

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2016
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NAME OF PROVIDER OR SUPPLIER  BROOKDALE BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3802 SARE RD BLOOMINGTON, IN 47401
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R 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00189410.</p> <p>Complaint IN00189410 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: January 7 and 8, 2016</p> <p>Facility number: 011076 Provider number: 011076 AIM number: N/A</p> <p>Census bed type: Residential: 37 Total: 37</p> <p>Sample: 03</p> <p>This State finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Q.R. completed by 14466 on January 15, 2016.</p>	R 0000		

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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R 0217  Bldg. 00	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure the use of properly trained staff members to provide the identified care services for 1 of 3 residents reviewed for suprapubic catheters. (Resident #A).</p> <p>Findings include:</p>	R 0217	The 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 all statutory	02/10/2016

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	<p>The clinical record of Resident #A was reviewed on 01/07/2016 at 1:00 p.m. Diagnoses included, but were not limited to: multi factional vascular dementia and neurogenic bladder.</p> <p>A nurses note dated 12/13/15 at 01:15 a.m., indicated LPN #2 was informed by a CNA that Resident #A's suprapubic catheter was out and found in the garbage. Resident #A had stated that it came out. New catheter was inserted by aseptic technique and resident tolerated the procedure.</p> <p>Interview with the facility DON on 1/07/16 at 11:30 a.m., indicated the facility did not provide training and/or demonstration related to suprapubic catheter insertion.</p> <p>Interview with LPN #2 on 01/08/2016 at 10:25 a.m., indicated they did attempt to call the DON, left message, and after 30 minutes with no return call, put in another suprapubic catheter without a problem. When asked if they were trained or observed for suprapubic catheter placement at the facility, LPN #2 indicated they were not.</p> <p>On 01/07/2016 at 10:30 a.m., the Administrator provided the suprapubic</p>		<p>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 all mitigating factors.</p> <p>#R 217</p> <p>1. Corrective Action for Affected Resident: There was no negative outcome for Resident #A from failure to comply with state and community regulation of not following company policy if accidental dislodgement occurs with a suprapubic catheter. No harm occurred to the residents as a result of the occurrence.</p> <p>1. How to Identify Other Residents With Potential for Similar Events: Failure to follow company policy regarding suprapubic catheters may have had the impact to affect other residents, however no other residents were affected during this timeframe.</p> <p>1. Systemic Changes: The Executive Director and Health Wellness Director will instruct associates on nursing skills following company policy. The Executive Director and Health and Wellness Director will monitor and educate nurses on appropriate skills and policies and procedures that comply with community.</p> <p>1. Monitoring Q.A. Plan: All nursing practices will be reviewed by the Health and Wellness Director</p>	

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	<p>catheter care protocol, dated January 2003, and indicated the policy was the one currently being used by the facility. The protocol indicated if accidental dislodgement occurs, cover with 4x4 sterile gauze dressing and secure with tape. Notify physician for orders.</p> <p>Review on 1/8/15 at 9:30 a.m. of Resident #A's shift report dated 12/13/15, only indicated a new catheter was inserted.</p> <p>Documentation and interview of LPN #2 did not indicate LPN #2 had followed facility policy and procedure.</p>		<p>or Executive Director for compliance. 1.Expected compliance will be on or before February 10th, 2016 and ongoing.</p>				