

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155468	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2015
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NAME OF PROVIDER OR SUPPLIER BRECKENRIDGE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 325 W NORTHWOOD DR SULLIVAN, IN 47882
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 31, June 1, 2, 3, & 4, 2015.</p> <p>Facility number: 000525 Provider number: 155468 AIM number: 100267010</p> <p>Census bed type: SNF/NF: 30 Total: 30</p> <p>Census payor type: Medicare: 8 Medicaid: 21 Other: 1 Total: 30</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</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 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>	
F 0240 SS=D Bldg. 00	<p>483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that</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>promotes maintenance or enhancement of each resident's quality of life.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's room was arranged to promote quality of life for 1 of 27 residents reviewed for quality of life. (Resident #32)</p> <p>Finding includes:</p> <p>On 5/31/15 at 11:55 a.m., Resident #32 was observed in bed. The resident was sitting up in a low bed with blue floor mats positioned on both sides of the bed. The resident's over bed table was on the outside of the left floor mat, out of reach of the resident. Drinks and personal items were on the table.</p> <p>During the observation the resident indicated the table was always positioned that way when he was in bed. He indicated he couldn't reach the drinks, and couldn't color (an activity he enjoyed) without use of the table because it was out of his reach. The resident pointed to his art supplies stored in his room.</p> <p>On 6/3/15 at 1:15 p.m., Certified Nursing Assistant (CNA) #2 was interviewed. The CNA indicated the resident was usually in bed when day shift came on duty in the</p>	F 0240	<p>F240 Requires a facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each residents quality of life. The facility will ensure this requirement is met through the following corrective measures.</p> <p>1) A basket and cup with long straw have been placed on a tray on floor mat. This will be in reach of resident while in low bed. 2) All residents in a low bed with mats have the potential to be affected. An audit was completed to make sure no other resident in low beds with mats were affected. See corrective measures below. 3) The staff was in-serviced on Residents Rights- quality of life (Exhibit A). Staff was also reminded to keep residents drinking cup and items of his choice within reach on floor mat.</p> <p>4) Administrator or her designee will monitor resident's environment for enhancement of his quality of life. Administrator or her designee will monitor for this resident's drinking cup to be within reach and basket for items of his choice (i.e. art supplies). This monitoring will be conducted daily through observation x 4 weeks, then one time weekly x 4 weeks, then every two weeks for 2 months, then quarterly thereafter (Exhibit B). Brenda Marshall, RNSurveyor Supervisor Long Term Care</p>	06/15/2015

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F 0323 SS=D Bldg. 00	<p>low bed with floor mats on both sides of the bed. The staff member indicated the mats made it difficult to position the table within reach of the resident and the resident utilized the call light and waited for staff to give him a drink.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 4/18/15, reviewed on 6/3/15 at 2:00 p.m. coded the resident with moderate cognitive impairment. The assessment indicated the resident was non-ambulatory, required extensive assistance of two for transfers, and extensive assistance of one for eating.</p> <p>3.1-32(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and</p>		<p>DivisionIndiana State Department of Health2 N. Meridian StreetIndianapolis, IN 46204Dear Ms. Marshall:Facility #: 000525 Provider # 155468Survey Event ID: UJ5911 Survey Date: June 4, 2015Per your request for addendum dated July 8th, 2015 regarding F240. Response:The facility purchased a stationary bedside stand of approximately 21 inches in height. The stand was placed at bedside and Physical Therapy was requested to screen the resident to confirm the bedside stand to be an appropriate intervention. This screen was completed on 7/08/15 and is attached for review. The interventions in place were deemed to be appropriate and promote independent ability to reach and acquire personal items as desired. The resident's careplan has been reviewed and updated. Administrative staff will visit with the resident at least weekly to confirm continued satisfaction and ability to acquire items from bedside at will. The Physical Therapy Screen is attached under supporting documentation. It is labeled Resident #32 PT screen.</p>				

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	<p>assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure an extension cord was utilized in a safe manner for 3 of 3 observations of extension cord use in a resident's room. (Resident #7).</p> <p>Finding includes:</p> <p>On 5/31/15 at 2:37 p.m., Resident #7's room was observed. The resident was present. A non-grounded extension cord was observed plugged into the wall outlet located between the two beds in the resident's room. The extension cord was observed wrapped in a tied fashion around the resident's left bed quarter rail. Nothing was plugged into the extension cord at the time of the observation.</p> <p>On 6/1/15 at 10:20 a.m., a non-grounded extension cord was observed plugged into the wall outlet between the two beds in Resident #7's room. The cord was wrapped in a tied fashion around the resident's left bed rail. The resident's tablet was observed plugged into the extension cord at the time of the observation. The resident was present in the room.</p> <p>On 6/3/15 at 2:00 p.m., during an interview with Resident #7, a</p>	F 0323	<p>F323 Free of Accident Hazards/Supervision/DevicesThe facility will ensure this requirement is met through the following corrective measures.1) The non-grounded extension cord was removed from resident's room and replaced with a grounded power strip. This grounded power strip is used for resident's kindle.2) All residents have the potential to be affected. An audit was completed to make sure no other residents have non-grounded extension cords in their rooms.3) Policy for use of power strips was reviewed and no changes made (Exhibit C). The Maintenance staff was in-serviced on the above policy and educated on the importance of using grounded power cords as opposed to non-grounded power cords (Exhibit D). A letter was mailed to responsible parties about power strip policy. (Exhibit E)4) The Administrator or her Designee will conduct rounds ensuring that there are no non-grounded power cords used in resident rooms. this audit will be done one time weekly x4 weeks, every two weeks x2 months, then quarterly thereafter (Exhibit F).</p>	06/15/2015			

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	<p>non-grounded extension cord was observed plugged into the wall outlet between the two beds in Resident #7's room. The cord was wrapped in a tied fashion around the resident's left bed rail. The resident indicated her son had brought in the extension cord so that she could keep her tablet charged. Nothing was observed plugged into the extension cord at the time of this observation.</p> <p>On 6/4/15 at 10:55 a.m., during the environmental tour with the Maintenance Supervisor, a non-grounded extension cord was observed plugged into the wall outlet between the two beds in Resident #7's room and wrapped in a tied fashion around the resident's left bed rail. The Maintenance Supervisor indicated the extension cord was not a grounded cord. He indicated the facility policy was extension cords would not be used in resident rooms. He indicated he was unaware the resident had the extension cord in her room.</p> <p>Resident #7's medical record was reviewed on 6/2/15 at 1:56 p.m. The resident's quarterly Minimum Data Set (MDS) dated 2/25/15, indicated the resident had no cognitive deficit.</p> <p>On 6/4/15 at 11:35 a.m., the Administrator provided a current policy,</p>			

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F 0371 SS=D Bldg. 00	<p>dated January 2015, titled "Electronic Items in Resident Rooms." The policy indicated "Electronic devices brought into the facility by a resident/legal representative with the intention to be utilized in the resident room...shall be maintained in a manner that does not place the resident utilizing the device, or other residents of the facility, at risk."</p> <p>3.1-45(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food was stored in a sanitary manner for 1 of 2 kitchen observations. This deficient practice had the potential to affect 27 of 27 residents receiving food from the kitchen.</p> <p>Finding includes: On 5/31/15 at 10:30 a.m., during the initial kitchen tour with Cook #1, the following was observed:</p>	F 0371	F371 Requires that a facility must (1) Procure food from a source approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. The facility will ensure this requirement is met through the following corrective measures.1) Foods will be stored, prepared, distributed and served under sanitary conditions. All food products will be covered, labeled and dated. 2) All residents have the potential to be affected. Policy will be followed of all food products being covered, labeled	06/15/2015

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F 0465 SS=E Bldg. 00	<p>Four trays, identified by Cook #1, as prepared for noon meal service, were observed in the walk in refrigerator uncovered. Desserts and salads were on the trays.</p> <p>Five of six glasses of Mighty Shakes were observed in the walk in freezer, not covered or labeled.</p> <p>A facility policy titled "Proper Storage of & Thawing of Meats/Eggs/Potentially Hazardous Foods," dated 11/2014, provided by the Administrator on 6/4/15 at 1:00 p.m., included but was not limited to, "Policy: It is the policy of the Dietary Department that food shall be stored according to acceptable sanitation standards...7. All food products must be covered, labeled and dated."</p> <p>3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to ensure the environment was free of odors and/or maintained in good repair for 2 of 3 hallways (100 and</p>	F 0465	<p>and dated. 3) The Dietary staff was in-serviced on proper storage and thawing of meats/eggs/Potentially hazardous foods (Exhibit G)4) The Dietary Manager will monitor food storage for proper storage of foods five times a week for 4 weeks, then one time a week x 4 weeks, then every two weeks for two months, then quarterly (Exhibit H).</p> <p>F465 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1) The resident in room 111 was discovered to have a Urinary</p>	06/15/2015

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	<p>200 halls).</p> <p>Findings include:</p> <p>1. On 5/31/15 at 11:51 a.m., a strong urine odor was noted coming from Room #111. A bed side commode inside the room was observed with urine in the bowl and a rust-like ring observed around the bottom of the bowl. A toilet seat riser was observed with yellow splatter with a foul odor. The toilet was observed to be unflushed and urine was observed in the toilet bowl. The resident was observed awake and present in the room.</p> <p>On 5/31/15 at 2:00 p.m., a strong urine odor was noted coming from Room #111. The resident was observed awake and present in the room.</p> <p>On 6/4/15 at 1:40 p.m., a strong urine odor was noted coming from Room #111. The resident was observed awake and present in the room.</p> <p>On 6/4/15 at 11:20 a.m., during an interview with the Housekeeping Supervisor, she indicated the resident in Room #111 had just started to be incontinent of urine over the past couple of weeks. She indicated she noticed the strong urine odor in the room on 5/31/15 and noticed the bed side commode had</p>		<p>Tract Infection. She has since been on an antibiotic. There is no pervasive urine odor at this time from room 111. The bedside commode inside room was cleaned as well as the toilet seat riser. Toilet will be flushed after each use as well. Room 103 door frame entering shared bathroom has been painted. Room 104 cover plate from the wall socket at the foot of residents bed was replaced. The bed was moved down away from wall socket as well. In room 108, the base molding under the sink in the shared bathroom was repaired. In room 206, the base molding under the sink in the shared bathroom was repaired.</p> <p>2) All the residents have the potential to be affected by deficient practice. 3) Nursing staff in-serviced on the bed-side commode policy and bed side commode sanitation policy (Exhibit I). Housekeeping staff will be in-serviced on Bathroom cleaning. (Exhibit J) All staff will be in-serviced how to complete a work order for when they notice areas requiring repairs (Exhibit K). The Preventative Maintenance policy was reviewed and no changes made. The maintenance director was in-serviced on the Preventative Maintenance policy and the importance of Preventative maintenance (Exhibit L).4) The Administrator or her designee will conduct</p>				

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	<p>urine in the bottom with a rust-like ring around the bottom of the bowl.</p> <p>2. During an environmental tour with the Maintenance Supervisor on 6/4/15 beginning at 10:55 a.m., and ending at 11:30 a.m., the following were observed:</p> <p>100 hall:</p> <p>Room #103-The doorframe entering the shared bathroom was observed to be marred. The Maintenance Supervisor indicated he was not aware of the issue. He indicated it was likely due to wheelchair hitting the frame.</p> <p>Room #104: The cover plate from the wall socket at foot of the resident's bed was observed to be missing. The resident's bed and nebulizer machine were observed to be plugged into the socket. The Maintenance Supervisor indicated he had repaired this once before. He indicated he was not aware of the current situation.</p> <p>Room #108: The base molding under the sink in the shared bathroom was observed to be missing and the wallcovering was observed to be torn and peeling. The Maintenance Supervisor indicated he was unaware of the issue.</p>		<p>rounds ensuring that there is no pervasive urine odor coming from room 111. This audit will be completed 5x per week x4 weeks, then weekly x4 weeks, then every two weeks for 2 months, then quarterly thereafter (Exhibit M). The Administrator or her designee will conduct rounds to make sure the rooms in the 100 and 200 hallways are maintained and in good repair with any needed repairs identified and corrective actions scheduled. This audit will be done 1x per week x 4 weeks, then 1x every two weeks x2 months, then quarterly thereafter (Exhibit N).</p>		

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	<p>200 Hall:</p> <p>Room #206: The base molding under the sink in the shared bathroom was observed to be missing and the wallcovering was observed to be torn and peeling. The Maintenance Supervisor indicated he was unaware of the issue</p> <p>In an interview on 6/4/15 during the environmental tour that began at 10:55 a.m., Maintenance Supervisor indicated he performed weekly preventative maintenance rounds. He indicated he observed 10 resident rooms every week. He indicated he used a preventative maintenance checklist when he performed the room rounds. The Maintenance Supervisor indicated the facility had a work order system. He indicated staff would complete a work order form when issues were found. He indicated he would gather and review the work orders everyday. He indicated he would attempt to address the issues identified as soon as possible, but he would prioritize the work orders by severity of need.</p> <p>On 6/4/15 during the environmental tour that began at 10:55 a.m., the Maintenance Supervisor provided a current copy of a document titled, "Preventative Maintenance-Resident</p>			

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	<p>Rooms." The document indicated areas maintenance would look at included, but were not limited to, cove base, electrical receptacles and switches, wallpaper and doors.</p> <p>On 6/4/15 during the environmental tour that began at 10:55 a.m., a review of the current work orders indicated none of the identified issues had been provided to the Maintenance Supervisor in the form of a work order.</p> <p>On 6/4/15 at 1:00 p.m., a current policy titled, "Reporting Necessary Repairs" was provided by the Administrator. The policy indicated, "Areas requiring repairs shall be identified and communicated for the scheduling of said repairs....Procedure: 1. Should facility personnel note an area in need of repair within the facility a work order shall be completed and given to the maintenance supervisor...4. The maintenance supervisor shall attempt to make needed repairs...."</p> <p>3.1-19(f)</p>			

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

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