

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2015
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NAME OF PROVIDER OR SUPPLIER  BROOKSIDE HAVEN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N GAVIN ST MUNCIE, IN 47303
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00178090 and IN00178153.</p> <p>Complaint IN00178090 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F323.</p> <p>Complaint IN00178153 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F323.</p> <p>Survey date: July 30 and 31, 2015</p> <p>Facility number: 000311 Provider number: 15E064 AIM number: 100285520</p> <p>Census bed type: NF: 38 Total: 38</p> <p>Census payor type: Medicaid: 37 Other: 1 Total: 38</p> <p>Sample: 5</p> <p>These deficiencies reflects State findings</p>	F 0000	F-0000This Plan of Correction is prepared and excuted because it is required by the provisions of the State and Federal regulations, and not because Brookside Haven agrees with the allegations and citations listed on the statements of deficiencies. This Plan of Correction shall operate as Brookside Haven's written credible allegation of compliance. Brookside Haven respectfully request paper compliance on the attached Plan of Correction.	

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.

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F 0157 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>			

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	<p>Based on record review and interview, the facility failed to ensure the physician was notified when there was an accident resulting in injury for 1 of 4 residents reviewed for physician notification. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 7/30 /15 at 11:06 a.m. Diagnoses for Resident B included, but were not limited to, mood disorder, depression, hemorrhage subdural, Schizoaffective, neurogenic bowel and neurogenic bladder.</p> <p>A nursing note dated 7/13/15 at 5:45 a.m., indicated Resident B was found "nude, laying on floor beside roommate. Res [Resident] noted to have dried blood to face et head. Upon cleaning area, res appears to have sm [small] amt [amount] bleeding from inside lower lip. Res [Resident] uncooperative with assessment, biting this writer. Res [Resident] noted to have swelling et [and] bruising to right outer eyelid.... Family/MD to be notified later in morning due to early hr." The next nursing note was dated 7/13/15 at 10:00 a.m. The note indicated " Res [Resident] family notified at this time of incident</p>	F 0157	<p>F- 157</p> <p>1.) Resident "B" was seen by NP on 7/14/15 with no new orders, following the alleged incident from 7/13/15, which required dermabon application. Facility Immediately in-serviced and re-educated all licensed staff on facility policy and procedure regarding Change in a Resident's Condition or Status, including physician notification.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) Facility Immediately in-serviced and re-educated all licensed staff on facility policy and procedure regarding Change in a Resident's Condition or Status, including physician notification.</p> <p>4.) DON, HFA or Designee will monitor facility policy and procedure regarding any change in a Resident's Condition or Status, including physician notification, daily X30 days, then weekly X60 days and monthly X3 months to ensure on-going compliance with physician notification. Don and HFA will report to the Q.A. Committee during regular scheduled Quality Assurance Committee (QAA) meetings and will follow any recommendations as deemed necessary to ensure on-going compliance X6 months.</p> <p>5.) Date Completed: 08/17/2015</p>	08/17/2015			

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	<p>that occurred on third shift this morning at 5:45 a.m." The note lacked any indication the physician had been notified.</p> <p>In an interview on 7/30/15 at 1:20 p.m., LPN #1 indicated the physician should have been notified of the incident.</p> <p>In an interview on 7/31/15 at 10:00 a.m., the Director of Nursing indicated the physician should have been notified of the incident.</p> <p>In a telephone interview on 7/30/15 at 2:30 p.m. , LPN #2 from the Medical Director's office indicated there was no note in Resident B's clinical record that the facility had notified the physician of the incident.</p> <p>In a telephone interview on 7/31/15 at 9:30 a.m., LPN #2 from the Medical Director's office indicated the call center did not have any record of ever being notified of Resident B's incident on 7/13/15.</p> <p>An undated current policy titled "Incident /Accident Policy and Procedure" indicated the following: "...Purpose: An incident report should be written factual, nonjudgmental description of an incident, which should</p>			

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F 0282 SS=D Bldg. 00	<p>be completed within 24 hours of the incident. We complete an incident report for the sole purpose to gather information and to follow through for any negative outcomes. This document is not made a part of the legal record nor do we maintain completed reports in our office. Said reports are not available for review after seven (7) days from date of incident or accident. An incident report shall cover any situations that are not considered routine, as listed below: ... Any fall, cut, injury, skin tear, etc. by a resident regardless how minor it may appear to be. ...."</p> <p>This federal tag relates to Complaints IN00178090 and IN00178153.</p> <p>3.5-1(a)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review, interview and observation, the facility failed to ensure care plan interventions were followed for 2 of 4 residents reviewed for care plans. (Residents C and F)</p>	F 0282	<p>F- 282 1.) Facility immediately reviewed all care plans and CNA assignment sheets, including (resident "C" and resident "F") to ensure all interventions are documented on</p>	08/17/2015

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	<p>Findings include:</p> <p>1. The clinical record for Resident C was reviewed on 7/30 /15 at 11:54 a.m. Diagnoses for Resident C included, but were not limited to, dementia, Huntington's Disease, depression, anxiety and psychosis.</p> <p>A care plan dated 10/17/14 and revised 4/23/15 titled "Falls" had interventions including , but not limited to, low bed with mat on the floor and helmet to be worn when out of bed.</p> <p>Observations were noted as follows: 7/31/15 at 9:45 a.m., Resident C in Broda chair, no helmet. 7/31/15 at 10:55 a.m., Resident C in Broda chair, no helmet. 7/31/15 at 11:30 a.m., Resident C in Broda chair, no helmet. 7/31/15 at 12:00 p.m., Resident C in Broda chair, no helmet. 7/31/15 at 1:00 p.m., Resident C in Broda chair, no helmet.</p> <p>During an interview on 7/31/15 at 1:11 p.m., CNA #8 indicated she knew Resident C was to have the helmet on while out of bed but failed to put the helmet on per the Resident C's care plan. CNA #8 indicated the needs of the</p>		<p>the CNA assignment sheets to ensure each resident's written plan of care is followed. Director of Nursing in-serviced and re-educated all Nurses, CNA's and QMA's on following each resident's individual plan of care to ensure on-going compliance.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) Facility immediately reviewed all comprehensive care plans and CNA assignment sheets, including (Resident " C" and Resident "F") to ensure all interventions are documented on the CNA assignment sheets to ensure each resident's written plan of care is followed. Director of Nursing in-serviced and re-educated all Nurses, CNA's and QMA's on following each resident's individual plan of care to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being.</p> <p>4.) DON, MDS Coordinator will continue to monitor all new orders and update each comprehensive care plan and CNA assignment sheets daily to ensure on-going compliance for each resident's individual plan of care. Director of Nursing will report to the Q.A. Committee during regular scheduled Quality Assurance Committee (QAA) meetings and will follow any recommendations as deemed</p>				

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	<p>resident's are on the CNA assignment sheet.</p> <p>Review of the CNA Assignment sheet indicated Resident C was to wear a helmet whenever out of bed.</p> <p>2. The clinical record for Resident F was reviewed on 7/31/15 at 8:57 a. m. Diagnoses included, but were not limited to, dementia, Huntington's, muscle spasticity, ocular hypertension and glaucoma. .</p> <p>Review of the nursing notes dated 2/10/15 on 7/31/15 at 8:57 a.m. indicated Resident F was being transferred with a Hoyer mechanical lift by one Certified Nursing Assistant (CNA). Resident F fell from the Hoyer and was sent to the hospital for evaluation and treatment. Resident F sustained a laceration to the right post - auricular area of the head measuring 4 cm and a laceration on the right parietal area if the head measuring 4 cm. Resident F was returned to the facility with 5 sutures in the laceration located on the right post - auricular and 12 staples in the laceration located on the right parietal.</p> <p>A care plan dated 4/1/14 and last revised on 7/2/15 titled" ADL's" (Activities of Daily Living) had interventions included,</p>		<p>necessary to ensure on-going compliance X6 months.</p> <p>5.) Date Completed: 08/17/2015</p>		

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	<p>but not limited to, "May use hoyer lift x 2 assist for transfers".</p> <p>A care plan dated 4/1/14 and last revised 7/2/15 titled "Falls" had interventions included, but not limited to, "May use hoyer lift for transfers with 2 assist."</p> <p>During an interview on 7/31/15 at 1:55 p.m., CNA #9 indicated Inservice related to Hoyer Lift transfers was given recently. CNA #9 indicated nurses would assist with hoyer lifts if another CNA was not available.</p> <p>During an interview on 7/31/15 at 1:57 p.m., CNA # 10 indicated all nursing staff was aware all Hoyer transfers must have 2 person assistance.</p> <p>A current policy undated titled "Hydraulic Lift (Hoyer Lift)" indicated the following: "...Purpose To enable two individuals to lift and move a resident safely. ..."</p> <p>A current undated skills check list titled "Hydraulic Lift (Hoyer Lift)" indicated the following: "... Steps of Procedure Must have 2 staff for this procedure. ..."</p> <p>This federal tag relates to Complaints</p>			

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F 0323 SS=D Bldg. 00	<p>IN00178090 and IN00178153.</p> <p>3.1-35 (g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to implement effective interventions to prevent a hazardous environment for 1 of 4 residents (Resident B) reviewed for environmental hazards. The facility further failed to ensure the care plan was followed for safe use of a Hoyer lift resulting in injury from a fall for 1 of 4 residents (Resident F) reviewed for accidents. This resulted in Resident F receiving two head injuries requiring Emergency room treatment including sutures and staples.</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 7/30/15 at 11:06 a.m. Diagnoses for Resident C included, but were not limited to, mood disorder,</p>	F 0323	<p>F-323</p> <p>1.) Resident "B" side of room was immediately re-assessed for any further environmental barriers or clutter. Over bed table was removed from resident "B" side of room.</p> <p>2.) Facility immediately reviewed/updated as deemed necessary the comprehensive care plan and CNA assignment sheet including (Resident "B" and Resident "F") for all individual comprehensive care plans of each resident which require a Hoyer Lift for transfers .</p> <p>*Regarding Resident "F" facility reported to ISDH a reportable on February 11, 2015 for an incident/accident on February 10, 2015. Surveyors were in facility on March 25, and March 26, 2015, POC was sent in and approved on April 13, 2015. On May 13, 2015 a revisit</p>	08/17/2015

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	<p>depression, hemorrhage subdural, Schizoaffective, neurogenic bowel and neurogenic bladder.</p> <p>During an interview on at 7/30/15 at 1:35 p.m., LPN # 3 indicated Resident B had a history of spastic movements due to his diagnosis of a subdural hemorrhage. LPN # 3 also indicated Resident B had a history of getting out of bed and crawling on the floor.</p> <p>Review of nursing notes dated 7/24/15 at 6:25 a.m. indicated the following: "Res [Resident] was found this a.m. by CNA's with laceration to right eyebrow, upon examination it appears Res pulled bedside table over in bed with him, laceration appeared swollen and red, no bruising noted at this time, Res was sent to ER for eval and Tx [treatment]. Dry blood was present was cleaned with no first aide necessary. Res was alert to self, 0 s/s [signs and symptoms] of distress noted. Pain was noted..."</p> <p>Review of a current care plan for "Self Care Deficit" dated 1/20/15 and revised 7/24/15, indicated an intervention for "no bedside tables in the room" was placed on 7/24/15.</p> <p>Review of a current care plan for "Visual Function" dated 1/20/15 and revised</p>		<p>by ISDH was conducted and the Division of Long Term Care, Indiana State Department of Health found facility to be in substantial compliance on April 10, 2015. There has been no other Hoyer incidents, the facility continues to follow the POC as stated in the 2567 dated April 10, 2015.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.)</p> <p>1.) DON immediately re-in serviced/re-educated all staff on environmental barriers and clutter for resident "B" side of room. HFA, DON or Designee will observe room daily for any further environmental barriers or clutter.</p> <p>2.) Director of Nursing immediately in-serviced all CNA's on Hoyer lift policy (requiring no less than two staff members) also completed re-education to all CNA's on February 10, 2015 by observing each CNA perform the proper use of lift. All new employed CNA's shall be observed performing the proper use of the mechanical lift during their 3-day orientation by the Director of Nursing to ensure the safety of all resident's during transfers. Another in-service/re-education scheduled for August 17, 2015 for all nursing staff on proper use of lift.</p>				

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	<p>4/30/15, included, but not limited to, the following interventions: "Minimize environmental barriers" and "Keep resident's room as uncluttered as possible."</p> <p>Tour of Resident B's room on 7/30/15 at 9:20 a.m. indicated no over the bed table in the room. Resident B had a low bed with a mat on the floor. Resident B was not in the room at the time.</p> <p>2. The clinical record for Resident F was reviewed on 7/31/15 at 8:57 a. m. Diagnoses included, but were not limited to, dementia, Huntington's, muscle spasticity, ocular hypertension and glaucoma.</p> <p>Review of the nursing notes dated 2/10/15 on 7/31/15 at 8:57 a.m. indicated Resident F was being transferred with a Hoyer mechanical lift by one Certified Nursing Assistant (CNA). Resident F fell from the Hoyer and was sent to the hospital for evaluation and treatment. Resident F sustained a laceration to the right post - auricular area of the head measuring 4 cm and a laceration on the right parietal area if the head measuring 4 cm. Resident F was returned to the facility with 5 sutures in the laceration located on the right post - auricular and 12 staples in the laceration located on the</p>		<p>*Regarding Resident "F" facility reported to ISDH a reportable on February 11, 2015 for an incident/accident on February 10, 2015. Surveyors were in facility on March 25, and March 26, 2015, POC was sent in and approved on April 13, 2015. On May 13, 2015 a revisit by ISDH was conducted and the Division of Long Term Care, Indiana State Department of Health found facility to be in substantial compliance on April 10, 2015. There has been no other Hoyer incidents, the facility continues to follow POC as stated in the 2567 dated April 10, 2015.</p> <p>4.) 1.) HFA, DON or Designee will continue to make daily environmental rounds to ensure on-going compliance. HFA will report to the Q.A. Committee during regular scheduled Quality Assurance Committee (QAA) meetings and will follow any recommendations as deemed necessary to ensure on-going compliance.</p> <p>2.) HFA will continue to monitor all orientation check list for observation within the 3-day orientation for performance of proper use of hoyer lift. HFA will report to the Q.A. Committee during regular scheduled Quality Assurance Committee (QAA) meetings and will follow any recommendations as deemed</p>	

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	<p>right parietal.</p> <p>A care plan dated 4/1/14 and last revised on 7/2/15 titled " ADL's" (Activities of Daily Living) had interventions included, but not limited to, "May use hoyer lift x2 assist for transfers".</p> <p>A care plan dated 4/1/14 and last revised 7/2/15 titled "Falls" had interventions included, but not limited to, "May use hoyer lift for transfers with 2 assist."</p> <p>During an interview on 7/31/15 at 1:55 p.m., CNA #9 indicated Inservice related to Hoyer Lift transfers was given recently. CNA #9 indicated nurses would assist with hoyer lifts if another CNA was not available.</p> <p>During an interview on 7/31/15 at 1:57 p.m., CNA # 10 indicated all nursing staff was aware all Hoyer transfers must have 2 person assistance.</p> <p>A current policy undated titled "Hydraulic Lift (Hoyer Lift)" indicated the following: "...Purpose To enable two individuals to lift and move a resident safely. ..."</p> <p>A current undated skills check list titled "Hydraulic Lift (Hoyer Lift)" indicated</p>		<p>necessary to ensure on-going compliance X6 months.</p> <p>5.) Date Completed: 08/17/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E064	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/31/2015
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE HAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N GAVIN ST MUNCIE, IN 47303		
(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>the following: "... Steps of Procedure Must have 2 staff for this procedure. ..."</p> <p>This federal tag relates to Complaints IN00178090 and IN00178153.</p> <p>3.1-45(a)(2)</p>				