

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2011	
NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 11049 STATE ROAD 101 BROOKVILLE, IN47012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00093049.</p> <p>Complaint IN00093049 - Substantiated. Federal/State deficiency related to the allegation is cited at F328.</p> <p>Survey dates: July 19 and 20, 2011</p> <p>Facility number: 000550 Provider number: 155480 AIM number: 100286110</p> <p>Survey team: Barbara Gray, RN</p> <p>Census bed type: SNF/NF: 84 Total: 84</p> <p>Census payor type: Medicare: 12 Medicaid: 53 Other: 19 Total: 84</p> <p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 24,</p>			F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <p>Please find enclosed the plan of correction for the survey ending July 15, 2011. Due to the low scope and severity of the survey findings, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, please contact me.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11049 STATE ROAD 101 BROOKVILLE, IN47012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0328 SS=D	<p>2011 by Bev Faulkner, RN</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to provide 1 resident with proper toenail care that resulted in long, turned up toenails, for 3 residents sample for podiatry care in the total sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A was observed lying in bed on 7/19/11 at 3:30 P.M., with the head of her bed elevated 45 degrees and oxygen running at 3 liters per minute per nasal cannula. Resident #A's toenails were observed with family members present. Resident #A's toenails were long and turned up. The length of her toenails were more prominent on her left foot with the great toenail, 2nd toenail, and 3 toenail turned upward. The left foot small toenail was long and digging into the skin of her 4th toe. The 4th toenail on the left foot was average length. Resident #A's right</p>	F0328	F 328 Requires th facility too ensure that the residents receive proper treatment and care for the following special services: injections; parenteral and enteral fluids; colostomy; ureterostomy, or lleostomy care; standard tracheal suctioning; respiratory care; foot care; and prostheses.The facility will ensure this requirement is met through the following.1. Resident #A was not harmed. Podiatry appointmnet was scheduled for resident.2. All resident s have the potential to be affected. All residents were reviewed to ensure podiatrry care has been provided as applicable.3. F328 reviewed. Social Service Director educated on F328. (See attachment A)4. The administrator or designee will audit 5 resident's charts weekly times 4 weeks, then every 2 weeks times 1 month, then monthly times 3 months then quarterly times 2 quarters to ensure social services has made	07/27/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11049 STATE ROAD 101 BROOKVILLE, IN47012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>great toenail was normal in length. All other toenails on the right foot were long with the 4th toenail more prominent in length and turned up.</p> <p>Resident #A's record was reviewed on 7/20/11 at 11:08 A.M. Diagnoses included but were not limited to chronic obstructive pulmonary disease, coronary artery disease, congestive heart disease, hyperlipidemia, hypertension, history of deep vein thrombosis, venous stasis, cellulitis, and insulin dependent diabetes.</p> <p>A significant change Minimum Data Set assessment for Resident #A indicated she required extensive assistance of 2 persons for bed mobility, transfer, and dressing. Resident #A required extensive assistance of 1 person for bathing, hygiene, and toileting.</p> <p>A July, 2011, physician's recapitulation order for Resident #A indicated a weekly skin assessment.</p> <p>Resident #A's admission sheet indicated Resident #A was admitted to the facility on 7/23/10.</p> <p>A consent for podiatry services for Resident #A was signed on 7/23/10.</p> <p>A care plan for Resident #A initiated</p>		<p>podiatry referrals as applicable. (See attachment B) The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly.5. The above plan of correction will be completed on or before July 27, 2011.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11049 STATE ROAD 101 BROOKVILLE, IN47012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>5/27/11, indicated the following: Problem</p> <p>-The resident requires up to 2 persons assist in performing her activities of daily living due to dementia, cognitive deficit, decreased mobility, shortness of breath, long term oxygen therapy, hypertension, chronic obstructive pulmonary disease, depression, and insulin dependent diabetes. Goal - The resident will present a neat and odor free appearance daily. Interventions - Provide assist with activities of daily living as resident requires. Nail care as needed.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 7/20/11 at 12:20 P.M., indicated Resident #A's daughter signed the consent form for Resident #A to receive podiatry services.</p> <p>An interview with the Director of Nursing (DON) on 7/20/11 at 3:02 P.M., indicated she only observed one of Resident #A's great toes. The DON indicated there was family present during her observation. The DON indicated Resident #A needed to see a podiatrist.</p> <p>The DON indicated Resident #A had not received podiatry services since her admission.</p> <p>This federal tag relates to Complaint IN00093049.</p>				

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

PRINTED: 08/10/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11049 STATE ROAD 101 BROOKVILLE, IN47012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3.1-47(a)(7)				