

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2011
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NAME OF PROVIDER OR SUPPLIER  BRENTWOOD AT HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN46342
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R0000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: October 17 and 18, 2011</p> <p>Facility number: 02627 Provider number: 02627 AIM number: N/A</p> <p>Survey team: Kathleen (Kitty) Vargas, RN, TC Lara Richards, RN Heather Tuttle, RN</p> <p>Census bed type: Residential: 117 Total: 117</p> <p>Census payor type: Other: 117 Total: 117</p> <p>Sample: 14</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/20/11 by Suzanne Williams, RN</p>	R0000	<p><b>Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective</b></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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R0118	<p>(c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.</p> <p>Based on record review and interview, the facility failed to ensure employees who worked as nurse aides were certified for 1 of 27 nurse aide certifications reviewed. This deficient practice had the potential to affect 117 of 117 residents who resided in the facility. (Nurse Aide #1)</p> <p>Findings include:</p> <p>The certification files for CNAs (Certified Nurse Aides) were reviewed on 10/18/11 at 1:30 p.m. Nurse Aide #1 was hired on 12/14/10. There was no current nurse aide certification available for review.</p> <p>Interview with the Business Office Manager on 10/18/11 at 2:30 p.m., indicated the employee had worked as a nurse aide in the facility since December, 2010. She indicated the employee had completed the nurse aide training class prior to her date of hire. She also indicated there was no certification for the employee at the state registry for nurse</p>	R0118	<p><b>R 118 Personnel- deficiency</b></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> <li>· No residents were affected by alleged deficient practice.</li> <li>· Nurse aide #1 has been terminated from employment at this community.</li> </ul> <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> <li>· Nurse aides currently employed at this community, certifications will be verified through the state board of health licensing bureau by 11/1/11.</li> <li>· Any newly hired nurse aides certifications will be verified prior to their 1 st day of employment.</li> <li>· Any nurse aides that have recently completed their clinicals and are waiting to take their certification tests will be permitted to work as nurse aides for 120 days, if they do not obtain the certifications within 120 days they will be terminated from employment.</li> </ul> <p><i>What measures will be put in place or</i></p>	11/11/2011			

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R0144	<p>aides.</p> <p>Review of the current nurse aide schedule on 10/18/11 at 2:45 p.m., indicated Nurse Aide #1 had worked as a nurse aide on the Memory Care Unit on 10/11/11, 10/13/11, and 10/18/11. She was scheduled to work as a nurse aide on 10/20/11.</p> <p>Interview with the Business Office Manager on 10/18/11 at 2:30 p.m., indicated Nurse Aide #1 would not be allowed to work as a nurse aide until she received her certification.</p> <p>(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to keep the resident's environment clean related to hair clippings, dirt or dust on the sink, hair dryers, chairs, floor, cabinet and shelves and discolored floor tile in 1 of 1 beauty shop and stained carpet and discolored</p>	R0144	<p><i>what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> <li>The Business Office Director or designee will verify newly hired nurse aide certifications prior to their first day of employment.</li> <li>The Business Office Director or designee will track nurse aides waiting to take their certification tests, if certification is not obtained within 120 days their employment will be terminated.</li> </ul> <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <ul style="list-style-type: none"> <li>Nurse aide certifications will be reviewed monthly by executive director during QA meeting to ensure compliance.</li> <li>Regional Directors will review during routine site visits and annual comprehensive process review.</li> </ul> <p><i>By what date will these systemic changes be implemented?</i></p> <ul style="list-style-type: none"> <li>11/1/11</li> </ul> <p><b>R 144 Safety and Sanitation Standards</b></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> <li>The carpet in apartment 101 has been cleaned as of 10/19/11.</li> </ul>	11/30/2011			

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	<p>bathroom floor tile in 1 room on the East Wing. This deficient practice had the potential to affect 117 of 117 residents residing in the facility. (The beauty shop and Room 101)</p> <p>Findings include:</p> <p>1. On 10/18/11 at 10:47 a.m., the following was observed:</p> <p>A. The carpet was stained in room 101. The bathroom floor tile behind the toilet had a black discoloration. Interview with the Maintenance Director at that time, indicated the carpet was in need of cleaning and the bathroom tile was discolored. One resident resided in the room.</p> <p>B. There was a large amount of hair clippings on the floor of the beauty shop. There were hair clippings on the barber chair and in the sink. The sink was dirty where the resident's hair was washed. The two hair dryers had a large amount of dried sticky substance on the inside. There was dust noted on the black seats where the dryers were. There was adhered dirt around the cabinets and the floor tile was discolored. There was adhered dirt under the floor register. The five tiered shelf was full of dust and dirt. There was a brown cabinet located in the</p>		<ul style="list-style-type: none"> <li>- The linoleum floor in the bathroom for apartment 101 will be replaced by 11/11/11.</li> <li>- The beauty shop floor, chairs, sink, hairdryers, cabinets, shelving, ,and floor register was cleaned free of hair and dust on 10/18/11.</li> </ul> <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> <li>- The Housekeeping Supervisor and the Executive Director will complete sanitation rounds of resident apartments by 11/11/11.</li> <li>- Any resident apartments found to have any sanitation issues will be corrected by 11/30/11 <i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></li> <li>- The beauty shop will be cleaned by the beautician routinely</li> <li>- The Housekeeping supervisor or designee will complete 10 random sanitation rounds / checklist of resident apartments, including the beauty shop monthly to identify any areas of concern.</li> </ul> <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <ul style="list-style-type: none"> <li>- Sanitation Rounds / checklist will be reviewed by the QA committee monthly for at least 6 months to ensure compliance.</li> <li>- Regional directors will review during routine site visits and annual comprehensive process review.</li> </ul>				

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R0151	<p>corner with a large amount of dust noted on top.</p> <p>Interview with the Maintenance Director at the time, indicated the beauty shop was in need of cleaning.</p> <p>(h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations.</p> <p>Based on record review and interview, the facility failed to maintain updated vaccinations for 1 of 5 cats currently residing in the facility. (Resident #14's cat)</p> <p>Findings include:</p> <p>The facility provided a list of facility pets on 10/17/11. The veterinary examinations and immunizations for Resident #14's cat were reviewed on 10/17/11 at 2:30 p.m.</p> <p>The rabies vaccination certificate indicated the cat was vaccinated on 9/7/10. The certificate also indicated the vaccination expired on 9/7/11.</p> <p>Interview with the Resident Care Director on 10/18/11 at 11:30 a.m. indicated the vaccination for Resident's 14's cat was expired.</p>	R0151	<p><i>By what date will these systemic changes be implemented?</i></p> <p>11/30/11</p> <p><b>R 151 Safety and Sanitation Standards</b></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> <li>Resident # 14's cat will be vaccinated by 11/11/11 or it will be removed from the community.</li> </ul> <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> <li>The Executive Director completed an audit of community pet records on 10/19/11.</li> <li>No residents were affected by the alleged deficient practice.</li> </ul> <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> <li>The Executive Director or Designee will review community pet vaccinations records routinely to ensure compliance.</li> </ul>	11/11/2011			

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R0349	<p>(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on observation, interview and record review, the facility failed to ensure the clinical records were complete related to the lack of a physician's order for oxygen therapy, for 1 of 8 records reviewed in a sample of 14. (Resident #1)</p> <p>Findings include:</p>	R0349	<p>If a pet is found to be out of compliance the resident / family will be asked to remove the pet from the community until compliance is achieved. <i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <p>Pet records/ vaccinations will be reviewed by the QA committee monthly ensure compliance.</p> <p>Regional directors will monitor on routine site visits and annual comprehensive process review.</p> <p><i>By what date will these systemic changes be implemented?</i></p> <p>11/11/11</p> <p><b>R 349 Clinical Records-noncompliance</b></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <p>Resident #1 deceased on 10/27/11.</p> <p><i>How will the facility identify other</i></p>	11/07/2011			

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	<p>Resident #1 was observed on 10/17/11 at 11:15 a.m. in her room. The resident was seated in a wheelchair and had oxygen infusing per a nasal cannula. The oxygen tank was set at 5 liters per minute. Interview with Qualified Medication Aide (QMA) #1 at that time, indicated the oxygen was set at 5 liters.</p> <p>The record for Resident #1 was reviewed on 10/17/11 at 10:45 am. The resident had diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, hypertension and diabetes. The resident was receiving hospice services.</p> <p>Review of the service notes indicated the resident was sent to the hospital on 9/7/11 for exacerbation of chronic obstructive pulmonary disease. She was readmitted the facility on 10/6/11.</p> <p>Review of the current physician orders dated 10/6/11, indicated there was no order for oxygen therapy.</p> <p>The hospice notes dated 10/12/11 were reviewed. The notes indicated the resident was receiving oxygen at 4 and 1/2 liters per nasal cannula.</p> <p>Interview with the Resident Care Director on 10/17/11 at 1:15 p.m., indicated she had observed Resident #1 with her oxygen</p>		<p><i>residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> <li>· The Resident Care Director or Designee will review resident clinical records/ physicians orders for resident receiving oxygen therapy, for accuracy by 11/07/11 <i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></li> <li>· The Resident Care Director or designee will review resident clinical records / physicians orders within 24 hours of readmit to the community, for accuracy.</li> <li>· Resident Care Director or designee will review telephone orders within 24 hours for accuracy.</li> </ul> <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <ul style="list-style-type: none"> <li>· Weekly audit of orders will be reviewed by QA committee during monthly meeting to ensure compliance.</li> <li>· Regional Director of Quality Services will review audits during routine site visits and annual Comprehensive Process review.</li> </ul> <p><i>By what date will these systemic changes be implemented?</i></p> <ul style="list-style-type: none"> <li>· 11/7/11</li> </ul>				

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R0356	<p>set at 8 liters per minute earlier in the day.</p> <p>The Resident Care Director was interviewed on 10/18/11 at 1:50 p.m. She indicated the clinical record for the resident was incomplete. She indicated there was no physician's order for oxygen therapy for the resident.</p> <p>(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <ol style="list-style-type: none"> <li>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</li> <li>(2) The resident ' s hospital preference.</li> <li>(3) The name and phone number of any legally authorized representative.</li> <li>(4) The name and phone number of the resident ' s physician of record.</li> <li>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</li> <li>(6) Information on any known allergies.</li> <li>(7) A photograph (for identification of the resident).</li> <li>(8) Copy of advance directives, if available.</li> </ol> <p>Based on record review and interview, the facility failed to ensure the resident's emergency files were updated and available for 5 of 7 current records reviewed for emergency information in a sample of 14. (Residents #1, #2, #3, #4 and #5)</p>	R0356	<p><b>R 356 Clinical Records-noncompliance</b></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> <li>o Emergency Files for resident # 2, 3, 4 and 5 have been updated. Resident #1 deceased on 10/27/11.</li> </ul>	11/14/2011			

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	<p>Findings include:</p> <p>1. The record for Resident #4 was reviewed on 10/17/11 at 12:48 p.m. Review of the resident's emergency file indicated there was no photograph of the resident in the file. Further review of the emergency file indicated the resident's advance directive was not in file.</p> <p>Interview with LPN #1 on 10/17/11 at 1:40 p.m., indicated she did not know who was responsible for updating the resident's emergency file.</p> <p>2. The record for Resident #5 was reviewed on 10/17/11 at 11:30 a.m. The resident was admitted to the facility on 10/1/11.</p> <p>Review of the book which contained the residents' emergency files on 10/17/11 at 1:25 p.m., indicated there was no emergency file for Resident #5.</p> <p>Interview with LPN #1 on 10/17/11 at 1:40 p.m., indicated she has admitted residents before and had not completed an emergency file for them.</p> <p>Interview with the Director of Nursing on 10/18/11 at 1:50 p.m., indicated she was unaware of everything that was required to be in the file. The Director of Nursing</p>		<p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> <li>· The Resident Care Director or Designee will review and update resident emergency files by 11/14/11.</li> </ul> <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> <li>· The Resident Care Director or designee will update resident emergency files upon admission to the community.</li> <li>· The resident Care Director or designee will audit resident emergency files routine for completeness.</li> </ul> <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <ul style="list-style-type: none"> <li>· The resident Care Director or designee will audit 20 resident emergency files monthly for completeness.</li> <li>· Emergency file audits will be reviewed by the community QA committee monthly times 6 months to ensure compliance.</li> <li>· Regional directors will monitor during routine site visits and annual comprehensive review process.</li> </ul> <p><i>By what date will these systemic changes be implemented?</i></p> <ul style="list-style-type: none"> <li>· 11/14/11</li> </ul>				

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	<p>further indicated that there was really no staff member who frequently checked and updated the emergency files.</p> <p>3. The record for Resident #1 was reviewed on 10/17/11 at 10:45 a.m. Review of the resident's emergency file indicated there was no photograph of the resident in the file. Further review of the emergency file indicated the resident's hospital preference was not listed in the emergency file.</p> <p>Interview with the Resident Care Director on 10/18/11 at 2:00 p.m., indicated the file was not complete.</p> <p>4. The record for Resident #2 was reviewed on 10/17/11 at 2:10 p.m. The resident resided in the Memory Care Unit. The resident's emergency file was not available for review.</p> <p>Interview with the Resident Care Director on 10/18/11 at 1:00 p.m., indicated the book which contained the emergency files for all the residents who resided in the Memory Care Unit was missing.</p> <p>5. The record for Resident #3 was reviewed on 10/18/11 at 9:10 a.m. The resident resided in the Memory Care Unit. The resident's emergency file was not available for review.</p>						

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R0414	<p>Interview with the Resident Care Director on 10/18/11 at 1:00 p.m., indicated the book which contained the emergency files for all the residents who resided in the Memory Care Unit was missing.</p> <p>(k) 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>Based on observation, record review and interview, the facility failed to ensure all employees washed their hands after direct resident contact and glove removal during medication administration. This affected 4 residents observed during medication pass. (QMA #1, Residents #1, #10, #11 and #12)</p> <p>Findings include:</p> <p>The medication administration pass was observed on 10/17/11 at 11:15 a.m. QMA (Qualified Medication Aide) #1 was observed obtaining a blood glucose reading for Resident #1. The QMA applied gloves, she obtained the blood sample and the glucose reading. She then removed her gloves. She did not wash her hands or use an alcohol gel. She then pushed the resident in her wheelchair to the dining room.</p>	R0414	<p><b>R 414 Infection Control</b></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> <li>o No residents were affected by the alleged deficient practice. All residents have potential to be affected.</li> </ul> <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> <li>· The Resident Care Director or Designee will complete hand washing skills checklist and medication pass skills checklist, with community QMA's and nurses by 11/30/11.</li> <li>· The Resident Care Director or designee will re-educate Associates on the community hand washing policy by 11/30/11.</li> </ul> <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> <li>· The Resident Care Director or</li> </ul>	11/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2011	
NAME OF PROVIDER OR SUPPLIER  BRENTWOOD AT HOBART				STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN46342			
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	<p>The QMA then set up medications for Resident #10. She gave the medication to the resident and touched the resident's arm. She did not wash her hands with soap and water and did not use alcohol gel.</p> <p>The QMA then set up medications for Resident #11. She gave the resident his oral medication and then had him walk to the nurses' station to receive his eye drops. The QMA donned gloves and administered eye drops to the resident. She then removed her gloves. She did not wash her hands with soap and water or use alcohol gel.</p> <p>The QMA walked with Resident #11 back to the dining room.</p> <p>The QMA then set up oral medications for Resident #12. She gave the oral medication to the resident.</p> <p>The policy titled "Handwashing" and dated 5/5/10 was provided by the Resident Care Director on 10/18/11 at 1:00 p.m. She indicated the policy was current.</p> <p>The policy indicated hands should be washed when soiled and after: -resident care -providing incontinent care -handling soiled linens</p>		<p>designee will complete random medication pass audits monthly.</p> <ul style="list-style-type: none"> <li>· The resident Care Director or designee will hold quarterly hand washing inservices.</li> <li>· Resident Care Director or designee will observe for proper hand washing routinely.</li> </ul> <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <ul style="list-style-type: none"> <li>· The QA committee will review the random medication pass audits monthly for a minimum of 6 months to ensure compliance.</li> <li>· Regional Director of Quality Service will review audits during routine site and during annual comprehensive process review.</li> </ul> <p><i>By what date will these systemic changes be implemented?</i></p> <ul style="list-style-type: none"> <li>· 11/30/11</li> </ul>				

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	<p>-any clinical procedure -assisting resident with toileting -removing gloves -eating or smoking -using the restroom -cleaning</p> <p>Interview with the Resident Care Director on 10/18/11 at 12:30 p.m., indicated the QMA should have washed her hands after removing her gloves.</p>				