

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 11/10/2014
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NAME OF PROVIDER OR SUPPLIER  BRENTWOOD AT HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342
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R000000	<p>This visit was for the Investigation of Complaint IN00159070.</p> <p>Complaint IN00159070- Substantiated. State residential deficiencies related to the allegations are cited at R053, R090 and R349.</p> <p>Survey date: November 10, 2014.</p> <p>Facility number: 002627 Provider number: 002627 AIM number: N/A</p> <p>Survey team: Cynthia Stramel, RN, TC</p> <p>Census bed type: Residential: 123 Total: 123</p> <p>Census payor type: Other: 123 Total: 123</p> <p>Sample: 5</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on November 11, 2014, by Janelyn Kulik, RN.</p>	R000000	<p>The following is the Plan of Correction for <b>Brentwood at Hobart</b> in regards to the Statement of Deficiencies dated 11/10/14. This 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 any related sanction or fine. Rather, it is a 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 identified issues. We have not provided a detailed response to each allegation or finding, 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.</p> <p>-</p>	
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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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R000053	<p>410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse.</p> <p>Based on record review and interview, the facility failed to follow interventions put into place following resident to resident verbal abuse for 1 of 3 resident's reviewed for abuse. (Resident #C and Resident #D)</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 11/10/14 at 10:00 a.m. The resident resided on the Memory Care Unit. Resident diagnoses included, but were not limited to, dementia and emphysema.</p> <p>The resident's wife, Resident #D also resided on the Memory Care Unit. Her diagnoses included, but was not limited to, dementia.</p> <p>Resident #C Nursing note dated 10/28/14 at 6:00 a.m., indicated a Resident Aide (RA) witnessed the wife get up and start yelling at resident who was seated in the room, the RA intervened and returned both residents to bed.</p>	R000053	<p>This 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 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><b>1.Res.# C and #D are allowed to be in each others presence only in common areas under supervision.</b></p> <p><b>1.Staff to be interviewed by Health and wellness director and memory care director by 11/17/14 to identify any other residents that may have been effected by the</b></p>	11/17/2014			

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	<p>Resident #C Nursing note dated 11/3/14 at 11:15 a.m. indicated, "Nurse was letting home health nurse into resident's room when spouse of resident refused to open door. Resident sitting on floor without 02...nurse had resident removed from room via w/c (wheelchair) for safety".</p> <p>Resident #D Nursing note dated 11/3/14 at 4:00 p.m. indicated, "Resident threatening to shoot her spouse and not wanting his good health or safety to be observed by staff because she states he needs to learn his lesson..."</p> <p>Resident #C Nursing note dated 11/3/14 at 10:30 a.m., indicated staff was instructed to closely monitor the residents when in common areas and they were to be in separate rooms at night. Memory Care Director (MCD) spoke with Executive Director (ED) regarding wife verbally threatening the husband with a gun on 11/2. Resident #C was errantly relocated to Room 422.</p> <p>Interview with LPN #1 on 11/10/14 at 10:15 a.m., indicated the husband and wife argued often and had been moved to rooms on opposite ends of the unit last week.</p>		<p><b>alleged deficient practice and will address each instance per policy if indicated.</b></p> <p><b>1.Res. #D sent to behavioral hospital for behavior management and medication review. Res. #C and Res.# D plan of care have been updated and staff on unit educated on service plans and residents rights by 11/17/14</b></p> <p><b>1.Memory Care Director or designee to review resident behaviors daily and discuss monthly in QA meeting times 6 months.</b></p> <p><b>Completion Date</b></p>				

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	<p>Interview with LPN #2 on 11/10/14 at 4:00 p.m., indicated she had received report of the verbal incident on the following day. She was told the wife had made gun gestures with her hand to the husband while threatening to shoot him.</p> <p>Interview with RA #1 on 11/10/14 at 1:15 p.m. indicated the husband and wife argued frequently. They would be fine one moment and yelling the next moment. These were not new behaviors. The RA indicated the couple had been moved to separate rooms, but last night the husband slept in the wife's room because he had been given a pass to do so. The RA indicated the wife was fine this morning, but had become combative with staff this afternoon, and had barricaded herself in the room. The husband was not currently in the room.</p> <p>Further review of Resident #C Nursing notes dated 11/9/14, time ineligible, indicated, "No behaviors, MCD says it's okay for them to room together (he and spouse) for the night".</p> <p>Interview with the ED on 11/10/14 at 4:15 p.m. indicated she was not aware the resident's were allowed to room together last night, they were to be in separate rooms at night. She indicated she would further educate staff.</p>						

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R000090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p>			

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	<p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to notify the State Agency of an allegation of verbal abuse for 1 of 3 allegations reviewed. (Resident #C and #D)</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 11/10/14 at 10:00 a.m. The resident resided on the Memory Care Unit. Resident diagnoses included, but were not limited to, dementia and emphysema.</p> <p>The resident's wife, Resident #D also resided on the Memory Care Unit. Her diagnosis included, but was not limited to, dementia.</p> <p>Resident #D Nursing note dated 11/3/14 at 4:00 p.m. indicated, "Resident</p>	R000090	<p><b>1. Verbal altercation between Res #C and Res # D reported to ISDH on 11/10/14.</b></p> <p><b>2. All residents had the potential to be effected by the alleged deficient practice. Staff re-educated on resident abuse policy on 11/14/14</b></p> <p><b>3. Executive Director or designee to quiz staff on all shifts monthly on each shift regarding abuse policy times 6 months</b></p> <p><b>4. QA committee to review staff abuse quizzes monthly at QA</b></p>	11/21/2014			

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	<p>threatening to shoot her spouse and not wanting his good health or safety to be observed by staff because she states he needs to learn his lesson..."</p> <p>Resident #C Nursing note dated 11/3/14 at 10:30 a.m., indicated staff was instructed to closely monitor the residents when in common areas and they were to be in separate rooms at night. Memory Care Director spoke with Executive Director (ED) regarding wife verbally threatening the husband with a gun on 11/2.</p> <p>Interview with LPN #2 on 11/10/14 at 4:00 p.m., indicated she had received report of the verbal incident on the following day. She was told the wife had made gun gestures with her hand to the husband while threatening to shoot him.</p> <p>The current policy Reportable Unusual Occurrence was received from the Wellness Director on 11/10/14 at 12:00 p.m. Verbal abuse was included and was defined as, "... use of oral or gestured language that willfully includes disparaging and derogatory terms to resident or their families..." The policy indicated verbal abuse included resident to resident threats of harm.</p> <p>Interview with the ED on 11/10/14 at</p>		<p>meeting</p> <p>5. Completion date</p>				

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R000349	<p>4:15 p.m., she indicated this was verbal abuse and should have been reported to her, and should have been reported to the State Agency.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (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, record review and interview, the facility failed to ensure each resident's clinical record was complete and accurate related to documentation of a head wound and follow up assessment of head wound for 1 of 3 resident's reviewed for falls. (Resident #C)</p> <p>Findings include:</p> <p>On 11/10/14 at 9:00 a.m., Resident #C was observed seated near the dining area on the Memory Care unit. He had a raised, gray bruised area approximately 2 centimeters (cm) long by 1 cm wide above his left eye brow. There was a laceration approximately 2 cm long</p>	R000349	<p>1. Res #C's injuries were completely assessed by the resident care director on 11/10/14</p> <p>2. All resident incidents within the past 60 days reviewed by resident care director on 11/11/14 and no other residents were identified to be effected</p> <p>3. Resident Care Director or designee to review all resident incidents and documentation within 24 hours of occurrence to ensure all assessments are complete and accurate. Nursing staff educated on how to complete</p>	11/21/2014			

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	<p>through the middle of the bruised area. LPN #1 indicated the resident had fallen and hit his head.</p> <p>The record for Resident #C was reviewed on 11/10/14 at 10:00 a.m. The resident resided on the Memory Care unit. The resident's diagnoses included, but were not limited to, dementia and emphysema. The record indicated the resident had several falls recently.</p> <p>Post Fall Investigation dated 10/30/14 at 11:30 p.m., indicated resident had fallen outside while getting out of car. There was no injury noted.</p> <p>Post Fall Investigation dated 11/3/14 at 11:00 a.m., indicated resident had fallen in his room. No injury was reported.</p> <p>Post Fall Investigation dated 11/4/14 at 7:15 p.m., indicated resident had fallen in the dining room. Again there was no injury reported.</p> <p>Skin Integrity Tracking Summaries dated 10/31/14 and 11/7/14, indicated the resident had edema to his Right leg that was being monitored. There was no documentation of the head injury.</p> <p>Interview with the Wellness Director on 11/10/14 at 11:50 a.m., indicated skin</p>		<p><b>assessments and documentation by 11/17/14.</b></p> <p><b>4. Resident incident reports to be reviewed by QA committee monthly</b></p> <p><b>1. Completion date</b></p>				

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	concerns were to be documented on an initial incident report, then monitored weekly on the skin tracking form until healed. She indicated the resident's head injury occurred on 10/30/14 fall. Review of the Nursing notes dated 11/4/14 indicated resident was sent to hospital for evaluation and returned with diagnoses of head laceration. She further indicated there was no documentation of the wound on the fall reports or on the weekly skin tracking forms, and it was unclear when the head injury had occurred.				