) for cellulitis. On 2/25/23 the interdisciplinary Team (IDT) to discuss Resident C's skin impairments on her LLE, a bruise to her left buttocks and a rash to her upper buttocks. A late-entry NP note was dated effective for 2/27/23, but was note was not recorded until 3/8/23 at 4:38 p.m. It was an acute visit for follow-up related to Resident C's cellulitis. The NP note still indicated Resident C was seen by an out-patient wound clinic for her chronic wounds, even though the facility had taken over treatment of her edema since 1/26/23. A weekly skin check was conducted on 3/1/23 and noted chronic edema and venous stasis to her BLEs. On 3/2/23 four new skin events were opened as Resident C acquired new open areas as follows: a. right medial lower leg which measured 6.5 cm long by 4.7 cm wide and 0.1 cm deep. b. left lateral lower leg which measured 1.6 cm long by 3.0 cm wide. c. left lower shin which measured 1.5 cm long by 3.1 cm wide by 0.1 cm deep. d. left lateral posterior calf which measured 3.2 cm long by 8.1 cm side and 0.1 cm deep. Interventions/treatments for the area was to continue compressions and encourage elevation. Resident C's current comprehensive care plans			

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	were reviewed. The care plan lacked documentation/revision to encourage Resident C to elevate her legs. A nursing progress note, dated 3/5/23 at 3:38 p.m., indicated, Resident C's family member raised concerns about the new BLE wounds. Resident C's BLE were being treated for cellulitis and had completed a course of antibiotics. Her BLE both still has redness but were not warm to touch. There was noted tenderness on the sites with open areas and 2 blisters (both leaking) and a small open wound on LLE. Skin prep was being applied on blisters they were covered with alginate dressing and ABD pad. Medihoney was being applied on open wound. The daughter indicated she would take Resident C to the wound clinic. A hospital summary record dated 3/6/23 indicated, Resident C was treated for a wound infection. " ...Patient who presented to the IU West ED [emergency department] sent from wound clinic for evaluation of BLE wounds & cellulitis. History obtained from pt's [patient], pt's family at bedside and EMR [electronic health record]. She has a history of BLE wounds following trauma from a MVC [motor vehicle crash] about 1 year ago. Those wounds completely healed per daughter, but she had continued to follow with out-patient PT [physical therapy] wound for compression wrapping for chronic BLE edema. About 4 weeks ago, her ECF [extended care facility] took over management of her LE wrapping. Daughter states things seemed to be going ok at first, but when she and her husband returned from an out of town trip on 3/2/23, the patient had BLE redness and open wounds for which she was told the patient had just completed a 5 day course of Keflex for infected wounds/cellulitis ... pt's legs were not			

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	wrapped at the time and she does believe they had had them wrapped for at least the 5 days prior. Since 3/2/23, pt's legs have looked worse each day with worsening redness and wounds. The facility eventually wrapped her legs, but family noted that pt was having yellow serous drainage from her wounds which were soaking through the dressings. Daughter made an appointment with West PT [physical therapy] wound for today and after evaluation in the wound clinic, pt was sent to the ED for further management. Pt endorses pain in her bilateral lower legs and was as mild nausea without emesis ...." She was admitted to the hospital with a primary diagnosis of BLE cellulitis with infected venous stasis ulcers/open wounds, although sepsis was rules out, she was found to have staph MRSA and Acinetobacter. During an interview with the DON and the WN on 4/4/23 at 11:27 a.m., the DON indicated Resident C had chronic wounds and used antibiotics long enough to have developed a resistance. The DON indicated the facility completed treatments as ordered and had encourage Resident C to consider a 2-gram sodium diet to reduce her sodium intake, but she and her family had declined. Further, the new areas on her legs also coincided with a UTI and there was no way to determine where the infection came from since she had been in the hospital and went out-patient to the wound clinic. On 4/3/23 at 12:45 p.m., the DON provided a copy of current facility policy titled, "Skin Management Program," revised 5/2022. The policy indicated, "It is the policy of American Senior Communities to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop			

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	pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with profession standards of practice to promote healing, prevent infection and prevent new ulcers from developing ... interventions to prevent wounds from developing and/or promote healing will be initiated based upon the individual's risk factors ... a plan of care will be initiated to include resident specific risk factors and contributing factors with appropriate interventions implemented ...." 2. On 3/31/23 at 2:00 p.m., Resident E's closed record was reviewed. She was a long-term care resident who had resided in the facility since 2016. At the time of her discharge on 3/13/23 she had active diagnoses which included, but were not limited to, end stage renal disease and dependence on Dialysis, hypertensive (high blood pressure) heart disease with heart failure, and Alzheimer's. A nursing progress note, dated 3/2/23 at 6:11 p.m., indicated, Resident E's levothyroxine (a medicine used to treat an underactive thyroid gland) was increased to 200 mcg (micrograms). Side effects of levothyroxine can include, but is not limited to, difficult or labored breathing, fast, slow, irregular, pounding, or racing heartbeat or pulse, (which are similar symptoms of a panic attack). A nursing progress note, dated 3/4/23 at 10:04 p.m., indicated, Resident E had an episode of oxygen desaturation that morning. She stated that she had a "panic attack." Her oxygen saturation was check and was at 99% with supplemental oxygen at 2 L (liters) per minutes. No further			

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	respiratory distress or shortness of breath was noted. The record lacked documentation of what her desaturated oxygen level was and lacked documentation that the physician had been notified of the episode. Resident E had a physician's order for routine labs with instructions to collect a full CBC (complete blood count), CMP (comprehensive metabolic panel) and TSH (thyroid stimulating hormone) on the 1st Friday of March, June, September and December. She had a physician's order to check her Dialysis binder upon her return from appointments. The corresponding lab should have been collected on 3/1/23 but was collected a week later on 3/7/23. The lab results, (which were received on 3/9/23, after Resident E was transferred to the hospital) indicated early signs of infection as her white blood cell (WBC) count was 25.7 and her neutrophils, (a type of white blood cell that helps the body fight infection) was also high at 96.5. On 3/6/23 Resident E attended her schedule Dialysis appointment. A Dialysis Communication log indicated her vital signs were within normal limits, bruit and thrill were present in her fistula. Upon her return, the corresponding Dialysis Communication Log indicated, Resident E showed signs of increased anxiety and complained of left shoulder blade pain. When the nurse completed a set of vital signs, as ordered by the physician, her blood pressure (BP) was noted to be 87/54. The record lacked documentation the			

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	Communication Log had been reviewed by the nurse. The record lacked documentation the physician was notified of her increased anxiety and acute pain in her shoulder, and her low BP. On 3/8/23 Resident E attended her scheduled Dialysis appointment. A Dialysis Communication log indicated her vital signs were within normal limits, bruit and thrill were present in her fistula. Upon Resident E's return to the facility, she was not unloaded from the ambulance, instead the facility nurse was called to come assess Resident E in the ambulance as she had experienced a change of condition in route. A nursing progress note, dated 3/8/23 at 1:17 p.m., indicated EMS (emergency medical staff) called facility for nurse to assess resident upon arrival from dialysis. Writer assessed Resident while on EMS truck. Resident was noted with clammy skin, tachycardia (rapid heart rate), hypoxia (low oxygen saturation) and she was slow to respond. She feels "off." Her vital sings indicated her heart rate was 167, blood pressure was 97/72, respirations were 37 and staff was unable to obtain an oxygen saturation level. She was immediately sent to the ER for evaluation and treatment. A corresponding Dialysis Communication Log (which was not reviewed by the nurse as Resident E was sent directly to the hospital) indicated, Resident E had complained of right shoulder and back pain, which had increased in the previous days with a note to "please eval!" On 4/3/23 at 11:43 a.m., a nursing progress note			

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	was created late and placed with an effective date for 3/8/23 at 1:35 p.m., which indicated, the Dialysis center had notified the facility via a phone call that Resident E was not "looking good" and that she was having shoulder pain with no concerns of distress. Her vital signs were not out of range during treatment but upon arrival to the facility, EMS transport had nurse assess resident while still in ambulance. The nurse instructed EMS to take her to the ER. During an interview on 4/3/23 at 12:33 p.m., the Assistant Director of Nursing (ADON) indicated she put a late note in because she forgot to add it the day of but remembered that the Dialysis center had called to let the facility know that Resident E wasn't feeling good. She had been going to that Dialysis center for a long time and they knew her well, so the ADON expressed concern about why they would have sent her back to the facility in that condition. When the ADON called back to ask why, the center indicated she was not like that when she left Dialysis, that she must have had a change of condition during the ambulance ride. When she left the Dialysis center, she only complained of being a little more tired than usual. The ADON indicated, they would have sent her to the hospital when she returned from Dialysis anyway, since they had just received her lab results while she was out, and the lab indicated signs of infection. During the survey entrance conference on 3/29/23 at 10:06 a.m., a copy of the facilities current policy for Dialysis was requested and provided. The policy was titled, "Dialysis Care," revised 11/2017. The policy indicated, "It is the policy of American Senior Communities to ensure that residents requiring dialysis receive such services, consistent with professional standards of			

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BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

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	practice, the comprehensive person-centered care, and the residents' goals and preferences. The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with profession standards of practice ... the nurse in charge at the time of return will review paperwork for new orders and/or notes accompanying the resident ...." On 4/3/23 at 12:45 p.m., the DON provided a copy of current facility policy titled, "Resident Change of Condition Policy," revised 11/2018. The policy indicated, "It is the policy of this facility that all changes in resident conditions will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ...." On 4/3/23 at 12:45 p.m., the DON provided a copy of current facility policy titled, "Labs and Diagnostics," revised 11/2017. The policy indicated, "It is the policy of American Senior Communities to provide or obtain laboratory and diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services ...." This Federal tag related to Complaint IN00404071. 3.1-37(a)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning,			

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	is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observations, interviews, and record review, the facility failed to ensure respiratory equipment was stored properly to prevent the potential for cross contamination and infection for 3 of 11 residents reviewed for respiratory equipment/services and supplies (Residents 108, 334, and 184). Findings include: 1. During an observation on 3/29/23 at 9:57 a.m., Resident 108 was lying in his bed. He was alert. He had a Bi-pap machine sitting on his nightstand. The mask was not inside a protective bag. Resident 108 indicated he wore the mask 50% of the time and not all the time because the mask did not fit properly. He indicated he was not assessed for the fitting of his mask, now he was stuck with two masks that did not fit. He indicated his orders were for generic settings and not specific for him. A comprehensive record review was completed for Resident 108. He had the following diagnoses, but no limited to obstructive sleep apnea, neuromyelitis, type 2 diabetes, acute transverse myelitis in demyelinating disease of the central nervous system, pressure ulcer of sacrum, essential hypertension, atrial fibrillation, chronic embolism, gastro-esophageal reflux disease (GERD) and hyperlipidemia. 2. During an observation on 3/29/23 at 10:24 a.m., Resident 334 was lying on her right side in bed. She had a CPAP machine sitting on her	F 0695	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 108 was provided another well-fitted bi-pap mask in a protective bag on 4/21/2023. ·Resident 334 has discharged. ·Resident 184 has discharged. **2.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 who utilize	04/24/2023

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	nightstand with a mask and tubing. The mask was not inside a protective bag. A comprehensive record review was completed on 3/31/23 at 2:52 p.m. She had the following diagnoses, but not limited to anemia, coronary artery disease, hypertension, gastro-esophageal reflux disease (GERD), renal insufficiency, diabetes mellitus, hyperlipidemia, arthritis and osteoporosis.3. During an interview, on 3/30/23 at 10:02 a.m., Resident 184 indicated he wore oxygen (O2) as needed. He indicated he went to Indianapolis yesterday and they brought the portable O2 just in case. On 3/30/34 at 10:03 a.m., Resident 184's portable O2 canister was observed behind his bedside table, attached to it was a nasal cannula (NC) draped across the chair. It was not bagged. An O2 concentrator was observed behind the bedside table, it was attached to his CPAP (method of respiratory therapy when air is pumped into the lungs during spontaneous breathing). The CPAP mask and tubing were still connected. The mask was not bagged, and the tubing was draped over the bedside mobility rail. On 3/31/23 9:28 a.m., Resident 184's CPAP mask and tubing were observed draped over the mobility bar hanging in the air, The mask was not bagged. The NC tubing attached to the portable O2 was draped over the chair with the NC touching the floor. On 4/3/23 at 12:10 p.m., Resident 184's record was reviewed. The physician order, dated 3/30/23, indicated to provide O2 at 2 L per nasal cannula, as needed, for O2 levels below 90%.		respiratory services have the potential to be affected by the alleged deficient practice. · All residents who utilize respiratory equipment will be reviewed by IDT to ensure all equipment is stored properly to prevent infection by 4/24/2023. **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 will be in-serviced and educated by the DNS/designee by 4/24/2023. · All nursing employees will be in-serviced and educated on respiratory equipment storage by 4/24/2023. · DNS/designee will round on varying shifts to ensure respiratory equipment is store properly per policy **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?** · QA tool-Respiratory Storage-will be completed by DNS/Designee until compliance is maintained; increasing frequency if thresholds are not met. · The DNS/designee will be responsible for the completion of the QA Tool weekly x 4 weeks,	

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	A care plan, dated 3/17/23, indicated Resident 184 had the potential for impaired gas exchange related to chronic obstruction pulmonary disease (constriction of the airways and difficulty/discomfort in breathing), congestive heart failure (chronic condition where the heart does not pump blood as well as it should), and obstructive sleep apnea (intermittent airflow blockage during sleep). It included to administer O2 as ordered. On 4/3/23 at 11:47 a.m., the DON indicated the NC and CPAP masks should have been bagged. They should have all been bagged. On 4/4/23 at 2:26 p.m., the Assistant Director of Nursing (ADON) indicated the facility had 11 residents who were on oxygen and 9 resident who used CPAPs. A current policy, titled, "Oxygen Therapy and Devices," with no date, was provided by the Director of Nursing (DON), on 4/3/23 at 10:59 a.m. A review of the policy indicated, " ...Oxygen Devices ...place in a labeled bag when not is use ...." 3.1-47(a)(6)		then monthly x 6 months, and then quarterly thereafter until compliance is maintained with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · 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 the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 4/24/2023**	
F 0757 SS=E Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or			

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	§483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to include an indication for use of medications for 3 of 5 residents reviewed for unnecessary medications (Resident 108, 90, and 127). Findings include: 1. A comprehensive record review was completed for Resident 108. He had the following diagnoses, but no limited to neuromyelitis, type 2 diabetes, acute transverse myelitis in demyelinating disease of the central nervous system, pressure ulcer of sacrum, essential hypertension, atrial fibrillation, chronic embolism, gastro-esophageal reflux disease (GERD) and hyperlipidemia. Resident 108 had orders for the following medications. The medications did not include an appropriate indication for usage. a.) Benadryl (diphenhydramine hcl) 25mg capsule every 6 hours/PRN (as needed) for encounter for other specified aftercare.	F 0757	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 108 medication orders were reviewed to ensure adequate indication for use was	04/24/2023

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	b.) Cholecalciferol (vitamin D3) 1,250 mcg (50,000 unit) capsule, once a day on the fourth Friday of the month for encounter for other specified aftercare. c.) Clorpactin WCS-90 (oxycholorosene sodium) reconstituted solution at bedtime Monday and Thursday, special instructions: dilute with sterile water, catheter irrigation, instill 100ml over 5 minutes for encounter for other specified aftercare. d.) Ferrous gluconate 240mg (27mg iron) tablet twice a day for encounter for other specified aftercare. e.) Flonase Allergy Relief (fluticasone propionate) 50mcg/actuation spray suspension once a day to each nare for encounter for other specified aftercare. f.) Lipitor 40mg tablet once daily for encounter for other specified aftercare. g.) Lubricant eye drops (carboxymethylcellulose sodium) 1 drop to both eyes at bedtime for encounter for other specified aftercare. h.) Metoprolol tartrate 25mg tablet two times daily for encounter for other specified aftercare i.) Pantoprazole 40mg tablet, delayed release, 40mg one time daily for encounter for other specified aftercare. j.) Pregabalin 200mg capsule two times daily for encounter for other specified aftercare. k.) Saccharomyces boulardi 250mg capsule two times daily for encounter for other specified aftercare. l.) Thera M Plus (ferrous fumarate) (multivit-iron-fa-calcium-mins) 9mg iron 400mcg tablet one time daily for encounter for other specified aftercare. m.) Topamax (topiramate) 25mg tablet one time daily for encounter for other specified aftercare. n.) Torsemide 20mg tablet one time daily for encounter for other specified aftercare.		present on 4/21/2023. · Resident 90 medication orders were reviewed to ensure adequate indication for use was present on 4/21/2023. · Resident 127 medication orders were reviewed to ensure adequate indication for use was present on 4/21/2023. **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. · All residents' medication orders will be reviewed by IDT to ensure adequate indication for its use is present by 4/24/2023. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** · All clinical IDT members will be in-serviced and educated by DNS/designee on ensuring each medication order has an indication for use by 4/24/2023. · 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	

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	o.) Xarelto 20mg at bedtime for encounter for other specified aftercare p.) Ascorbic acid (vitamin C) 500mg tablet one time daily for encounter for other specified aftercare. q.) Lyrica (pregabalin) 150mg capsule one time daily for encounter for other specified aftercare. 2. A comprehensive record review was completed for Resident 90 on 3/31/23 at 1:59 p.m. She had the following diagnoses, but not limited to type 2 diabetes, sepsis, bipolar disorder, migraine unspecified, not intractable without status migrainosus, pain disorder, hyperlipidemia, essential hypertension, shortness of breath, and personal history of diabetic foot ulcer. Resident 90 had the following medication orders. The medications did not include an appropriate indication for usage. a.) Atorvastatin 20mg tablet at bedtime for encounter for other specified aftercare. b.) Brilinta (ticagrelor) 90mg tablet two times daily for encounter for other specified aftercare. c.) Colace (docusate sodium) 100mg capsule at bedtime for encounter for other specified aftercare. d.) Fenofibrate micronized 134mg capsule once a day for encounter for other specified aftercare. e.) Furosemide 40mg tablet one time per day for encounter for other specified aftercare. f.) Gabapentin 100mg capsule four times per day with 800mg to equal 900mg for encounter for other specified aftercare. g.) Methadone 10mg/5ml solution, 120ml oral one time daily for encounter for other specified aftercare. h.) Nicotine 21mg/24hr patch one time daily for encounter for other specified aftercare. i.) Silver sulfadiazine 1% cream one time daily as		meeting threshold. · DNS/Designee will ensure any new medication prescribed will include appropriate indication of usage. **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?** · QA tool-Unnecessary Meds-Diagnosis Attached-will be completed by DNS/Designee until compliance is maintained; increasing frequency if thresholds are not met. · The DNS/designee will be responsible for the completion of the QA Tool weekly x 4 weeks, then monthly x 6 months, and then quarterly thereafter until compliance is maintained with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · 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 the QAPI committee will re-evaluate the continued need for	

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	needed for other encounter for other specified aftercare. 3. A comprehensive record review was completed for Resident 127 on 3/31/23 at 2:17 p.m. She had the following diagnoses, but not limited to iron deficiency anemia, type 2 diabetes, chronic obstructive pulmonary disease (COPD), schizophrenia, unspecified mood disorder, anxiety disorder, depression, essential hypertension, heart failure, hyperlipidemia, and shortness of breath. Resident 127 had the following medication orders. The medications did not include an appropriate indication for usage. a.) Amlodipine 10mg tablet one time daily for encounter for other specified aftercare. b.) Atorvastatin 20mg tablet one time daily for encounter for other specified aftercare. c.) Cholecalciferol (vitamin D3) 1,250mcg (50,000 unit) capsule one time daily on Thursday for other specified aftercare. d.) Ferrous sulfate 325mg (65mg iron) tablet one time daily on Monday, Wednesday, and Friday. e.) Gabapentin 600mg three times daily for encounter for other specified aftercare. f.) Loratadine 10mg tablet one time daily for encounter for other specified aftercare. g.) Metformin 500mg tablet extended release 24-hour one time daily for encounter for other specified aftercare. h.) Miralax (polyethylene glycol 3350) 17 gram/dose powder one time daily for encounter for other specified aftercare. i.) Wixela inhub (fluticasone propion-salmeterol) 250-50mcg/dose blister with device two times daily for encounter for other specified aftercare. j.) Biofreeze (menthol) 4% gel topical as needed for encounter for other specified aftercare.		the audit. **Date of Compliance: 4/24/2023**	

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	During an interview with the MDS Coordinator on 4/3/23 at 11:10 a.m., she indicated she adds the diagnosis to the resident's chart, then Medical Records assigns the diagnoses to the medication orders. During an interview with Medical Records on 4/3/23 at 11:30 a.m., she indicated she will add the diagnoses to the orders, and they were behind due to COVID-19. A policy titled, "New Orders for Non-Controlled Substances," was provided by the DNS (Director of Nursing Services) on 4/3/23 at 9:00 a.m., it indicated, " ...facility should ensure medication orders include medication name, strength, dose, route, frequency, and indication for use (to reduce medication errors), and stop order, or administration parameters, if any ...." 3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or			

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	regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure staff used appropriate hand hygiene while assisting residents with eating for 4 of 5 residents requiring assistance with eating in the memory care area (Resident 20, 34, 47, and 65) Findings include: On 3/29/23 at 12:57 p.m., Certified Nursing Aide (CNA) 7 was observed standing while assisting Resident 20 with her lunch. On 3/29/23 at 1:07 p.m., CNA 7 was assisting two residents with eating, Resident 20 and 65. She was observed touching Resident 20's clothing by rubbing her arm, then without hand washing, she used the same hand to provide several bites of food for Resident 65. On 3/29/23 at 1:09 p.m., CNA 7 was again observed to rub Resident 20's arm, then provided bites to Resident 65. She was observed using the same hand as she went back to forth while assisting Resident 20 and 65 with eating. On 3/29/23 at 1:11 p.m., CNA 6 was observed	F 0812	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?** · Residents 20, 34, 47, and 65 received assessment to ensure no s/sx infection present on 4/21/2023. **1.How will you identify other residents having the potential**	04/24/2023

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BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

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	assisting two resident with eating, Resident 34 and 47. She was observed to provide several bites of food to Resident 47, then without hand washing and using the same hand, assisted Resident 34 with her soup. On 3/29/23 at 1:12 p.m., CNA 7 provided a drink to Resident 20, then using the same hand gave a bite to Reside 65, then back to Resident 20. On 3/29/23 at 1:14 p.m., CNA 6 moved Resident 34's bowl of peaches in the spider-like grip, then with hand hygiene she returned to assist Resident 47 with eating. On 3/29/23 at 1:17 p.m., CNA 7 gave several bites to Resident 65, another bite to Resident 20. She goes back and forth between residents; she had bare hands and was not hand washing or gelling between residents. On 3/29/23 at 1:20 p.m., CNA 6 was assisting Resident 47 with eating. Resident 34 was reaching for a touching the unused food dishes of Resident 47. CNA 6 moved Resident 34's dishes farther away from Resident 34. She did not complete hand hygiene or hand gel before she continued to assist Resident 47 with eating. During an interview, on 3/29/23 at 1:24 p.m., CNA 7 indicated since they had so many resident to feed, they fed two resident at a time because it was easier. During an interview, on 3/29/23 at 1:28 p.m., Licensed Practical Nurse (LPN) 5 indicated the two activity staff that would normally help with assisting residents with eating were not here now, that was why they had 2 CNAs assisting 4 residents with eating at the same time.		**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. · All members of the IDT will be educated and in-serviced on appropriate hand hygiene while assisting residents with eating so that they can provide ongoing oversight of staff by 4/24/2023. · All staff will be educated and in-serviced on appropriate hand hygiene while assisting residents with eating by 4/24/2023. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** - The DNS/Designee will round during varying meal services to ensure residents are served with dignity and to ensure proper hand washing occurs during meal service. · 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. **1.How the corrective action(s) will be monitored to ensure the**	

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	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

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	During an interview, on 3/29/23 at 2:18 p.m., CNA 6 indicated when she assisted residents with eating she would use one hand for one resident and one hand for the other resident. During an interview, on 3/30/23 at 9:44 a.m., the Director of Nursing (DON) indicated the staff assisting resident with eating should have assigned one hand to assisting one resident and the other hand to assisting the other resident. No cross contamination was allowed. A current policy, titled, "Hand Hygiene in the Dining Room," dated 11/22, was provided by the DON, on 4/3/23 at 9:00 a.m. A review of the policy, indicated, " ...During meal service, use an alcohol based hand rub ...after touching a resident ...." 3.1-21(i)(3)		**deficient practice will not recur, i.e. what quality assurance program will be put into place?** · QA Tool-Food Safety Hygiene-will be completed by Infection Preventionist/Designee until compliance is maintained; increasing frequency if thresholds are not met. · The Infection Preventionist/designee will be responsible for the completion of the QA Tool weekly x 4 weeks, then monthly x 6 months, and then quarterly thereafter until compliance is maintained with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · 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 the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 4/24/2023**	