| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROWNSBURG HEALTH CARE CENTER | 1010 HORNADAY RD<br>BROWNSBURG, IN 46112 |

| (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 |
|---|---|---|---|---|
| F000000 | This visit was for a recertification and state licensure survey.<br><br>Survey Dates: May 12-16, 2014<br><br>Facility Number: 000113<br>Provider Number: 155206<br>AIM Number: 100287670<br><br>Survey Team:<br>Laura Brashear, RN, TC<br>Mary Weyls, RN<br>Lora Brettnacher, RN<br>Kewanna Gordon,RN<br>Megan Burgess, RN<br><br>Census Bed Type:<br>SNF: 1<br>SNF/NF: 86<br>Total: 87<br><br>Census Payor Type:<br>Medicare: 13<br>Medicaid: 52<br>Other: 22<br>Total: 87<br><br>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. | F000000 | SUBMISSION OF THIS PLAN OF CORRECTION SHALL NOT CONSTITUTE OR BE CONSTRUED AS AN ADMISSION BY BROWNSBURG HEALTH CARE CENTER THAT THE ALLEGATIONS CONTAINED IN THE SURVEY REPORT ARE ACCURATE OR REFLECT THE PROVISION OF NURSING CARE AND SERVICES TO THE RESIDENTS OF BROWNSBURG HEALTH CARE CENTER.THIS PROVIDER RESPECTFULLY REQUESTS THAT THE 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION OF COMPLIANCE AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVISIT ON OR AFTER JUNE 15, 2014. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155206 | A. BUILDING 00<br>B. WING | 05/16/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROWNSBURG HEALTH CARE CENTER | 1010 HORNADAY RD<br>BROWNSBURG, IN 46112 |

| (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 |
|---|---|---|---|---|
| | Quality review completed 05/22/14 by Brenda Marshall, RN. | | | |
| F000157<br>SS=D | 483.10(b)(11)<br>NOTIFY OF CHANGES<br>(INJURY/DECLINE/ROOM, ETC)<br>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).<br><br>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.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155206 | A. BUILDING 00<br>B. WING | 05/16/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROWNSBURG HEALTH CARE CENTER | 1010 HORNADAY RD<br>BROWNSBURG, IN 46112 |

| (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 |
|---|---|---|---|---|
| | Based on interview and record review the facility failed to ensure that the physician was notified of changes in a pressure sore for 1 of 2 residents reviewed with pressure areas.(Resident #67)<br><br>Findings include:<br><br>Resident #67's clinical record was reviewed on 5/15/14 at 2:53 p.m.<br><br>A physician's telephone order, dated 3/16/14 at 7:50 p.m., indicated the resident was to be admitted to the hospital due to a UTI [urinary tract infection].<br><br>Re-admission orders were noted on 3/25/14. An physician's order was noted of "Silver alginate to sacral wound after NS [normal saline] cleanse, cover with ABD pad, secure pad with tape, change q [every] 3 X [times] weekly.<br><br>A re-admission assessment. dated 3/25/14, indicated a stage 4 pressure area (wound caused from pressure) measuring 2.5 cm X 1.7 cm X 4 cm.<br><br>A form titled "Wound or Pressure Sore Identification and Progress Record", documented on 3/31/14, indicated the resident had a pressure ulcer on the Sacrum measuring 2.5 cm (L) [Length] | F000157 | **F157 NOTIFICATION OF CHANGES**<br>1.RESIDENT#67 PRESSURE WOUND WAS ASSESSED FOR ACCURACY OF WOUND DOCUMENTATION.CARE PLAN AND RESIDENT CARESHEET WERE REVISED AS NEEDED. MD WAS NOTIFIED OF RESIDENT SKINCONDITION.<br>2.RESIDENTS WITH CHANGE IN CONDITION HAVE THE POTENTIAL TO BE AFFECTED BY THE ALLEDGED DEFICIENT PRACTICE.FACILITY STAFF CONDUCTED A SKIN ASSESSMENT ON ALL RESIDENTS TO ENSURE ALL AREAS OF SKIN ISSUES HAVE BEEN IDENTIFIED AND DOCUMENTED ACCURATELY.<br>3.LICENSED NURSE STAFF HAVE BEEN INSERVICED ON WOUND PROGRAM, INCLUDING ASSESSMENT AND DOCUMENTATION AND MD NOTIFICATION OF CHANGES BY DON/DESIGNEE BY JUNE 15, 2014.WEEKLY SKIN ASSESSMENT IS COMPLETED BY THE LICENSED NURSE AND DOCUMENTED ON THE SKIN FORM.PRESSURE WOUNDS ARE MEASURED WEEKLY BY THE LICENSED NURSE AND DOCUMENTED IN THE MEDICAL RECORD.RESIDENTS ARE ASSESSED UTILIZING THE “AT RISK FOR SKIN BREAKDOWN FORM” UPON ADMISSION, WITH SIGNIFICANT CHANGE AND | 06/15/2014 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112 | |

| (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 |
|---|---|---|---|---|
| | 3.0 (W) [width] and 4.0 (D) [depth] without tunneling (passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound). Documentation on the form indicated on 4/7/14, 4/14/14, and 4/20/14 "tunneling". Documentation to indicate where the tunneling was located and measurement of tunneling was lacking. The most recent documentation on 5/12/14 indicated the measurements at 3.0 (L) X 2.0 (W) X 4.0 (D) without tunneling indicating an increase in size of the pressure sore.<br><br>Documentation to indicate the physician had been notified of the increase in the size of the area was lacking.<br><br>During interview of the ADON (Assistant Director of Nursing) on 5/16/14 at 10 a.m., the ADON indicated the night shift nurse measures the pressure areas. The ADON indicated she was not aware that tunneling had been identified. The ADON indicated the Physician had not been notified of the change in the area.<br><br>A facility policy titled "Prevention of Pressure Ulcers" dated 10/24/2011, received from the ADON on 5/16/14 at 11:02 a.m., indicated "Documentation will include but not limited to: Any | | NO LESS THAN QUARTERLY.THE IDT REVIEWS THE RESIDENTS CARE PLAN AT LEAST QUARTERLY FOR REVISIONS AND UPDATES TO THE PLAN.NURSE AIDES HAVE BEEN RE-INSERVICED ON PREVENTATIVE SKIN CARE INCLUDING HANDWASHING, PERI CARE AND REPORTING ANY ISSUES TO THE LICENSED NURSE BY DON/DESIGNEE BY JUNE 15, 2014.THE DON/DESIGNEE REVIEWS THE MD TELEPHONE ORDERS (MON-FRI) FOR RESIDENT CHANGE IN CONDITON AND MD NOTIFICATIONDON/DESIGNEE WILL MONITOR FOR COMPLIANCE WITH MD NOTIFICATION.<br>4.A WOUND/SKIN AUDITING TOOL WILL BE UTILIZED WEEKLY X 4, THEN MONTHLY THEREAFTER UNTIL COMPLIANCE IS MET BUT NO LESS THAN 6 MONTHS. DATA COLLECTED WILL BE SUBMITTED TO THE QA COMMITTEE MONTHLY FOR REVIEW AND FOLLOW UP. THE DON/DESIGNEE REVIEWS THE MD TELEPHONE ORDERS (MON-FRI) FOR RESIDENTCHANGE IN CONDITON AND MD NOTIFICATION ONGOING. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROWNSBURG HEALTH CARE CENTER | 1010 HORNADAY RD<br>BROWNSBURG, IN 46112 |

| (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 |
|---|---|---|---|---|
| | change in the resident's condition. The size and location of any red or tender areas. The size and location of skin tears, open area. Report any changes in the resident's skin condition to the resident or responsible party and to the attending physician.<br><br>3.1-5(a)(2) | | | |
| F000323<br>SS=E | 483.25(h)<br>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>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.<br>A. Based on observation, record review and interview the facility failed to ensure adequate supervision for 1 of residents reviewed for accidents, in that Resident # 28 was having unwitnessed falls from a wheelchair and current interventions were failing to prevent further falls.<br><br>B. Based on observation and interview the facility failed to ensure suction machines were available and/or had the necessary supplies to ensure they would | F000323 | **F323**<br>**SUPERVISION/ACCIDENTS**<br>1.SUCTION MACHINES HAVE BEEN PLACED IN THE CLEAN UTILITY ROOM (S) ON EACH NURSING STATION (MEMORY CARE UNIT SUCTION MACHINE IS IN THE DINING ROOM) WITH AN ELECTRICAL CORD LONG ENOUGH TO REACH THE EMERGENCY POWER OUTLET.RESIDENT #28 HAS BEEN RE-EVALUATED BY THERAPY TO ENSURE RESIDENT IS IN THE | 06/15/2014 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112 | |

| (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 |
|---|---|---|---|---|
| | be operable in the event of a power outage for 4 of 4 suction machines in use.<br><br>Findings include:<br><br>On 5/14/14 at 11:14 a.m., Resident #28 was observed in a reclining wheelchair with a shallow seat in the middle station lounge. The resident was throwing her right leg over the side of the chair, positioning herself at risk of propelling over the chair's edge. A staff member was observed, while passing by, to place the resident's leg back onto the leg rest.<br><br>Resident #28's clinical record was reviewed on 5/15/14 at 10 a.m. A nurses note, dated 1/3/14 at 7:40 p.m., indicated, "Res [resident] was found lying on (R) [right] side of body in front of Mw/ac [wheelchair] in her room. approx [approximately] 4 cm [centimeter] X [by] 4 cm bruise to left inner calf noted. Purple in color. ROM [range of motion] WNL [within normal limits]...."<br><br>On 1/18/14 at 1 p.m., a nurses note indicated, "At 11:00 a.m., client, some way, flipped herself out of w/c, landing on D.R. [dining room] floor. Client MAEW [moves all extremities well]. ROM [range of motion] WNL [within normal limits] for client. Denies, exhibits no s/s [signs or symptoms] of | | APPROPRIATE CHAIR.<br>2.RESIDENTS WHO FALL HAVE THE POTENTIAL TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE AND RESIDENTS WHO NEED SUCTIONING HAVE THE POTENTIAL TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE.NURSING STAFF HAVE BEEN RE-INSERVICED ON USE OF SUCTION MACHINES IN THE DINING ROOM BY THE ADON/DESIGNEE BY JUNE 15, 2014.<br>3. RESIDENTS ARE ASSESSED FOR FALL RISK UPON ADMISSION AND NO LESS THAN QUARTERLY OR WITH A SIGNIFICANT CHANGE. THE CHARGE NURSE INITIATES INDIVIDUALIZED FALL PREVENTION INTERVENTIONS UPON ADMISSION AND WITH EACH FALL.FALL INTERVENTIONS ARE DOCUMENTED IN THE CARE PLAN AND NURSE AIDE RESIDENT CARE SHEET.THE IDT REVIEWS FALLS DAILY (MON-FRI) TO ENSURE THE FALL INTERVENTIONS ARE APPROPRIATE AND EFFECTIVE.DIRECTOR OF NURSING IS RESPONSIBLE TO MONITOR FOR STAFF COMPLIANCE WITH FALL PREVENTION. 4. A FALL TRACKING LOG WILL BE UTILIZED MONTHLY ONGOING. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155206 | | 05/16/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROWNSBURG HEALTH CARE CENTER | 1010 HORNADAY RD<br>BROWNSBURG, IN 46112 |

| (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 |
|---|---|---|---|---|
| | pain or discomfort. Client does have purple skin discoloration to bridge of nose. Area around orbital socket reddened....."<br><br>A nurses note on 3/3/14 at 11 a.m. indicated, "Heard thump in dining room and found resident lying on rt [right] side. Resident assessed for injury (sic) found two skin tears.. notice redden area on side of forehead..."<br><br>A nurses note on 4/5/14 at 11:25 a.m., indicated, "CNA [certified nursing assistant] reported to nurse res [resident] had slid out of chair in MDR [main dining room] (sic) no injury noted. Neuros [neurological assessment] WNL[within normal limits] PERL[pupils equal and reactive to light] MAE [moves all extremities] ROM within normal limits.<br><br>A "Fall Review" form in the clinical record, dated 5/12/14, indicated on 5/10/14 at 11:25 a.m. the resident was found on the floor in the dining room. "no injuries."<br><br>A plan of care, dated 1/24/14, with an update on 4/21/14, indicated, "At risk for falls related to past history of falls. She has dementia and no awareness of own limits. No safety awareness she has the | | DATA COLLECTED WILL BE SUBMITTED TO THE QA COMMITTEE MONTHLY FOR REVIEW AND FOLLOW UP. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112 | |

| (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 |
|---|---|---|---|---|
| | potential for adverse side effects of meds [medications], poor posture in wheelchair, no awareness of limits of bed, decreased range of motion in bilateral knees, poor posture in wheelchair." Approaches were noted of the following, but not limited to, 1/18/14 "Keep client away from structures that client could use to leverage self out of w/c [wheelchair]. 1/20/18 "Make sure tilt-in-space w/c [wheelchair] in reclined position except at meals. 1/24/14 "Tilt in space wheelchair with calf straps in place make sure that chair is in reclined position except at meals, arms are up [wheelchair arms]." 3/4/14 Dycem in w/c [wheelchair] seat."<br><br>Review of an undated "Owner's Operation and Maintenance Manual" received on 5/16/14 at 12:31 p.m. from LPN #17, a unit manager, documentation indicated the chair the resident was currently utilizing was a "Fuze T50", and was documented as a tilt-in-space chair.<br><br>During interview of the ADON (Assistant Director of Nursing) on 5/15/14 at 2 p.m., the ADON indicated none of the resident's falls were witnessed and indicated the resident fell from the "tilt-in-space" wheelchair except for one fall from her bed on 1/3/14. The ADON indicated after a fall on 1/18/14, | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112 | |

| (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 |
|---|---|---|---|---|
| | an intervention to keep the wheelchair reclined at all times except for meal times was implemented, along with an approach to keep the resident away from the dining room tables. A dycem was added after the fall on 3/3/14 to keep the resident from sliding down in the wheelchair. The ADON indicate no new interventions were added after the falls on 4/5/14 and 5/10/14.<br><br>During interview of the Occupational Therapist (OT) on 5/16/14 at 12:16 p.m., the OT indicated the resident was changed from a high back wheelchair to the current tilt-in-space chair when she declined to the point of not being able to reposition herself. The OT indicated she had "No idea how the resident is coming out of the chair." | | | |
| F000371<br>SS=E | 483.35(i)<br>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br>Based on observation, interview, and record review, the facility failed to ensure adequate hand sanitation during food distribution to 5 residents for 2 of 2 observations in 1 of 4 (Memory Care) dining rooms (Residents #52, #101, #98, | F000371 | **F371 FOOD HANDLING**<br>1. RESIDENT (S) #52, #101, #98, #90 AND #113 WERE IDENTIFIED BY THE SURVEYORS FOR THE ALLEGED DEFICIENT PRACTICE; THEREFORE | 06/15/2014 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROWNSBURG HEALTH CARE CENTER | 1010 HORNADAY RD<br>BROWNSBURG, IN 46112 |

| (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 |
|---|---|---|---|---|
| | #90, #113).<br><br>Findings include:<br><br>On 5/12/14 from 11:35 a.m. to 11:58 a.m., during the lunch dining observation, LPN #12 was observed to wash her hands for 9 seconds and then served Resident #52 her coffee and spoon. As LPN #12 continued to serve meal trays, she was observed to wash her hands for 6 seconds, picked up a spoon Resident #101 dropped on the floor, retrieved a new spoon from the pantry, and gave it to Resident #101.<br><br>On 5/15/14 from 11:50 a.m. to 12:03 p.m., during the lunch dining observation, QMA #13 was observed to wash her hands for 7 seconds and then set up the lunch tray for Resident #52. She was then observed to set up Resident #113's meal at the dining table and held the dinner roll with her left bare hand while buttering the top of the roll. Next, she was observed to wash her hands for 3 seconds, turned the water faucet off with her wet, bare hands, and then dried her hands with paper towel. She was then observed serving another tray from the cart of meal trays. QMA #13 was observed to wash her hands for 6 seconds, turned the water faucet off with both wet, bare, hands and retrieved the | | STAFF HAVE BEEN RE-INSERVICED ON PROPER HANDWASHING TECHNIQUE DURING RESIDENT CARE/DINING SERVICES BY THE DON/DESIGNEE BY JUNE 15, 2014<br>2.RESIDENTS RESIDING IN THE FACILITY HAVE THE POTENTIAL TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE. STAFF HAVE BEEN RE-INSERVICED ON PROPER HANDWASHING TECHNIQUE DURING RESIDENT CARE BY THE DON/DESIGNEE BY JUNE 15, 2014<br>3.STAFF HAS BEEN RE-INSERVICED ON PROPER HANDWASHING TECHNIQUE DURING RESIDENT CARE BY THE DON/DESIGNEE BY JUNE 15, 2014(INCLUDING A RETURN DEMONSTRATION SKILLS VALIDATION TOOL). A HANDWASHING SKILLS VALIDATION (RETURN DEMONSTRATION) WILL BE COMPLETED UPON HIRE AND AT LEAST YEARLY THEREAFTER. FACILITY STAFF WILL CONTINUE TO UTILIZE UNIVERSAL PRECAUTIONS ONGOING.<br>4.FACILITY MANAGEMENT STAFF WILL OBSERVE HANDWASHING PROCEDURES ON A RANDOM BASIS WEEKLY X4, THEN MONTHLY THEREAFTER UNTIL COMPLIANCE IS MET BUT NO LESS THAN 6 MONTHS. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112 | |

| (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 |
|---|---|---|---|---|
| | meal tray to serve Resident #90 her lunch. QMA #13 set up Resident #98's meal and removed the dinner roll from its package with her bare hands.<br><br>During an interview on 5/14/14 at 1:25 p.m., LPN #12 indicated facility policy stated one should handwash for 20 seconds.<br><br>During an interview on 5/15/14 at 12:25 p.m., QMA #13 indicated facility policy was to handwash for 15 seconds.<br><br>During an interview on 5/16/14 at 10:35 a.m., the Dietary Manager indicated nursing and dietary staff should not touch food with their hands.<br><br>The "Standard Operating Procedures Serving Food" policy dated May 12, 2013 was provided by the Administrator on 5/16/14 at 10:08 a.m. This current policy indicated the following:<br>"PURPOSE: To prevent food borne illness by ensuring that all foods are served in a sanitary manner.<br>PROCEDURES:<br>...avoid touching ready-to-eat foods with bare hands...."<br><br>An undated "Hand Washing" policy was provided by the Dietary Manager on 5/16/14 at 10:39 a.m. This current policy | | ISSUES IDENTIFIED WILL BE SUBMITTED TO THE QA COMMITTEE MONTHLY FOR REVIEW AND FOLLOW UP. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROWNSBURG HEALTH CARE CENTER | 1010 HORNADAY RD<br>BROWNSBURG, IN 46112 |

| (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 |
|---|---|---|---|---|
| | indicated the following:<br>"Policy: Dining Services staff is required to wash their hands in accordance with local and state health department regulations.<br>Purpose: To protect the public health from food borne illness...<br>...How to wash hands:<br>...apply soap...vigorously scrub hands and arms for 10-15 seconds...<br>...dry hands and arms with a paper towel. Use the paper towel to turn off the faucet...."<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | | |
| F000412<br>SS=D | 483.55(b)<br>ROUTINE/EMERGENCY DENTAL SERVICES IN NFS<br>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.<br>Based on interview and record review, the facility failed to ensure residents were provided routine dental services for 1 of | F000412 | **F412 DENTALSERVICES**<br><br>1.RESIDENT#127 WILL BE REFERRED TO THE DENTIST | 06/15/2014 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112 | |

| (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 |
|---|---|---|---|---|
| | 1 resident reviewed who met the criteria for dental services (Resident #127).<br><br>Findings include:<br><br>During a family interview on 5/13/2014 at 2:22 P.M., Resident #127's responsible party, indicated Resident #127 had to have his meat ground due to difficulty with swallowing and missing teeth. He indicated he had not been seen by a dentist.<br><br>Resident #127's record was reviewed on 5/16/2014 at 8:58 A.M., Resident #127 had diagnoses which included, but were not limited to, oropharangeal dysphagia and dementia.<br><br>A document titled "Record of Admission" provided by the Assistant Director of Nursing (ADON) on 5/16/2014 at 9:52 A.M., indicated Resident #127 was a recipient of Medicaid.<br><br>During an interview on 5/16/2014 at 9:35 A.M., with the Assistant Director of Nursing (ADON) and the Business Office Manager (BOM) present, the ADON indicated Medicaid residents were not provided routine dental services. She indicated if they had a complaint, the facility would ensure they were seen by a | | 2.RESIDENT'SIN NEED OF DENTAL SERVICES HAVE THE POTENTIAL TO BE AFFECTED BY THE ALLEDGEDDEFICIENT PRACTICE.<br><br>3.STAFFWILL BE INSERVICED ON TRACKING DENTAL VISITS BY THE ADMINISTRATOR/DESIGNEE BYJUNE 15, 2014.<br>SOCIAL SERVICE/DESIGNEE WILLUTILIZE A TRACKING LOG TO ENSURE RESIDENTS ARE SEEN BY THE DENTIST ON A SEMIANNUAL BASIS AND AS NEEDED.<br><br>4.ADENTAL **TRACKING LOG** WILL BE UTILIZEDTO ENSURE COMPLIANCE IS MET. DATACOLLECTED WILL BE SUBMITTED TO THE QA COMMITTEE MONTHLY FOR REVIEW AND FOLLOWUP. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155206 | A. BUILDING 00<br>B. WING | 05/16/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROWNSBURG HEALTH CARE CENTER | 1010 HORNADAY RD<br>BROWNSBURG, IN 46112 |

| (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 |
|---|---|---|---|---|
| | dentist.<br><br>3.1-24(a)(1) | | | |
| F000441<br>SS=E | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(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. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112 | |

| (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 |
|---|---|---|---|---|
| | (c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br>Based on observation, interview, and record review, the facility failed to ensure a sanitary environment to prevent infections and cross contamination for random observations of 1 of 6 nursing units. This had the potential to affect 12 residents residing on the secured nursing unit.<br><br>Findings include:<br><br>During a continuous observation on 5/15/2014 from 10:22 a.m. until 10:50 a.m., Unit Manager # 5, was observed covering her cough with her hand. Unit Manager #5 failed to sanitize her hands after coughing into her hand. Unit Manager #5 was observed pulling the handle to the locked unit. Unit Manager #5 was observed holding Resident # 109 ' s hands and patting her shoulders. Unit Manager # 5 then removed a soiled table cloth from the table that Resident #109 was sitting at and replaced it. Unit Manager #5 did not sanitize her hands during this observation.<br><br>During an observation on 05/16/2014 from 11:50 a.m., until 12:10 p.m., QMA # 13 instilled eye drops into Resident # 98's left and right eyes with ungloved | F000441 | **F441 HANDWASHING**<br>1.RESIDENT#98 EYE DROPS ARE INSTILLED ACCORDING TO FACILITY POLICY. RESIDENT #65 MEDICATIONS ARE ADMINISTERED USING CORRECT HANDWASHING PROCEDURE.<br>RESIDENT #109 STAFF HAVE BEEN RE-INSERVICED ON PROPER HANDWASHING TECHNIQUE DURING RESIDENT CARE BY THE DON/DESIGNEE BY JUNE 15, 2014.2. RESIDENTS RESIDING IN THE FACILITY HAVE THE POTENTIAL TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE. STAFF HAVE BEEN RE-INSERVICED ON PROPER HANDWASHING TECHNIQUE DURING RESIDENT CARE BY THE DON/DESIGNEE BY JUNE 15, 20143. STAFF HAS BEEN RE-INSERVICED ON PROPER HANDWASHING TECHNIQUE DURING RESIDENT CARE BY THE DON/DESIGNEE BY JUNE 15, 2014 (INCLUDING A RETURN DEMONSTRATION SKILLS VALIDATION TOOL).A HANDWASHING SKILLS VALIDATION (RETURN DEMONSTRATION) WILL BE COMPLETED UPON HIRE AND AT LEAST YEARLY THEREAFTER. FACILITY | 06/15/2014 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112 | |

| (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 |
|---|---|---|---|---|
| | hands. QMA #13 used the tip of the medication dropper to open the resident ' s eye. QMA #13 then washed her hands at the sink for twelve seconds and turned the faucet off with her wet hand. QMA # 13 then returned to the medicine cart. At this time, she crushed pills for Resident #65 and placed them in a medicine cup. She then took a spoon full of the pudding from an uncovered pudding container that had previously been observed sitting on top of the med cart and placed it in the cup with the crushed pills. QMA # 13 then took the medication and pudding mixture and served the mixture to Resident #65. QMA #13 then washed her hands for 10 seconds and used her wet hand to turn the faucet off.<br><br>During an interview on 05/16/14 at 12:10 p.m., QMA #13 indicated she opened the pudding when she came into work and she kept it on top of the medicine cart for use with crushed medications all day. QMA #13 indicated the pudding should have been sealed between uses. QMA #13 indicated proper technique of eye drop instillation included the tip not touching the patient during the procedure. QMA # 13 indicated that proper hand washing should take thirty seconds or the length of time it takes to sing the happy birthday song. | | STAFF WILL CONTINUE TO UTILIZE UNIVERSAL PRECAUTIONS ONGOING. 4. FACILITY MANAGEMENT STAFF WILL OBSERVE HANDWASHING PROCEDURES ON A RANDOM BASIS WEEKLY X 4, THEN MONTHLY THEREAFTER UNTIL COMPLIANCE IS MET BUT NO LESS THAN 6 MONTHS. ISSUES IDENTIFIED WILL BE SUBMITTED TO THE QA COMMITTEE MONTHLY FOR REVIEW AND FOLLOW UP. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112 | |

| (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 |
|---|---|---|---|---|
| | A review of a document, received from the Administrator on 5/16/14 at 10:08 a.m., entitled, "Introduction to Employee Health," indicated, "Hand washing is required before and after contact with a patient...."<br><br>A review of a policy entitled, "Hand washing," received from the Administrator on 5/16/14 at 10:08 a.m., indicated hand washing should be conducted, "....After contact with blood, body fluids, secretions, mucous membranes...." The policy further indicated to, "Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for ten (10) to fifteen (15) seconds under a moderate stream of running water....dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel."<br><br>A review of a policy and procedure entitled, "Medication Administration Guide," received from the ADON on 5/16/14 at 1:10 p.m., indicated, "Cover and date fluids, applesauce or other soft foods used to administer medications." The section of this document entitled, "How to Administer Eye Medications," indicated to, "Wash your hands and apply clean disposable gloves." This policy further indicated, "The medication | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 05/16/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112 | |

| (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 |
|---|---|---|---|---|
| | container should NOT [sic] touch the resident's eye or eyelid to maintain medication sterility."<br><br>3.1-18(l) | | | |