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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/24/2024 |
| NAME OF PROVIDER OR SUPPLIER Brookside Care Strategies | | STREET ADDRESS, CITY, STATE, ZIP CODE 505 N Gavin St Muncie, IN 47303 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>32663</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications received from the contracted pharmaceutical company were labeled appropriately for 1 of 9 residents reviewed for medication use.</p> <p>Findings include:</p> <p>During a medication administration observation on 7/23/24 at 5:29 a.m., two bottles of oral Nystatin (antifungal) were observed in the medication cart and lacked labeling with resident identifiers and instructions. Bottle 1 lacked the resident's name, dosage and time/frequency the medication was to be given. The bottle also had a sticker with an opened date of 7/10/24. Bottle 2 lacked the resident's name, dosage, and time/frequency the medication was to be given.</p> <p>During an interview, on 7/23/24 at 5:29 a.m., RN 1 indicated she did not know to whom the medications were prescribed. There were two residents who were currently prescribed the medication. No other bottles of Nystatin were observed in the medication carts. The medications should have been labeled with the residents name and directions for use.</p> <p>During an interview, on 7/23/24 at 9:31 a.m., the DON indicated she did not know to whom the medication was prescribed, nor how it was received from the pharmacy without the appropriate labels.</p> <p>A current facility policy, dated 7/12, titled Provider Pharmacy Requirements and provided by the DON on 7/24/24 at 12:00 p.m., indicated the following:</p> <p>Procedure:</p> <p>ii. All prescription medications have labels that show:</p> <ol style="list-style-type: none"> 1. The generic and/or brand name of the product. 2. The strength and dosage form of the medication, including: strength per ml of liquid medications, when appropriate. 3. The Medication's expiration date. <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>4. The resident's name.</p> <p>5. Specific directions for use.</p> <p>6. Prescribers name.</p> <p>7. Dispensing date.</p> <p>8. Name, address, and telephone number of the dispensing pharmacy.</p> <p>9. Identification of dispensing pharmacist.</p> <p>10. Prescription number.</p> <p>11. Quantity dispensed.</p> <p>12. Precautionary labels indicating special storage requirements or procedures.</p> <p>This citation relates to Complaint IN00438969.</p> <p>3.1-25(j)</p> |