STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155480	A. BUILDING 00 B. WING	08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKVILLE HEALTHCARE CENTER	11049 STATE ROAD 101 BROOKVILLE, IN 47012

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 13, 14, 15, 16, & 17, 2018 Facility number: 000550 Provider number: 155480 AIM number: 100286110 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 6 Medicaid: 30 Other: 11 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review on August 20, 2018	F 0000	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 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 evidence of compliance 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.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide fingernail care	F 0677	F677 Requires the facility to provide a resident who is unable to	08/24/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	for a resident dependent on staff for Activities of Daily Living (ADL's), for 1 of 4 residents reviewed for ADL's. (Resident 40) Findings include: Resident 40's record was reviewed on 8/15/18 at 10:31 a.m. Her diagnoses included but were not limited to, osteoarthritis, osteoporosis, and tremors. Her Significant Change Minimum Data Set (MDS) assessment dated 6/25/18, indicated she required extensive assistance of 1 person for personal hygiene. A plan of care for Resident 40 initiated 7/9/18, indicated she required 1 to 2 persons assistance for ADL's due to her complaint of pain, physical immobility, and incontinence. Her interventions included nail care as needed. On 8/13/18 at 11:08 a.m., Resident 40 was observed to have long, jagged fingernails with a dark substance underneath the nails. During an interview with Resident 40's family member on 8/14/18 at 11:14 a.m., she indicated Resident 40 often looked like her fingernails needed cut. Resident 40 continued to be observed on 8/15/18 at 10:10 a.m., 8/16/18 at 10:29 a.m., and 8/17/18 at 10:13 a.m., with long, jagged fingernails with a dark substance underneath the nails. During an interview with CNA 3 on 8/17/18 at 10:17 a.m., she indicated CNA's were responsible for resident's nail care unless the resident was a diabetic. She indicated resident 40's fingernails needed cleaned and clipped. The Fingernail Care procedure provided by the DON on 8/17/18 at 11:32 a.m., indicated the following: "Purpose: Cleanliness and good		carry out the activities of daily living receives the necessary services to maintain good nutrition, grooming, and person and oral hygiene. 1. Resident A (40) was provided with fingernail care. 2. All residents have the potential to be affected. All residents were assessed for the need for fingernail care. No concerns were noted. 3. The Fingernail Care policy & procedure was reviewed with no changes made. (See attachment A).The staff was in serviced on the above procedure. 4. The DON or her designee will review 5 residents daily to ensure proper fingernail is being provided. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly time four weeks, then every two weeks times two months, then quarterly thereafter until compliance is 100% obtained and maintained.(Attachment B.) The audits will be reviewed during the facilities quarterly assurance meetings and the plan of correction will be adjusted accordingly if warranted. The above corrective measures will be completed on or before August 24, 2018.	

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	grooming contribute to the dignity and self-esteem of resident. Policy: Nails should be kept short, clean, and free of rough or jagged edges. Fingernail care is provided when assigned, if fingernails appear soiled or have jagged edges, and as indicated." 3.1-38(a)(3)(E)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure clinical records were complete for one resident with chronic constipation that had no documentation of stool consistency. This affected 1 of 1 resident reviewed for constipation. (Resident 39) Findings include: On 8/14/18 at 9:55 a.m., Resident 39 said she has chronic constipation, does not have a bowel movement very often, is nauseated a lot, vomits almost every day, sometimes several times because her bowels won't move. Resident 39's record was reviewed on 8/14/18 at 1:49 p.m. The record indicated Resident 39 had	F 0689	F689 Requires the facility to be free of accident hazards/supervision/devices. 1. Resident B (39) bowel monitoring form was reviewed. 2. All residents have the potential to be affected. All residents were assessed for proper bowel consistency. No concerns were noted. 3. The Bowel Elimination Monitoring policy & procedure was reviewed with no changes made. (See attachment C).The staff was in serviced on the above procedure. 4. The DON or her designee will review 5 residents daily to ensure bowel movement	08/24/2018

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	diagnoses that included, but were not limited to, hiatal hernia with repair, high blood pressure, muscle weakness, diabetes mellitus, diabetic neuropathy, chronic pain, difficulty swallowing, anxiety, gastro-esophageal reflux disease, depression, abdominal surgery with wound dehiscence, and constipation. An Admission Minimum Data Set (MDS) assessment, dated 3/19/18, indicated Resident 39 had severe impairment in cognitive skills for daily decision making, was always incontinent of bowel, and had constipation. A Quarterly MDS, dated 6/20/18, indicated Resident 39 was moderately impaired in cognitive skills for daily decision making and was always incontinent of bowel. A care plan, last reviewed on 6/12/18, had a focus for: "The resident is at risk for constipation due to: difficulty walking, dementia. Goal: The resident will have a soft formed bowel movement at least every three days through next review. Interventions: 1. Monitor bowel movements. 2. Administer medications, as ordered. 3. Encourage the resident to drink fluids, as diet permits. 4. Should resident exceed three days without a bowel movement, follow specific physician orders, if present, or facility bowel protocol to promote bowel improvement. Offer extra fluids per order." A care plan, last reviewed on 6/12/18, indicated: "The resident suffers from chronic constipation due to: decreased mobility, narc[otic] use, lax[ative] use. Goal: The resident will have a soft formed bowel movement at least every three days through next review. Interventions: 1. Monitor bowel movements. 2. Administer medications as		consistency is being provided. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly time four weeks, then every two weeks times two months, then quarterly thereafter until compliance is 100% obtained and maintained. (Attachment B)The audits will be reviewed during the facilities quarterly assurance meetings and the plan of correction will be adjusted accordingly if warranted. The above corrective measures will be completed on or before August 24, 2018.	

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	ordered. 3. Encourage the resident to drink fluids, as diet permits. 4. Monitor bowel sounds, PRN (as needed). 5. Should resident exceed three days without a bowel movement, follow specific physician orders, if present, or facility protocol to promote bowel movement. Milk of mag[nesium] (laxative) per order." Review of "BM (Bowel Movement) Records" dated July and August 2018, failed to indicate the description or consistency of the stool. The instructions on the "BM Record" indicated: "Enter "O" or leave the space bank if the resident has no BM during your shift. For each BM, enter the description (type) of feces using the chart below. Multiple entries may be made on each date on the same shift, if applicable." A "Bristol Stool Chart", on both sides of the "BM Record", had the type of stool listed from type 1 through type 7, which described stool from hard lumps that are hard to pass to watery stool with no solid pieces. On 8/16/18 at 2:20 p.m., the Director of Nurses (DoN) indicated that CNAs communicate to the nurses what the consistency of stool is. On the day to day report sheets, it would be documented if a resident is having diarrhea, and it is passed on in report. The nurses know that on the fourth day without a bowel movement, they have to start laxatives. It might be on the 24 hour nursing report sheets, but it isn't a part of their permanent record. The DoN said they chart by exception, for example; if a resident had loose stools they would chart that. On 8/16/18 at 2:25 p.m., multiple July and August 24 hour nursing shift report sheets were observed and consistency of stools was not written on the report sheets.			

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	A policy titled "Bowel Elimination Monitoring" was provided by the DoN on 8/15/18 at 2:57 p.m. The policy included, but was not limited to, "Purpose: Assessment of bowel function will ensure provision of necessary intervention to prevent potential constipation and/or fecal impaction. Policy: It is the policy of this facility to monitor the bowel function of each resident on a daily basis in an effort to intervene, as needed, should a resident fail to evacuate on a regular basis (e.g., normal routine for resident). Procedure: 1. It is the responsibility of the day shift nursing personnel to monitor the BM record of each resident assigned to their care on a daily basis...7. The resident's bowel function shall continue to be monitored to ensure adequate evacuation...." 3.1-45(a)(1) 3.1-45(a)(2)			