

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155703	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/29/2015
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE VILLAGE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 CHURCH AVE JASPER, IN 47546
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F 000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey Dates: May 26, 27, 28 and 29, 2015.</p> <p>Facility Number: 003240 Provide Number: 155703</p> <p>Census bed type: SNF: 23 SNF/NF: 4 Total: 27</p> <p>Census payor type: Medicare: 15 Other: 12 Total: 27</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>This plan of correction is to serve as Brookside Village's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Brookside Village or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for compliance.</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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F 226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure the abuse policy was followed, in that, the policy for the criminal background checks was not completed in a timely manner for 1 of 10 employee files reviewed. (LPN # 8)</p> <p>Findings include:</p> <p>The employee files were reviewed on 5/28/15 at 2:00 P.M. and the criminal background check for LPN #8 was not completed within the 3 (three) day time requirement.</p> <p>During an interview with the Health Care Administrator on 5/28/15 at 2:30 P.M., she indicated LPN #8 started working with Residents in the facility on 3/17/15, but LPN #8's background check was not completed within the 3 day time requirement.</p> <p>On 5/29/13 at 10:00 A.M., the facility's abuse policy entitled "Abuse Prevention" was provided by the DON (Director of</p>	F 226	<p>F226 483.13(c)DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES LPN #8 has a current criminal background check in her employee file. All current employee files have been audited and found to contain criminal background checks. The systemic change is: The Human Resources Coordinator will maintain a spread sheet of all new hires indicating the date of hire and the date background check is initiated. No employees will be allowed to work if the Background Check is not initiated within 3 days of hire. In addition, the Human Resources Coordinator has received education on the facility Abuse Prevention Policy and the Associate Background Screening policy. The Administrator or designee will complete a quality assurance audit of the criminal background check spread sheet 5 days a week, for 4 weeks, to review for a criminal background check being initiated within 3 days of hire. This audit tool will continue thereafter, weekly for a duration of 12 months. The results of these reviews will be</p>	06/26/2015

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F 441 SS=D Bldg. 00	<p>Nursing) and reviewed. The policy read as follows: "...The personnel director...will conduct employment background checks and criminal conviction checks on persons making application for employment with this facility. Such investigation will be initiated prior to employment or offer of employment."</p> <p>On 5/29/13 at 10:00 A.M., the facility's policy entitled "Associate Background Screening" was provided by the DON and reviewed. The policy read as follows: "...Anyone accepting employment (both licensed and unlicensed staff) will be subjected to a limited criminal history check as a condition of employment..."</p> <p>3.1-28(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</p>		discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	<p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</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, interview, and record review, the facility failed to ensure proper contact isolation procedures were followed, in that, personal protective equipment was not utilized and/or proper handwashing was not performed and/or handwashing was not performed for 2 of 3 residents who met the criteria for review of contact isolation. (Resident #63, Resident #49)</p>	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS Both Resident #63 and Resident #49 have discharged to home from the facility. The facility currently has one resident for whom Contact Precautions are prescribed and are being maintained. PPE (gowns and gloves) are being used upon entry and soap and water hand-washing is occurring rather than alcohol based hand gel.	06/26/2015

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	<p>Findings include:</p> <p>1. During an interview on 5/26/15 at 9:00 A.M. the ADON (Assistant Director of Nursing) indicated Resident #63 was in Contact Isolation for an active C-Diff (Clostridium Difficile) (a spore forming bacterium) infection in the bowel.</p> <p>During an observation of 5/26/15 at 11:53 A.M., CNA #5 was observed to pass a meal tray through the doorway of Resident #63 to LPN #10. LPN #10 indicated, at that time, she was not able to receive the tray because Resident #63 had experienced an episode of bowel incontinence. At that time, 3 areas of liquid stool were observed on the floor near the foot of the bed. CNA #10 was then observed to enter the room of Resident #63 without applying any PPE (Personal Protective Equipment), set the meal tray on a table, and touch the surface of the table with an ungloved hand. During an interview, at that time, CNA #5 indicated she needed to perform handwashing and was observed to touch the bathroom door with an ungloved hand.</p> <p>During an observation on 5/26/15 at 11:56 A.M., CNA #5 was observed to exit the room of Resident #63. CNA #5</p>		<p>The systemic change includes that nursing staff and therapy staff will complete a competency validation for hand-washing, with soap and water, as appropriate when exiting the isolation room; and donning and removing personal protective equipment when entering and exiting the room. These skill check offs will be completed upon hire, annually and as needed. Nursing and therapy staff has received education on the wearing of PPE upon entry of contact precaution rooms and the use of soap and water hand washing rather than alcohol based hand gel when exiting a contact precaution room. This education will be completed upon hire, annually and as needed. The SDC or designee will complete a QA audit of staff performance for PPE use and hand washing in contact precaution rooms on 2 staff interactions daily for one month, then 5 staff interactions weekly for five months and 6 staff interactions monthly for an additional six months for a total 12 months of monitoring. Should the facility have no residents requiring contact precautions during any part of this monitoring period the SDC or designee will review verbally with staff members per the above frequencies. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3</p>				

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	<p>was observed to touch the inside surface of the door with a bare hand. CNA #5 was observed to not use a paper towel to grasp the inside surface of the door.</p> <p>During an interview, at that time, CNA #5 indicated she would normally apply PPE before entering the room of Resident #63, however she was in a hurry to get the lunch trays passed and had not applied PPE before entering the room of Resident #63.</p> <p>The clinical record of Resident #63 was reviewed on 5/28/15 12:23 P.M. The record indicated the diagnoses of Resident #63 included, but were not limited to, Clostridium difficile infection.</p> <p>The May 2015 Physician's Order Recap included, but was not limited to, an order for, "...Contact Precautions..."</p> <p>A Care Plan dated 5/23/15 for "Resident has need for isolation related to active infectious disease (sic) loose stools (sic) and C.Diff" include, but was not limited to, interventions of, "...Use principles of infection control and universal/standard precautions..."</p> <p>During an interview on 5/26/15 at 11:59 A.M. the DON (Director of Nursing) indicated it was the policy of the facility</p>		<p>months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p>		

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	<p>for staff to apply PPE prior to entering a room designated as Contact Isolation.</p> <p>The policy and procedure for C-Diff (Clostridium Difficile provided by the HFA (Health Facilities Administrator) on 5/26/15 at 2:32 P.M. indicated, "...A resident with a suspected or known active case of C-Diff that has been confirmed must be placed in contact isolation because C-Diff is transmitted by direct or indirect contact. This means that the patient and the environment can cause others to contract the same infection...Once the PPE is removed the staff will then wash their hands and use a paper towel to open the door to the room leaving behind all the equipment and PPE used on the affected resident...Alcohol gels are not an acceptable form of decontaminating your hands, soap and water must be used...PPE must be used when handling the resident with C-Diff or any environmental object in the resident's room..."</p> <p>2. During an interview on 5/26/15 at 9:02 A.M. the ADON (Assistant Director of Nursing) indicated Resident #49 was in Contact Isolation for an active MRSA (Methicillin Resistant Staphylococcus Aureus) urine infection.</p>			

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	<p>During an interview on 5/27/15 at 9:30 A.M., LPN #10 indicated it was the policy of the facility to strongly encourage all people to wear PPE (Personal Protective Equipment) during any interaction with a resident in contact isolation.</p> <p>On 5/27/15 at 9:35 A.M., ST (Speech Therapist) #1 was observed sitting in a chair in the room of Resident #49. ST #1 was then observed to use hand sanitizer and exit the room by grasping to door knob with a bare hand. ST #1 was observed to not use PPE, not perform handwashing, and/or not use a paper towel to grasp the interior door knob before exiting the room of Resident #49.</p> <p>During an interview on 5/27/15 at 9:50 A.M., RN #5 indicated handwashing should be performed before exiting the room of Resident #49 and/or a paper towel should be used to grasp the interior door knob.</p> <p>During an interview on 5/27/15 at 10:45 A.M., LPN #10 indicated PPE should be utilized when entering a Contact Isolation room.</p> <p>The clinical record of Resident #49 was reviewed on 5/28/15 at 8:30 A.M. The</p>			

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	<p>record indicated the diagnoses of Resident #49 included, but were not limited to, urinary tract infection.</p> <p>The May 2015 Physician's Order Recap included, but was not limited to, orders for, "...Bactrim DS [an antibiotic]...twice a day for 14 days...Contact precautions d/t [due to] MRSA in urine..."</p> <p>A Care Plan dated 5/8/15 for, "...Resident has need for isolation related to active infectious disease MRSA in urine..." included, but was not limited to, interventions of, "...Use principles of infection control and universal/standard precautions..."</p> <p>A preliminary urine culture report dated 5/24/15 indicated Resident #49 experienced an active MRSA urine infection.</p> <p>During an interview on 5/29/15 at 10:15 A.M., ST (Speech Therapist) #1 indicated PPE was not applied prior to entering the room of Resident #49 because she did not anticipate exposure to the organism.</p> <p>A Policy and Procedure for "Methicillin Resistant Staphylococcus Aureus" provided by the DON (Director of Nursing) on 5/28/15 at 3:27 P.M. indicated, "...Infectious MRSA describes</p>			

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R 000 Bldg. 00	<p>a residents [sic] who has an active MRSA infection with evidence of infection...Contact precautions are additional infection control practices that are put into place to prevent the spread of infectious disease within the community...staff will then wash their hands and use a paper towel to open the door to the room...alcohol gels are not an acceptable form of decontaminating your hands, soap and water must be used,...PPE must be used when handling the resident with MRSA or any environmental object in the resident's room.</p> <p>3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(l)</p> <p>This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.</p> <p>Residential Census: 36 Sample: 7</p> <p>These deficiencies reflect State findings</p>	R 000	<p>This plan of correction is to serve as Brookside Village's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Brookside Village or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services</p>	

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R 116 Bldg. 00	<p>cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>Based on interview and record review, the facility failed to ensure the abuse policy was followed, in that, the policy for the criminal background checks was not completed in a timely manner for 1 of 10 employee files reviewed. (CNA #10)</p> <p>Findings include:</p> <p>The employee files were reviewed on 5/28/15 at 2:00 P.M. and the criminal background check for CNA #10 was not completed within the 3 (three) day time requirement.</p> <p>During an interview with the Health Care Administrator on 5/28/15 at 2:30 P.M., she indicated CNA #10 started working with Residents in the facility on 10/9/14,</p>	R 116	<p>in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for compliance.</p> <p>R116 410 IAC 16.2-5-1.4(a) Personnel -Noncompliance CNA #10 has a current criminal background check in her employee file. All current employee files have been audited and found to contain criminal background checks. The systemic change is: The Human Resources Coordinator will maintain a spread sheet of all new hires indicating the date of hire and the date background check is initiated. No employees will be allowed to work if the Background Check is not initiated within 3 days of hire. In addition, the Human Resources Coordinator has received education on the facility Abuse Prevention Policy and the Associate Background Screening policy. The Administrator or designee will complete a quality assurance audit of the criminal</p>	06/26/2015	

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	<p>but CNA #10's background check was not completed within the 3 day time requirement. CNA #10's background check was completed on 1/22/15.</p> <p>On 5/29/13 at 10:00 A.M., the facility's abuse policy entitled "Abuse Prevention" was provided by the DON (Director of Nursing) and reviewed. The policy read as follows: "...The personnel director...will conduct employment background checks and criminal conviction checks on persons making application for employment with this facility. Such investigation will be initiated prior to employment or offer of employment."</p> <p>On 5/29/13 at 10:00 A.M., the facility's policy entitled "Associate Background Screening" was provided by the DON and reviewed. The policy read as follows: "...Anyone accepting employment (both licensed and unlicensed staff) will be subjected to a limited criminal history check as a condition of employment..."</p>		background check spread sheet 5 days a week, for 4 weeks, to review for a criminal background check being initiated within 3 days of hire. This audit tool will continue thereafter, weekly for a duration of 12 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.		