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| 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 07/31/2014 |
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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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| F000000 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 23, 24, 25, 28, 29, 30, and 31, 2014</p> <p>Facility number: 000311 Provider number: 15E064 AIM number: 100285520</p> <p>Survey team: Ginger McNamee, RN TC Toni Maley, BSW (July 23, 24, and 25, 2014) Karen Lewis, RN (July 28, 29, 30, and 31, 2014) Tina Smith-Staats, RN (July 28, 29, 30, and 31, 2014)</p> <p>Census payor type: NF: 38 Total: 38</p> <p>Census payor type: Medicaid: 37 Other: 1 Total: 38</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.</p> | F000000 | F-0000This Plan of Correction is prepared and executed 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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| F000157 SS=D | <p>Quality review completed by Debora Barth, RN.</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> <p>Based on interview and record review,</p> | F000157 | F-157 1.) All licensed nursing staff were | 08/18/2014 | | | |

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| | <p>the facility failed to notify a family of weight loss for 1 of 3 residents reviewed with a family interview completed. (Resident #39)</p> <p>Findings include:</p> <p>During a family interview on 7/25/14 at 11:48 a.m., Resident #39's family indicated they were not notified when the resident first started losing weight.</p> <p>Resident # 39's clinical record was reviewed on 7/28/14 at 8:49 a.m. Her diagnoses included, but were not limited to, abnormal loss of weight, obsessive compulsive disorder, cerebral palsy, anxiety, and unspecified intellectual disabilities.</p> <p>Review of the resident's weight record indicated the resident weighed 119.4 pounds on 1/6/14. The record indicated the resident weighed 98.5 pounds on 2/5/14, a 20.9 pound weight loss.</p> <p>Review of Resident #39's clinical record lacked an indication of the family being notified of a weight loss until 3/21/14.</p> <p>During an interview with the Director of Nursing on 7/30/14, at 1:50 p.m., she indicated she could not find any indication of the family being notified of</p> | | <p>re-educated, in-serviced to ensure compliance on the policy and procedure to notify family, physician, and resident that have been identified for change in condition or concerns that have been identified for (resident #39).</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) Director of nursing re-educated, in-serviced all nursing staff regarding the importance of following Policy and Procedure on notifying family of "Change in a Resident's Condition or Status".</p> <p>4.) DON, HFA, or Designee will monitor 24-hour report sheet/new orders to ensure family notification of any change in condition or concerns daily X2 months, weekly X2 months and monthly X2 months . (See exhibit "A") SWAT Team will continue to meet weekly and monitor weekly weights and appropriate notification to family of any weight loss. DON will report to the quality Assurance Committee (QAA) and will follow any recommendations.</p> <p>5.) Date Completed: 8/18/2014</p> | | | | |

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| F000174 SS=D | <p>the February weight loss.</p> <p>The undated "Change in a Resident's Condition or Status" policy was provided on 7/31/14 at 11:22 a.m., by the Director of Nursing. The policy indicated the resident's next-of-kin or representative (sponsor) would be notified when there was a significant change in the resident's physical, mental, or psychosocial status.</p> <p>3.1-(a)(2)</p> <p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. Based on interview and record review, the facility failed to ensure residents were able to make telephone calls privately for 2 of 9 residents interviewed regarding telephone privacy. (Resident #34 and an anonymous resident)</p> <p>Findings include:</p> <p>1. Resident #34 was determined to be interviewable during the stage one survey process. During an interview on 7/23/14 at 2:59 p.m., Resident #34 indicated she did not have a private place to make a telephone call. She indicated phone calls</p> | F000174 | <p>F- 174</p> <p>1.) Facility maintenance department immediately replaced our cordless phone at nurse's station to ensure that all residents upon their request (24/7) may have privacy during their phone use as identified for (resident # 34 and an anonymous resident). Re-educated, in-serviced all nursing staff of proper use of the cordless phone in a timely manner upon resident request.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) Immediately replaced cordless</p> | 08/18/2014 |

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| | <p>were made at the nurses' station and everyone could hear you. She further indicated there was no portable or cordless telephone for the residents to use.</p> <p>A nursing note entry, dated 7/4/14 at 6:30 p.m., indicated Resident #34 requested to use the telephone at the nurses' station and was told "waiting for return call and business phone first." The entry further indicated Resident #34 "became very upset" and began calling the staff names.</p> <p>A comprehensive health care plan, initiated on 3/3/14 and reviewed on 6/13/14, indicated the resident preferred to establish own activity preferences. One of the approaches listed on the care plan was "it is very important for me to be able to talk to my family on the telephone."</p> <p>A comprehensive health care plan, initiated on 2/20/14 and reviewed on 3/14/14 and 6/13/14, indicated the resident will exhibit verbal and physical aggression, and resistance to care at times. One of the approaches listed on the carelist for this problem was "encourage my family and friends to communicate frequently with me via visits and phone calls."</p> | | <p>phone and placed on daily preventive maintenance log to ensure compliance for resident privacy phone use upon their request and that the cordless phone is functional and still in place. Social Service informed all resident's and had each resident sign a form that upon their request they may use the cordless phone for privacy.</p> <p>4.) Maintenance supervisor will report to the Quality Assurance (QAA) Committee quarterly and will follow any recommendations and report to the HFA daily should cordless phone become inoperable or missing.</p> <p>5.) Date Complete: 8/18/2014</p> | | |

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| | <p>During an interview on 7/30/14 at 9:11 a.m., the Maintenance Supervisor indicated the pay phone in the break room did not work.</p> <p>During an interview on 7/30/14 at 9:15 a.m., QMA #1 indicated the telephones on the wall in each hall way did not dial out. She indicated the residents have to dial out on the telephone at the nurses' station and then be transferred to one of the phones in the hallways.</p> <p>2. A resident, who requested to remain anonymous and was determined to be interviewable during the stage one survey process, indicated during an interview on 7/25/14 at 1:29 p.m., he/she did not have a private place to make a telephone call. He/she indicated the residents have to use the phone at the nurses' station and that it was not private at all. He/she further indicated the telephone may need to be used by the nurse.</p> <p>During an interview on 7/30/14 at 9:38 a.m., the anonymous resident indicated the facility did not have a cordless telephone and had been told, in the last month and a half, he/she could not use the telephone due to staff waiting on a return call from a physician.</p> <p>3. During an interview on 7/31/14 at</p> | | | |

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| F000241 SS=D | <p>7:26 a.m., the Administrator and the Social Services Designee (SSD) indicated there was a cordless telephone at the nurses' station.</p> <p>During an interview on 7/31/14 at 7:29 a.m., CNA #3 was at the nurses' station and indicated she thought the facility had a cordless telephone, but could not find it. She further indicated she did not know if the cordless telephone worked.</p> <p>During an interview on 7/31/14 at 7:31 a.m., the SSD was at the nurses' station and she indicated she could not find the cordless telephone or the base to charge the cordless telephone.</p> <p>An undated "ADMISSION AGREEMENT", provided by the Director of Nursing on 7/31/14 at 11:22 a.m., indicated "There is a telephone provided for the resident's convenience and privacy, however, there is a charge for long distance calls."</p> <p>3.1-3(f)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his</p> | | | | | | |

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| | <p>or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to provide dignified dining accommodations for 2 of 38 residents observed for dining. (Resident #'s 18 and 19)</p> <p>Findings include:</p> <p>1. During a 7/23/14, 11:45 a.m. to 12:45 p.m., lunch meal observation and a 7/24/14, 12:20 p.m. to 12:45 p.m., lunch meal observation, Resident #19 ate her meal while seated in a wheelchair in the hallway. She was seated at an over-bed table between a dresser and medication carts. Throughout both meals she faced the equipment. The hallway was not an established dining area and was used as a thoroughfare throughout the meal. She ate both meals from Styrofoam plates and used plastic utensils.</p> <p>During a 7/24/14, 12:27 p.m., interview, Resident #19 indicated she ate in the hallway because she was accused of stealing food from others' trays. She then indicated she had thrown a cup two or three months ago and now had to eat from paper and plastic. She indicated she truly desired real silverware.</p> <p>During a 7/24/14, 12:25 p.m., interview,</p> | F000241 | <p>F-241</p> <p>1.) Facility had evaluated dining request of resident #'s 18 and 19 and was attempting to meet resident's personal request and needs. HFA immediately re-assigned dining accommodations for (resident #'s 18 and 19) to main dining room. Both resident #'s 18 and 19 currently are receiving regular flatware and silverware. Social Services updated Care Plans on both resident #'s 18 and 19 to reflect their dining changes.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) All residents will dine in dining area or their rooms upon request, if the resident is not a choke risk.</p> <p>4.) Social Service, or Designee will monitor for residents dining preference quarterly and PRN, will document in Social Service notes. Care Plan Team will monitor weekly X2 months, then quarterly thereafter. (See Exhibit "B") Social Service will report to the Quality Assurance (QAA) Committee quarterly and will follow any recommendations.</p> <p>5.) Date Completed: 8/18/2014</p> | 08/18/2014 |
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| | <p>QMA #1 indicated she did not know why Resident #19 ate in the hallway but she "always does".</p> <p>During a 7/24/14, 12:35 p.m., interview, the Administrator indicated she did not remember why Resident #19 ate in the hallway but she believed it would be in her care plan. She thought Resident #19 used paper and plastic due to suicidal threats.</p> <p>During a 7/24/14, 2:55 p.m., interview, the Social Services Designee indicated Resident #19 had at one time had behavioral issues in the dining room. She indicated the event occurred in 2013, if she was remembering correctly. She indicated she could not find documentation of attempts to reintroduce the resident back into the common dining area.</p> <p>Resident #19's clinical record was reviewed on 7/29/14 at 3:35 p.m. The resident's diagnoses included, but were not limited to, bipolar, borderline personality disorder, anxiety, and depression.</p> <p>The resident's 6/17/14, quarterly Minimum Data Set assessment indicated the resident had no cognitive impairment.</p> | | | |

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| | <p>The resident had a 5/2/14 care plan review. The resident's care plan indicated as a problem/need she used plastic ware and paper products with no further explanation. She had an intervention of sits in hallway with tray for meals.</p> <p>2. During a 7/23/14, 11:45 a.m. to 12:45 p.m., lunch meal observation and a 7/24/14 12:20 p.m. to 12:45 p.m. lunch meal observation, Resident #18 ate her meal while seated in a wheelchair in the hallway. She was seated at an over-bed table between a dresser and medication carts. Throughout both meals she faced either equipment or the back of another resident who was also eating in the hallway. The hallway was not an established dining area and was used as a thoroughfare throughout the meal.</p> <p>During a 7/24/14, 12:25 p.m., interview, QMA #1 indicated she was unsure why Resident #18 ate in the hallway but it might be for behaviors.</p> <p>During a 7/24/14, 12:30 p.m., interview, Resident #18 indicated she did not know why she sat in the hallway but she believed she had been asked to eat there when she first came to the facility.</p> <p>During a 7/24/14, 12:35 p.m., interview,</p> | | | | | | |

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| | <p>the Administrator indicated she did not remember why Residents #18 ate in the hallway but she believed it would be in the resident's care plans.</p> <p>During a 7/24/14, 2:55 p.m., interview, the Social Services Designee indicated Resident #18 had at one time had behavioral issues in the dining room and she would look for documentation. She indicated the event occurred in 2013 if she was remembering correctly. She indicated she could not find documentation of attempts to reintroduce the resident back into the common dining area.</p> <p>Resident #18's clinical record was reviewed on 7/29/14 at 3:00 p.m. The resident's diagnoses included but were not limited to, history of traumatic brain injury, dysphasia, depression, anxiety, agitation, and delusions.</p> <p>The resident had a 4/29/14, quarterly Minimum Data Set assessment indicating the resident had moderate cognitive impairment.</p> <p>The resident's care plan review was 5/9/14. The resident had a problem of potential for nutritional risk with an approach of sit in the hallway with tray for meals.</p> | | | | |

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| F000334 SS=E | <p>3.1--3(t)</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and</p> | | | |
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| | <p>potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to ensure residents and their families were able to exercise their right to make informed choices by providing the resident or their family annual education for the Influenza vaccine for 4 of 5 residents reviewed. (Resident #15, Resident #5, Resident #27 and Resident #14).</p> <p>Findings include:</p> | F000334 | <p>F- 334</p> <p>1.) Facility immediately developed and implemented policy and procedure on influenza and pneumococcal immunization and this is included in the admission process to ensure prior to offering immunizations to any resident, that the resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunizations. Each resident will be offered influenza immunization annually and</p> | 08/18/2014 |

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| | <p>1. The record review for Resident #15 on 7/28/14 at 1:34 p.m., indicated no evidence of education for the Influenza vaccine was given to the resident or the family prior to Resident #15 receiving the Influenza vaccine on 10/25/13 .</p> <p>2. The record review for Resident #5 on 7/28/14 at 8:35 a.m., indicated no evidence of education for the Influenza vaccine was given to the resident or the family prior to Resident #5 receiving the Influenza vaccine on 11/3/13.</p> <p>3. The record review for Resident #27 on 7/29/14 at 11:37 a.m., indicated no evidence of education for the Influenza vaccine was given to the resident or the family prior to Resident #27 receiving the Influenza vaccine on 10/30/13.</p> <p>4. The record review for Resident #14 on 7/29/14 at 8:08 a.m., indicated no evidence of education for the Influenza vaccine was given to the resident or the family prior to Resident #14 receiving the Influenza vaccine on 10/30/13.</p> <p>5. During an interview on 7/30/14 at 10:35 a.m., with the Corporate Nurse Consultant, she indicated residents and families were given education regarding the flu vaccine prior to the vaccine being administered.</p> | | <p>pneumococcal immunization after five years from the last one with the opportunity to refuse. The resident's medical record at a minimum, will have the documentation to support that the resident, or the resident's legal representative was provided education regarding the benefits and potential side affects of the influenza and pneumococcal immunizations and in addition the medical record will reflect either the resident did or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) Interim Director of Nursing and Social Service re-educated/in-serviced all nursing staff on the importance of educating the resident, or the resident's legal representative prior to the immunizations and documentation supporting either the resident received or refused the immunization.</p> <p>4.) DON and Social Services will maintain a log of resident and/or resident legal representative receiving education regarding the benefits and potential side effects prior to any immunization or refusal weekly X2 months and then monthly X4 months. (See exhibit "C") Director of Nursing and Social Service will report to the Quality Assurance Committee (QAA)</p> | | | | |

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| | <p>During an interview on 7/30/14 at 12:37 p.m., the Social Service Designee indicated she obtained the consent signatures for the vaccinations from the resident or their families and that nursing was to provide the education.</p> <p>During an interview on 7/30/14 at 3:15 p.m., the Director of Nursing indicated she had no further information on any education being provided to the residents or their families regarding the flu vaccine prior to administration of the vaccine.</p> <p>Review of the current, undated, immunization policy entitled "Influenza and Pneumococcal Vaccination", which included annual CDC influenza vaccine information sheets for 2002-2003 and 2007-2008, provided by the Director of Nursing on 7/31/14 at 10:20 a.m., included, but was not limited to, the following:</p> <p>"... Procedure:...</p> <p>3. Employees are to read and sign the Influenza Vaccine and Pneumococcal Vaccine Consent/Declination Form (#6041) and Pneumococcal Vaccine Consent/Declination Form (#0642) and What You Need to Know information statements regarding Influenza (Attachment A and Pneumococcal (Attachment B))..."</p> | | <p>quarterly.</p> <p>5.) Date Completed: 8/18/2014</p> | | | | |

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| F000356 SS=C | <p>3.1-18(b)(5)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the list of</p> | F000356 | F-356 1.) HFA immediately updated the | 08/18/2014 | | | |

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| | <p>"nursing staff on duty" was visible and/or updated on a daily basis as required. This had the potential to effect 38 of 38 residents who resided in the facility.</p> <p>Findings include:</p> <p>During the initial tour on 7/23/14 at 9:30 a.m., the daily nursing staff posting was not observed. During additional observations on 7/23/14 at 11:15 a.m., 7/23/14 at 2:30 p.m., 7/24/14 at 8:30 a.m., 7/24/14 at 2:20 p.m., 7:25/14 at 8:30 a.m., 7/25/14 at 12:45 p.m., 7/25/14 at 2:30 p.m., and 7/28/14 at 7:45 a.m., the daily nursing staff posting was not observed.</p> <p>The staff posting was observed in a clear plastic protective sleeve in a wall rack by the nurses's station on 7/28/14 at 12:30 p.m. The posting was folded over in the rack so it could not be seen unless unfolded. The last day posted was 7/24/14.</p> <p>During an interview with the Administrator on 7/28/14 at 2:30 p.m., she indicated the posting should not be folded over. She indicated it was to be clipped at the top to hold it in place. She indicated staffing had not been posted on 7/25/14, 7/26/14, 7/27/14, and 7/28/14.</p> | | <p>posting of "Nurse Staffing Information Data Sheets" which is to be updated on a daily basis and visible to all and must contain the following information:</p> <ul style="list-style-type: none"> • Facility name • The Current Date • Total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. • Registered nurses. • Licensed practical nurses or licensed vocational nurses. • Certified nurse aides • Resident Census <p>2.) Any resident has the potential to be affected.</p> <p>3.) HFA, or Designee will update the "Nurse staffing Information Data Sheet" daily and will be made visible to all to ensure continued compliance and shall contain the information below:</p> <ul style="list-style-type: none"> • Facility name • The Current Date • Total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. • Registered nurses. • Licensed practical nurses or licensed vocational nurses. • Certified nurse aides • Resident Census | | |

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| F000441 SS=D | <p>3.1-17(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or</p> | | <p>4.) HFA will monitor daily to ensure continued compliance X2 months, then weekly X2 months and then monthly X2 months. (See exhibit "D")HFA will report to the Quality Assurance Committee (QAA) and will follow any recommendations.</p> <p>5.) Date Completed: 8/18/2014</p> | |

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| | <p>their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, and interview, the facility failed to ensure proper infection control practices were followed during resident wound care for 1 of 3 residents reviewed for pressure ulcers. (Resident #42)</p> <p>Findings include:</p> <p>During a wound care observation on 7/29/14 at 3:00 p.m., LPN #2 was observed placing wound care supplies on the bed of Resident #42. LPN #2 explained the procedure to the resident then placed the supplies on a television stand and washed her hands. LPN #2 placed the supplies on a bedside table without a barrier. LPN #2 donned gloves and removed the old dressing from the right ankle and cleansed and redressed the wound all with the same gloves. She removed her gloves and replaced them with a new pair and removed the old dressing from the left heel, cleansed and redressed it. LPN #2 helped the resident</p> | F000441 | <p>F-441</p> <p>1.) Interim Director of Nursing immediately began re-education and in-servicing on Infection Control and hand-washing. Re-education and in-servicing will be completed for all staff August 13, 2014.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) Director of nursing will observe wound care and sign off with each nurse to ensure proper infection control practices are being followed. DON, will observe X3 treatments weekly X30 days, then at random. (See exhibit "E")</p> <p>4.) Director of nursing will observe wound care and sign off with each nurse to ensure proper infection control practices are being followed. DON, will observe X3 treatments weekly X30 days, then at random. Director of Nursing will report to the Quality Assurance Committee (QAA) and will follow any recommendations.</p> | 08/18/2014 |

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| | <p>to reposition to her left side and exposed the wound on the coccyx. LPN #2 replaced her contaminated gloves with clean gloves. LPN #2 removed the old dressing, cleansed and redressed the wound. Throughout the process, the nurse repeatedly reached into the boxes and bags of supplies on the bedside table while wearing contaminated gloves. The soiled dressings were placed on the bedside table next to the clean supplies.</p> <p>During an interview on 7/29/14 at 3:30 p.m., concerning the dressing change performed by LPN #2, the Director of Nursing indicated the infection control process had not been followed. She provided a copy of an undated steps of procedure sheet titled "Dressing Change (Clean)". The steps included but were not limited to the following:</p> <p>"...1. Place plastic bag near foot of bed to receive soiled dressing. 2. Create clean field with paper towels or towelette drape.... 5. Put on first pair of disposable gloves. 6. Remove soiled dressing and discard in plastic bag. 7. Dispose of gloves in plastic bag. 8. Put on second pair of disposable gloves.... 13. Remove gloves and discard with all unused supplies in plastic bag...."</p> | | 5.) Date Completed: 8/18/2014 | | | | |

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| F000464 SS=E | <p>3.1-18(j)</p> <p>483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. Based on observation and interview, the facility failed to provide adequate dining space for safety in the event of an emergency for residents choosing to dine in the lounge. This had the impact to affect 9 residents choosing to dine in the lounge at meals. (Resident #'s 7, 17, 34, 16, 21, 1, 36, 5, and 25)</p> <p>Findings include:</p> <p>During a 7/23/14, 12:05 p.m. to 12:45 p.m., lunch meal observation the following concerns were noted:</p> <p>Two long tables were set up in the lounge. The tables where placed end to end to form a long dining table. The table ran down the center of the room with one end at the television. The table had approximately 3 and 1/2 feet of free</p> | F000464 | <p>F- 464</p> <p>1.) Facility immediately re-arranged and removed some furnishings in the front lounge to provide adequate dining space for the safety of resident's #7, 17, 34, 16, 21, 1, 36, 5, and 25 in the event of an emergency during dining services.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) DON, HFA, or Designee will monitor/observe a dining service daily to ensure continued adequate dining space is being provided to ensure safety of resident's dining in lounge.</p> <p>4.)DON, HFA, or designee will monitor daily X2 months, then weekly X2 months and then monthly X2 months (See exhibit "F") and will report to the Quality Assurance</p> | 08/18/2014 |

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| | <p>space on each side and large living room style chairs against the wall behind the free space. Residents were then seated on both sides of the table and the free end equaling 9 seated residents. Two residents were seated in dining room chairs and seven residents were seated in wheelchairs. When seated at the table, there was 1 to 1 and 1/2 feet of empty space behind each resident chair. Once seated a resident could not exit the dining area without multiple residents moving from their seat to allow the resident to exit. Furniture or residents would have to be moved for staff to provide emergency care. Seated at these tables were Residents #7, #17, #34, #16, #21, #1, #36, #5, and #25.</p> <p>During a 7/24/14, 12:20 p.m. to 12:45 p.m., lunch meal observation, residents were again seated at a long table in the lounge. The tables were positioned in the same manner as described during the 7/23/14 lunch observation. Residents could not exit the dining area and staff could not have provided emergency care without residents or furniture being moved. Eight residents were seated at the table.</p> <p>During a 7/24/14, 12:35 p.m., interview, LPN #2 indicated a nurse would need to pull out chairs and move furniture to</p> | | <p>Committee (QAA) and will follow any recommendations.</p> <p>5.) Date Completed: 8/18/2014</p> | | | | |

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| F000520 SS=E | <p>provide emergency care for such things as choking or CPR for any resident seated in the lounge to dine.</p> <p>During a 7/24/14, 12:55 p.m., interview with the Director of Nursing, she indicated in order to provide care for emergency situations such as choking or CPR to a resident eating in the lounge, other residents would have to be moved. She indicated that was not acceptable.</p> <p>3.1-19(cc)(4)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> | | | | |

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| | <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation and interview, the facility's Quality Assurance Committee failed to identify and address the issue of safe dining space for the 9 of 9 residents dining in the lounge. (Resident #'s 7, 17, 34, 16, 21, 1, 36, 5, and 25)</p> <p>Findings include:</p> <p>During lunch meal observations on 7/23/14 and 7/24/14, adequate space for resident safety was not provided for related to the positioning of the tables and chairs in the lounge area.</p> <p>During an interview on 7/24/14 at 12:35 p.m., LPN #2 indicated a nurse would need to pull out chairs and move furniture to provide emergency care for such things as choking or CPR for any resident seated in the lounge to dine.</p> <p>During an interview on 7/24/14 at 12:55 p.m., the Director of Nursing indicated in order to provide care for emergency situations such as choking or CPR to a resident eating the lounge other residents would have to be moved. She indicated that was not acceptable.</p> <p>During an interview on 7/31/14 at 10:01</p> | F000520 | <p>F- 520</p> <p>1.) Facility immediately scheduled Quality Assurance Committee Meeting (QAA), scheduled for August 13, 2014 to ensure safety of resident's during dining services in lounge and will follow any recommendations. Facility re-arranged and removed some furnishings in the front lounge to provide adequate dining space for the safety of resident #'s 7, 17, 34, 16, 21, 1, 36, 5, and 25 in the event of an emergency during dining services.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) DON, HFA, or Designee will monitor/observe dining service to ensure continued adequate dining space is being provided to ensure safety of resident's dining in lounge.</p> <p>4.) Monitoring tools for dining services will be reviewed monthly X2 months (See exhibit "F") then quarterly in regular scheduled Quality Assurance Committee (QAA) meeting to ensure continued safety of all resident's. Facility rounds by HFA, DON, and Maintenance Supervisor will continue daily throughout facility to identify and correct any deficiencies. Any recommendations from the Quality Assurance Committee</p> | 08/18/2014 |

| 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 07/31/2014 |
|--|--|---|---|----------------------|---|
| 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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| | a.m., the Administrator indicated the Quality Assurance Committee had failed to identify and address resident safety related to spacing issues for residents dining in the lounge in case of emergency situations. 3.1-52(b)(2) | | (QAA) shall be followed. 5.) Date Completed: 8/18/2014 | | |