

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 09/18/2012
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NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112
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F0000	<p>This visit was for the Investigation of Complaint IN000115746.</p> <p>Complaint IN000115746 - Substantiated. Federal/state deficiencies related to the allegations are cited at F498.</p> <p>Survey dates: September 17 and 18, 2012.</p> <p>Facility number: 000113 Provider number : 155206 AIM number : 100287670</p> <p>Survey team : Michelle Hosteter, RN-TC Michelle Carter, RN</p> <p>Census bed type: SNF : 2 SNF/NF : 104 Total : 106</p> <p>Census payor type : Medicaid : 8 Medicare : 76 Other : 22 Total : 106</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Submission of this plan of correction will not constitute or be construed as an admission by Brownsburg Healthcare Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing care and services to the residents of Brownsburg Healthcare Center. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Review on or after September 30, 2012.</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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	Quality review completed on September 21, 2012 by Bev Faulkner, RN			

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F0498 SS=D	<p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure nurse aides were trained and were able to demonstrate proper technique according to facility policy in transferring a resident with a mechanical lift for 1 of 1 resident observed during a mechanical lift transfer out of a sample of 6 residents reviewed. This affected Resident B and involved CNA #1, CNA #2, and CNA #3.</p> <p>Findings include:</p> <p>A clinical record review for Resident B was completed on</p>	F0498	<p>It is the facility policy that all nurse aides/nurses are trained to use equipment correctly in order to maintain resident safety. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident B has her own mechanical bariatric lift which is kept in her room and used only for her. No other residents have been affected by this practice. All nursing staff have been trained on how to use every lift in the facility. They have been trained how to operate the lifts and how to use the slings by strap length and color. Training began on 9/19/12 and was completed on 9/30/12. Employee understanding was validated by return demonstration of actual lift usage on each other. All new employees will be trained in orientation via a skills test. Random monitoring will be done to validate continued understanding of correct lift usage. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents</p>	09/30/2012			

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	<p>9/17/12 at 11 A.M. Diagnosis included, but were not limited to, morbid obesity, osteoarthritis, degenerative joint disease and congestive heart failure.</p> <p>A care plan indicated Resident B required use of a mechanical lift due to weakness and lower extremity pain.</p> <p>An observation of a mechanical lift transfer for Resident B was completed on 9/18/12 at 10:30 A.M. CNA (Certified Nursing Aide) #1, CNA #2, CNA #3, LPN #4 and LPN #5 were present for the transfer. CNA #1 and CNA #2 were at the head and shoulders of the resident on opposite sides of the bed. CNA #3 and LPN #4 were at the waist and legs of the resident on opposite sides</p>		<p>have the potential to be affected. Every resident is screened on admission, readmission or with a change in condition for the type of transfer and lift required by the Therapy Director and DON. This information is placed in the chart, the care plan and on the C.N.A. assignment sheet. All nursing staff have been trained on all lifts used in the facility via a skills test with return demonstration of knowledge beginning on 9/19/12 and completed on 9/30/12. Random monitoring will be done for all nursing employees to validate proficiency of using lifts. Training will be done in orientation for new hires. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Random monitoring will be done on all lifts used in the facility. Proficiency will be evaluated through return demonstration. All new nursing employees will be trained during orientation. How will the corrective actions be monitored to ensure the deficient practice will not recur, ie., what Quality Assurance program will be put into place? DON or designee will monitor inservicing for and random monitoring of lift usage for all nursing employees. Training completion will be reviewed in the monthly QA Meeting and any concerns will be addressed via a written action plan monitored by the Administrator or designee</p>				

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	of the bed. CNA #1 brought the bariatric mechanical lift and placed the legs of the lift under the resident's bed with the legs placed on open locked position. CNA #1 and CNA #2 placed the gray fabric straps onto the hooks of the swivel bar of the lift. CNA #1 indicated she wasn't sure what the red and yellow straps were for. CNA #1 had to instruct CNA #2 on placing the strap onto the hook. CNA #3 and LPN #4 put the leg straps on and crossed them before hooking them onto the swivel bar. CNA #1 unlocked the lift and Resident B was lifted out of the bed and CNA #1 began to move the lift toward the resident's wheelchair. The resident indicated to CNA #1 something was needed about her head. CNA # 1 was observed to pull		until resolution occurs.	

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	<p>a portion of the sling form underneath the resident's neck to provide support to the resident's head and neck. CNA #1 had to direct CNA #3 to come behind the resident and when CNA #3 did , she placed two fingers on the material of the sling and pinched the fabric with her fingers. CNA #1 and CNA #3 then placed the resident with the sling over the wheelchair.</p> <p>The manual for the Invacare RPA-600-IE lift on page 9 instructed, "...Using the sling...When connecting slings equipped with color coded straps to the patient lift, The shortest of the straps MUST be at the back of patient for support. Using long section will leave little or no support for patient's back. The loops of</p>						

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	<p>the sling are color coded and can be used to place patient in various positions. The colors make it easy to connect both sides of the sling equally. Make sure that there is sufficient head support when lifting a patient... the pictures demonstrated on page 21 on 'lifting the patient' show one person operating the lift and the other supporting legs after transfer off of bed and then when moving the patient someone behind the sling supporting the patient in the sling..."</p> <p>The Assistant Director of Nursing (ADON) provided the policy titled "Hoyer lift policy," dated 5/25/05, on 9/18/12 at 8:45 A.M.</p> <p>The facility policy, dated</p>				

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	<p>5/25/05, for Hoyer lifts indicated, "... RULE: OPERATE AFTER INSERVICE:DO NOT operate a Hoyer lift unless you have been inserviced in its use. RULE: SUPPORT HEAD AND LEGS Be sure to support the resident's head and legs while seated in the Hoyer lift..."</p> <p>The ADON provided the bariatric mechanical lift manual and the inservice list, dated 9/7/12, for the bariatric lift on 9/18/12 at 11 A.M.</p> <p>The inservice list provided for the bariatric lift did not include the names of CNA #1, CNA#2, or CNA#3.</p> <p>In an interview with the Director of Nursing on 9/18/12</p>			

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	<p>at 11:30 A.M., she indicated the facility trains all staff on the different kinds of lifts before they use them. The ADON indicated at this time that all of the staff trained on the bariatric lift were on the inservice list provided. The DON and ADON verified that none of the staff identified as performing bariatric lift transfer were on the bariatric lift inservice list.</p> <p>This Federal tag relates to Complaint IN00115746.</p> <p>3.1-14(i)</p>			
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