

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2016
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NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11049 STATE ROAD 101 BROOKVILLE, IN 47012
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 21, 22, 23, 24, and 27, 2016</p> <p>Facility number: 000550 Provider number: 155480 AIM number: 100286110</p> <p>Census bed type: SNF/NF: 49 Total: 49</p> <p>Census payor type: Medicare: 0 Medicaid: 43 Other: 6 Total: 49</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on June 30, 2016</p>	F 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview and record review, the facility failed to provide adequate nursing staff to answer residents call lights timely and resulting in 1 resident urinating on herself. (Resident #16 and #17)</p> <p>Findings include:</p> <p>1. During an interview with Resident #16 on 6/22/16 at 9:25 a.m., she was queried if she felt the facility had enough staff available to make sure she got the care and assistance she needed without having to wait a long time and she answered "no." She stated "there should be more on than what there is sometimes. Sometimes we wait a long time for them to answer our call bell."</p> <p>On 6/27/16 at 1:13 p.m., Resident #16 was observed seated on her electric wheelchair in her bedroom drawing pictures. She indicated the facility needed more staff at night. She had urinated in her brief 2 times in the past 2 weeks waiting on staff to answer her call</p>	F 0246	<p>F246 Requires the facility to provide adequate nursing staff to answer residents call lights timely</p> <p>1. Resident #16 and #17 are on a toileting schedule.</p> <p>2. All residents have the potential to be affected. Staff was made aware of the importance to answer call lights and attend to the resident's need immediately. See below for corrective measures.</p> <p>3. The staff was educated on answering time lights immediately and meeting the needs of the resident timely. All staff are to assist with answering call lights and ensuring resident's needs are met.</p> <p>4. The DON or her designee conduct call light response time audits. The DON or her designee will monitor 3 call lights response and document how long the staff requires to meet the need of the resident. If the response is not answered within an appropriate time, the staff will be educated on the needs of the resident. The DON or her designee will utilize the nursing monitoring tool daily</p>	06/30/2016			

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	<p>light at night. She knew when she had to urinate approximately 30 minutes ahead of time and required assistance of 1 staff to help her go to the toilet. She had been informed by staff it was easier for them to change her brief in bed than it was for them to assist her to the toilet. She had not reported her concern to management or filed a grievance. The staff who assisted her to change her brief were aware and they would inform her she would get her brief changed as soon as they could get to her. She stated "It is not the staffs fault, they can only do so much, they just need more help."</p> <p>Resident #16's record was reviewed on 6/27/16 at 2:41 p.m. Her diagnoses documented on her June 2016 physician's recapitulation orders included but were not limited to, hypertension, macular degeneration, cerebrovascular accident, chronic back pain, and fibromyalgia.</p> <p>Resident #16's annual Minimum Data Set (MDS) assessment dated 4/13/16, indicated she was understood and had the ability to understand others. She required extensive assistance of 1 person for transfer and toileting. She had functional limitation in her range of motion on 1 side of her upper body. She required limited assistance of 1 person to walk in her room. She was frequently incontinent</p>		<p>times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.</p> <p>5. The above corrective measures will be completed on or before June 30, 2016.</p>	

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	<p>of urine.</p> <p>A plan of care for Resident #16 dated 4/25/16, indicated she was incontinent of bladder due to functional incontinence associated with dementia, cognitive loss, depression, cerebral vascular accident, pain, medication use, neuropathy, chronic back pain, fibromyalgia, a diagnosis of incontinence, and assist to toilet was required. She was at risk for rash, skin breakdown, social isolation, and infection. Her goal was to have no complications associated with urinary incontinence through her next review. Her interventions included but were not limited to, approaching her every 2 hours and ask or check for evidence of incontinence and toilet her every 2 hours.</p> <p>2. During an interview with Resident #17's son on 6/22/16 at 10:11 a.m., he was queried if there were enough staff available in the facility to make sure the residents got the care and assistance they needed without having to wait a long time and he answered "no." He indicated sometimes it took up to 30 minutes for staff to answer the call lights. He had sat in his mother's room for 30 minutes waiting on staff to answer her call light.</p> <p>Resident #17's record was reviewed on 6/22/16 at 10:15 a.m. Her diagnoses</p>			

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	<p>documented on her June 2016 physician's recapitulation orders included but were not limited to, chronic constipation, cerebrovascular accident, hypotension, aortic aneurysm, hyperlipidemia, chronic obstructive pulmonary disease, depression, decompensation, anxiety, insomnia, chronic back pain, esophagitis, and vascular dementia with paranoid and psychotic features.</p> <p>Resident #17's quarterly MDS assessment dated 4/14/16, indicated she was understood and usually had the ability to understand others She was severely impaired in her cognitive daily decision making skills. She required extensive assistance of 2 persons for bed mobility, transfer, dressing, and toileting. She required extensive assistance of 1 person for personal hygiene. She required supervision and set up for eating. She was frequently incontinent of bladder. She was at risk for pressure ulcers and had 1 unhealed stage 2 pressure ulcer. She had functional limitation in her range of motion in both upper and lower extremities. She did not walk and utilized a wheelchair for mobility.</p> <p>3.1-3(v)(1)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow a physician's order to provide a resident with a call light with no metal clip on it for a resident at high risk for skin tears and bruising, for 1 of 19 residents reviewed for physician's orders. (Resident #29)</p> <p>Findings include:</p> <p>Resident #29's record was reviewed on 6/24/16 at 9:41 a.m. Her diagnoses documented on her June 2016 physician's recapitulation orders included but were not limited to, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease,</p>	F 0282	<p>F282 Requires the facility to follow a physician's order to provide a resident with a call light with no metal clip on it for a resident at high risk for skin tears and bruising.</p> <p>1. Resident #29 call light was replaced to ensure metal clip was removed.</p> <p>2. All residents have the potential to be affected. All call lights were audited ensuring that safety equipment is in place per plan of care. See below for corrective measures.</p> <p>3. The care plan policy and procedure was reviewed with no changes made. (See attachment B) The staff was serviced the above procedure.</p> <p>4. The DON or her designee will conduct daily</p>	06/30/2016

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	<p>hypertension, generalized weakness, arthritis, history of deep vein thrombosis, edema, and peripheral vascular disease.</p> <p>Resident #29's quarterly Minimum Data Set (MDS) assessment dated 5/14/16, indicated she was understood and had the ability to understand others. She was cognitively intact in her daily decision making skills. She required total assistance of 2 persons for bed mobility and toileting. She required total assistance of 1 person for personal hygiene. She required extensive assistance of 1 person to dress and eat. She had functional impairment in her range of motion in both of her upper and lower extremities. She had 1 venous ulcer, a skin tear, and moisture associated skin damage.</p> <p>An order for Resident #29 initiated 2/22/15, documented on her June 2016 physician's recapitulation orders, indicated "no metal clasps on call string while in bed."</p> <p>On 6/21/16 at 10:58 a.m., Resident #29 was observed lying in bed covered with a blanket. She had scattered areas of purplish discolorations on both of her arms. She indicated she had a bruise on her right upper arm that happened when a staff member had been assisting her.</p>		<p>rounds to ensure call light interventions are in place according to the resident's plan of care. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.</p> <p>5. The above corrective measures will be completed on or before June 30, 2016.</p>				

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	<p>The purplish discoloration on her right upper arm was approximately the size of a half dollar. She indicated she had very thin skin and was on a blood thinner. She indicated she had discolorations on her legs also.</p> <p>On 6/22/16 at 2:16 p.m., Resident #29 was observed lying in bed covered with a blanket. Her call light was available and clipped on her blanket.</p> <p>On 6/23/16 at 10:08 a.m., Resident #29 was observed lying in bed covered with a blanket. Her call light was available and clipped on her blanket.</p> <p>On 6/24/16 at 9:24 a.m., Resident #29 was observed seated in bed covered with a blanket and the head of her bed elevated 45 degrees. She had top half bed side rails in the up position. Her call light string was tied around her bed rail and in reach of Resident #29.</p> <p>On 6/24/16 at 1:53 p.m., Resident #29's daughter was in visiting. She indicated Resident #29 always had discolorations on her arms. She indicated "all you have to do is touch her and it discolors her skin."</p> <p>On 6/27/16 at 9:35 a.m., LPN #1 was observed providing a dressing change to</p>			

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	<p>Resident #29's left lower leg venous ulcer. LPN #1 indicated she had changed Resident #29's dressing on her right lower leg skin tear earlier that morning because it had fallen off and had some bloody drainage. The ADON was in Resident #29's room assisting with Resident #29 positioning while LPN #1 completed the dressing change. The ADON indicated the discolorations on Resident #29's arm were always pretty much the same. She indicated the skin on Resident #29's arms and legs were paper thin and her skin bruised and tore easily. Resident #29 was positioned for comfort and her call light was clipped on her blanket.</p> <p>On 6/27/16 at 12:43 p.m., Resident #29 was observed lying in bed on her left side with a wedge behind her back and a pillow behind her head. Her call light was available and clipped on her blanket. LPN #1 and CNA #2 entered Resident #29's room and repositioned Resident #29 for comfort. LPN #1 indicated she was unsure of an order for Resident #29 related to her call light clasp. CNA #3 moved Resident #29's call light from her blanket and tied the call light string around the bed rail with the clasp hanging on the outside of the side rail.</p> <p>On 6/27/16 a 12:54 p.m., LPN #1</p>			

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F 0441 SS=E Bldg. 00	<p>indicated Resident #29 had an order for no clasp on her call string.</p> <p>3.1-35(g)(2)</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>			

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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 record review and interview, the facility failed to ensure the "Infection Monitoring Logs" were completed as part of the infection control program to accurately maintain a record of infections. This affected 23 of 49 residents residing in the facility. (Resident #1, 4, 5, 8, 9, 11, 12, 13, 18, 20, 22, 25, 26, 27, 36, 37, 38, 47, 55, 56, 59, 74, and 76)</p> <p>Findings include:</p> <p>On 6/24/16 at 10:45 a.m., the "Infection Monitoring Logs" and surveillance forms, for April 2016 and May 2016, were provided by the Assistant Director of Nurses.</p> <p>The April 2016 "Infection Monitoring Logs" had 16 residents listed, and were incomplete in the areas of the date the infection was resolved, and totals for the following areas: Skin/Cellulitis, open</p>	F 0441	<p>F441 Requires the facility to ensure the Infection Monitoring Logs are completed as part of the Infection control program to accurately maintain a record of infections.</p> <p>1. Resident #1, #4, #5, #8, #9, #11, #12, #13, #18 #20, #22, #25, #26, #27, #36, #37, #38, #47, #55, #56, #59, #74 and #76 infections were continuing to be monitored until resolved per the Infection Control Coordinator.</p> <p>2. All residents have the potential to be affected. Infection Resolution Date will be completed for all infections as of June 28, 2016. See below for corrective measures.</p> <p>3. The general policies policy and procedure was reviewed with no changes made. (See attachment C) The Infection Control Coordinator was inserviced on the above procedure.</p> <p>4. The DON or her designee will review the Infection Monitoring Logs monthly to ensure Infection Resolution date is documented. If the date is not clearly</p>	06/30/2016			

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	<p>area, urinary tract infections, urinary tract infections with catheter, respiratory infection, eye, new multidrug resistant organism, and other sites.</p> <p>The May 2016 "Infection Monitoring Logs" had 11 residents listed, and were incomplete in the areas of the date the infection was resolved, and totals for the following areas: Skin/Cellulitis, open area, urinary tract infections, urinary tract infections with catheter, respiratory infection, eye, new multidrug resistant organism, and other sites.</p> <p>On 6/24/16, at 2:30 p.m., the Corporate Nurse Consultant indicated the nurses do a culture; they get an order from the doctor and they go by the last date of the antibiotic and the person who fills out the log should be filling out the date the infection was resolved.</p> <p>On 6/24/16 at 2:40 p.m., the Assistant Director of Nurses indicated they had used a different form and these forms are temporary. She said if the infection isn't resolved they will put the resident on the infection monitoring log again; if the resident still has symptoms, they will go back on the sheet. She does the color coding to show where the different infections are located.</p>		<p>documented the DON will review the documentation and document her findings for the date resolved. The DON or her designee will utilize the nursing monitoring tool monthly times three months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.</p> <p>5.The above corrective measures will be completed on or before June 30, 2016.</p>	

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	<p>A document titled "General Policies" was provided by the Assistant Director of Nurses on 6/24/16 at 2:40 p.m. The policy included, but was not limited to:</p> <p>"Purpose: To establish guidelines and implement those guidelines related to the prevention and spread of contagious, infectious or communicable disease...Review of infection control policies...3. The Infection Control Practitioner will track the use of topical, oral, intramuscular and intravenous antibiotics. Tracking will include: a. physician evaluation prior to initiating therapy b. antibiotic therapy administered without proper culture and diagnosis c. unnecessarily prolonged therapy d. antibiotics inappropriate for the infection e. antibiotics prescribed over the phone 4. Records shall be maintained of such reviews."</p> <p>3.1-18(b)(1)(A) 3.1-18(b)(3) 3.1-18(l)</p>			

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

PRINTED: 07/18/2016

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/27/2016
NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11049 STATE ROAD 101 BROOKVILLE, IN 47012		
(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	