

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 07/08/2015
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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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(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
F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 1, 2, 6, 7, 8, 2015</p> <p>Facility number: 000311 Provider number: 15E064 AIM number: 100285520</p> <p>Census bed type: NF: 39 Total: 39</p> <p>Census payor type: Medicaid: 38 Other: 1 Total: 39</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.</p>	F 0000	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.	
F 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications</p>			

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

TITLE

(X6) DATE

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

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	<p>for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>A. Based on observation, record review and interview, the facility failed to ensure residents who received psychoactive medications had specific targeted behavior indicators for each psychoactive medication for 2 of 5 residents reviewed for unnecessary medications. (Resident #23 and #41)</p> <p>B. Based on record review and interview, the facility failed to ensure bowel monitoring was completed so that "as necessary" medications to relieve constipation could be used for 2 of 5 residents reviewed for unnecessary medications. (Resident #23 and #41)</p> <p>Findings include:</p> <p>A 1. The clinical record for Resident #23</p>	F 0329	<p>F-329</p> <p>1.) A.) Facility immediately reviewed all records including resident #23 and resident #41 and updated to include specific targeted behaviors for each psychoactive medication. Social Service Designee and Charge Nurse were re-educated on the use of behavior/interventions monthly flow records. Care Plans on all resident's were updated to include specific targeted behaviors that were being treated with psychoactive medication.</p> <p>B.) Facility immediately reviewed all records including resident #23 and resident #41 for Bowel Elimination documentation and if "as necessary" medication given per facility policy. Charge Nurses and CNA's were re-educated on Bowel Elimination</p>	08/01/2015

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	<p>was reviewed on 7/7/15 at 7:28 a.m. Diagnoses for Resident #23 included, but were not limited to, paranoid schizophrenia, dementia, depression, delusions, and anxiety.</p> <p>Current physician's orders for Resident #23 included, but were not limited to, the following orders:</p> <p>a. Lexapro (an antidepressant medication) 30 milligrams (mg) via gastrostomy tube (g-tube) every morning.</p> <p>b. Haldol (an antipsychotic medication) 0.25 milliliters (ml) [0.5 mg] via g-tube every morning.</p> <p>c. Haldol (an antipsychotic medication) 0.5 ml [1 mg] via g-tube every evening.</p> <p>d. Geodon (an antipsychotic medication) 80 mg via g-tube 2 times a day.</p> <p>e. Klonopin (an antianxiety medication) 0.5 mg via g-tube every morning.</p> <p>f. Klonopin (an antianxiety medication) 1 mg via g-tube every evening.</p> <p>Resident #23 had a current, 6/9/15, quarterly Minimum Data Set (MDS) assessment which indicated the resident had severe cognitive impairment and</p>		<p>monitoring and administering "as necessary" medication to relieve constipation.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) A.) SSD, DON or Designee will monitor new orders daily for psychotropic drug use, placing specific behaviors on behavior/intervention monthly flow records and updating care plans accordingly.</p> <p>B.) Director of Nursing will monitor daily the Bowel Elimination record and interventions to ensure on-going compliance.</p> <p>4.) A.) Social Service Consultant and RN consultant will monitor monthly to ensure on-going compliance on specific targeted behaviors for each psychoactive medication and updated Care Plans.</p> <p>B.) Charge Nurse will monitor Bowel Elimination daily on 2-10 shift. Bowel Elimination record will be monitored by DON or Designee daily X 60 days, then 2X weekly X 60 days then weekly X 2 months. Nurse Consultant will monitor monthly X6 months.</p> <p>DON, HFA will report to the Q.A. Committee on both A & B during</p>	

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	<p>never or rarely made decisions. The assessment indicated Resident #23 had no delusions or maladaptive behaviors during the assessment period.</p> <p>Resident #23 was not observed displaying any maladaptive behaviors during the survey dates of 7/1/15, 7/2/15, 7/6/15, 7/7/15, and 7/8/15.</p> <p>Review of the June 2015, "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD", indicated Resident #23 was monitored for removing her clothes in the common area and repetitive yelling out of staff names in the common area.</p> <p>Resident #23 did have behavioral health care plans. The health care plans did not associate each psychoactive medication with specific targeted behaviors.</p> <p>During an interview on 7/8/15, at 12:56 p.m., the Social Services Designee indicated she did not have health care plans with specific targeted behaviors or a method to identify which behaviors were being treated by each psychoactive medication for Resident #23 regarding her use of antipsychotic, antidepressant, and antianxiety medications.</p> <p>A 2. The clinical record for Resident #41</p>		<p>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.) Completion Date: 08/01/2015</p>	

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	<p>was reviewed on 7/6/15 at 12:38 p.m. Diagnoses for Resident #41 included, but not limited to, schizophrenia, depression, hallucinations, delusions, and dementia.</p> <p>Current physician's orders for Resident #41 included, but were not limited to, the following orders:</p> <ul style="list-style-type: none"> a. Prozac (an antidepressant medication) 20 mg by mouth every day. b. Remeron (an antidepressant medication) 7.5 mg by mouth at bedtime. c. Seroquel (an antipsychotic medication) 350 mg by mouth 2 times a day. d. Risperdal (an antipsychotic medication) 3 mg by mouth every morning. e. Risperdal (an antipsychotic medication) 4 mg by mouth at bedtime. <p>Resident #41 had a current, 6/9/15, quarterly Minimum Data Set (MDS) assessment which indicated the resident had severe cognitive impairment and never or rarely made decisions. The assessment indicated Resident #41 had displayed verbal and other behaviors 1 to</p>			

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	<p>3 days during the assessment period.</p> <p>Resident #41 was not observed displaying any maladaptive behaviors during the survey dates of 7/1/15, 7/2/15, 7/6/15, 7/7/15, and 7/8/15.</p> <p>Review of the June 2015, "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD", indicated Resident #41 was monitored for taking food from the trash and other residents' trays, and cursing at/calling other residents and staff names.</p> <p>Resident #41 did have behavioral health care plans. The health care plans did not associate each psychoactive medication with specific targeted behaviors.</p> <p>During an interview on 7/8/15, at 12:56 p.m., the Social Services Designee indicated she did not have health care plans with specific targeted behaviors or a method to identify which behaviors were being treated by each psychoactive medication for Resident #41 regarding his use of antipsychotic and antidepressant medications.</p> <p>Review of the current, undated, facility policy, title "BEHAVIOR MANAGEMENT POLICY", provided by the Social Services Designee on 7/8/15 at</p>			

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	<p>1:38 p.m., included, but was not limited to, the following:</p> <p>"...PROCEDURE:...</p> <p>5. If symptoms need management, realistic goals and interventions will be developed by the Interdisciplinary Team and documented in the resident's care plan...</p> <p>...9. Effectiveness of interventions will be monitored by review of documentation on the Social Service Alert Form by Social Service Director...."</p> <p>B 1. The clinical record for Resident #23 was reviewed on 7/7/15 at 7:28 a.m. Diagnoses for Resident #23 included, but were not limited to, paranoid schizophrenia, dementia, depression, delusions, and constipation.</p> <p>Resident #23 had a current, 6/9/15, quarterly Minimum Data Set (MDS) assessment which indicated the resident had severe cognitive impairment and never or rarely made decisions. The assessment indicated Resident #23 was totally dependent on one person for toileting.</p> <p>A health care plan problem, dated 11/5/14, indicated Resident #23 had a</p>			

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	<p>potential for constipation related to decreased mobility and the use of pain medication. One of the goals for this problem indicated the resident would have a soft formed stool at least every three days. Interventions for this problem included "report any abnormalities (abdominal distention and/or pressure/fullness, etc), administer medications as ordered, and follow the facility's bowel protocol."</p> <p>Current physician's orders for Resident #23 included, but were not limited to, the following orders:</p> <p>a. Colace (a laxative medication) 10 ml [100 mg] via g-tube once a day. The original date of this order was 12/19/12.</p> <p>b. Miralax (a laxative medication) 17 grams dissolved in 8 ounces of water via g-tube once a day. The original date of this order was 12/14/12.</p> <p>c. Milk of Magnesia (a laxative medication) 30 ml via g-tube once a day as needed for constipation. The original date of this order was 9/3/14.</p> <p>d. Dulcolax EC (a laxative medication) 5 mg give 2 tablets (10 mg) via g-tube at bedtime as needed on the third day without a bowel movement. The original</p>			

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	<p>date of this order was 10/23/13.</p> <p>e. Dulcolax (a laxative medication) 10 mg suppository insert 1 suppository rectally once a day as needed for constipation. The original date of this order was 12/8/14.</p> <p>f. Fleet enema (a laxative medication) use 1 enema rectally every day as needed for constipation. The original date of this order was 12/20/12.</p> <p>Review of the bowel monitoring for April 2015, indicated Resident #23 did not have a recorded bowel movement for the following time periods:</p> <p>April 3, 4, 5, 6, and 7, 2015, all zeros recorded. A zero indicated "none" for the bowel movement. A time period of 5 days without a recorded bowel movement.</p> <p>April 10, 11, 12, 13, and 14, 2015, all zeros recorded. A time period of 5 days without a recorded bowel movement.</p> <p>The nursing notes lacked any information related to any interventions having been given or tried during these time periods. Review of the April 2015, Medication Administration Record (MAR) indicated Resident #23 had been given a Dulcolax</p>						

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	<p>suppository on 4/14/15 at 7:00 p.m., the fifth day without a recorded bowel movement.</p> <p>B 2. The clinical record for Resident #41 was reviewed on 7/6/15 at 12:38 p.m. Diagnoses for Resident #41 included, but not limited to, schizophrenia, depression, delusions, dementia and constipation.</p> <p>Resident #41 had a current, 6/9/15, quarterly Minimum Data Set (MDS) assessment which indicated the resident had severe cognitive impairment and never or rarely made decisions. The assessment indicated Resident #41 needed limited assistance of one person for toileting.</p> <p>A health care plan problem, dated 9/16/14, indicated Resident #41 had a potential for constipation. One of the goals for this problem indicated the resident would have a soft formed stool at least every three days. Interventions for this problem included "report any abnormalities (abdominal distention and/or pressure/fullness, etc), the CNAs will inquire prior to end of their shift if the resident had a bowel movement - if the resident self-toilets, and follow the facility's bowel protocol."</p> <p>Current physician's orders for Resident</p>			

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	<p>#41 included, but were not limited to, the following orders:</p> <p>a. Miralax (a laxative medication) 17 grams dissolved in 8 ounces of water by mouth once a day. The original date of this order was 9/6/12.</p> <p>b. Milk of Magnesia (a laxative medication) 30 ml by mouth once a day as needed for constipation. The original date of this order was 11/17/10.</p> <p>c. Dulcolax EC (a laxative medication) 5 mg give 2 tablets (10 mg) by mouth at bedtime as needed on the third day without a bowel movement. The original date of this order was 12/20/12.</p> <p>d. Dulcolax (a laxative medication) 10 mg suppository insert 1 suppository rectally once a day as needed on the fourth day without a bowel movement. The original date of this order was 12/20/12.</p> <p>e. Fleet enema (a laxative medication) use 1 enema rectally at bedtime as needed on the fifth day without a bowel movement. The original date of this order was 12/20/12.</p> <p>Review of the bowel monitoring for April 2015, and May 2015, indicated Resident</p>			

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	<p>#41 did not have a recorded bowel movement for the following time periods:</p> <p>April 22, 23, 24, 25, and 26, 2015, all zeros recorded. A zero indicated "none" for the bowel movement. A time period of 5 days without a recorded bowel movement.</p> <p>May 27, 28, 29, and 30, 2015, all zeros recorded. A time period of 4 days without a recorded bowel movement.</p> <p>The nursing notes lacked any information related to any interventions having been given or tried during these time periods. Review of the April 2015, Medication Administration Record (MAR) indicated Resident #41 had been given Milk of Magnesia on 4/24/15 at 6:40 p.m. No other as needed medications were documented as having been given on the April 2015, MAR after 4/24/15. Review of the May 2015, MAR indicated no as needed medications having been given after 5/17/15.</p> <p>During an interview on 7/8/15 at 12:23 p.m., LPN #1 indicated the bowel movements are documented by the CNAs on the CNA assignment sheets kept at the nurses station.</p> <p>During an interview with the</p>			

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	<p>Administrator and the Director of Nursing on 7/8/15 at 1:37 p.m., additional information was requested related to the bowel monitoring for Resident #23 and Resident #41.</p> <p>Review of the current, undated facility policy, titled "BOWEL ELIMINATION PROTOCOL", provided by the Director of Nursing on 7/8/15 at 2:21 p.m., included, but was not limited to, the following:</p> <p>"POLICY: It is the responsibility of the nursing personnel to document, monitor and implement appropriate measures relative to the management of bowel function...</p> <p>...5. The evening shift Charge Nurse will review the ADL [Activities of Daily Living] sheet in regards to bowel movements. When reviewing the Charge Nurse must review the current day and the previous day. If a resident had no bowel movement by the evening of the third day and the abdominal assessment shows signs/symptoms for intervention, the bowel regimen will be imitated. The bowel regimen will include an abdominal assessment for bowel sounds, distention or firmness. The Charge Nurse will indicate on the 24 hour report sheet the name the resident that will require</p>			

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F 0514 SS=D Bldg. 00	<p>administration of either Dulcolax Tabs, suppositories or enema per protocol.</p> <p>6. The evening shift Charge Nurse will administer two Dulcolax tabs at HS [bedtime] and document this on the MAR. The abdominal assessment will be noted in the nurse's notes.</p> <p>7. If the resident has had no bowel movement and the abdominal assessment shows signs/symptoms for intervention by the evening of the fourth day, per rectum a Bisacodyl suppository will be administered at HS and documented on the MAR. The abdominal assessment will be noted in the nurse's notes.</p> <p>8. If the resident has had no bowel movement and the abdominal assessment shows signs/symptoms for intervention by the fifth day, administration of one phosphate (fleet) enema PRN [as needed] is to be administered and documented on the MAR...."</p> <p>3.1-48(a)(4) 3.1-48(a)(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that</p>			

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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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(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>are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure current hospice nursing documentation was maintained in the clinical record for 1 of 1 resident reviewed for hospice services. (Resident #7)</p> <p>Findings include:</p> <p>Resident #7's clinical record was reviewed on 7/7/15 at 10:46 a.m. The resident's diagnoses included, but were not limited to, dementia with depression, hypertension, coronary artery disease, liver cyst, macular degeneration, neuropathy, osteoporosis, peripheral edema, chronic obstructive pulmonary disease, and traumatic brain hemorrhage.</p> <p>Review of Resident #7's hospice record indicated the last documented CNA note was for a visit on 6/4/15 and the last documented RN note was a visit on 6/2/15.</p> <p>Review of the resident's hospice sign in</p>	F 0514	<p>F- 514</p> <p>1.) Facility immediately notified Hospice of missing documentation for resident #7 for dates of visits on 6/9/15 and 6/23/15. Hospice Nurse came to facility, HFA and the Hospice Nurse found that the documentation was in the chart just out of sequence. Hospice also completed an audit of all hospice resident charts to ensure all documentation is in place.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) Hospice will provide all documentation to the HFA for each visit within 24 hours, HFA will place documentation in chart. HFA will monitor Hospice books daily for visits to ensure documentation is in place within 24 hour of visit.</p> <p>4.) HFA will monitor Hospice books daily for visits to ensure documentation is in place to correspond with date signed with-in</p>	08/01/2015

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	<p>sheet indicated the hospice RN had visited on 6/9/15 and 6/23/15.</p> <p>During an interview with LPN #1 on 7/8/15 at 1:20 p.m., she indicated a hospice CNA had made visits every Tuesday and Thursday and she had electronically signed the CNA's documentation to verify the visits. LPN #1 indicated the hospice RN had been in to visit the resident but she could not remember if the RN had come in weekly or every two weeks. LPN #1 indicated someone from hospice would bring in a stack of notes and file them all at one time in the hospice record about every two weeks.</p> <p>3.1-50(a)(1)</p>		<p>24 hours. DON, HFA will report to the Q.A. Committee on 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.) Completed Date: 08/01/2015</p>	